

# **The Human Right to Health Care: A Distributive Cliché**

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For Anna

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## **Abstract**

The universal human right to health care is a cliché that is frequently invoked by politicians and various activist groups to express the idea that inequalities in the distribution of medical resources are unjust. These disgruntled social reformers are largely uninformed about the true nature of human rights, claiming that any society in which some citizens go without comprehensive medical services is institutionalising immorality by violating Article 25 of the 1948 Universal Declaration of Human Rights. Such uninformed and exaggerated claims only serve to distort the public conception of human rights, obscure the legitimate demands of social justice, and impose unrealistic expectations on health care systems of limited resources. In this paper, I intend to uncover the true meaning of the universal right to health care, ultimately rejecting the commonly held notion that inequality in the distribution of medical resources necessarily entails a violation of human rights.

In Chapters One and Two, I dissect the notion of human rights in order to further define Article 25, discussing any moral and practical implications the acceptance of this right has for both the individual and society. Chapters Three and Four concern the just allocation of health care resources within society, in accordance with the right to health care, and will assess appropriate distributive principles for the health care institution.

## **The Human Right to Health Care: A Distributive Cliché**

Nobody talks more passionately of his rights than he who, in the depths of his soul, is doubtful about them.

**Friedrich Nietzsche**

The universal human right to health care is a cliché that is often invoked by disgruntled social reformers to express the idea that inequalities in the distribution of medical resources are an injustice. It is frequently claimed by these people that universal access to health care is a basic human entitlement, and that any society in which some citizens go without comprehensive medical services is institutionalising immorality. Referring to human rights is a straightforward way of gaining support for any cause; rights have the benefit of being easy for laymen to understand without the need for any prior ethical literacy, often being no more than a few sentences long. They also have the supreme benefit of provoking a strong emotive response from people. If an objection to a current political system can be summed up with the simple catch-phrase “practice X violates human right Y”, then without the need for any further explanation the average citizen will whole-heartedly support reform. As such, human rights are an invaluable tool for politicians and activists, who habitually use talk of rights to convince the voting citizen that a current state of affairs is an affront to human decency.

Proponents of medical reform buttress their position by referencing the United Nations, taking this organisation to be the definitive authority on the subject of human rights. In particular, the often quoted Article 25 of the Universal Declaration of Human Rights (1948) is taken as unquestionable proof that “[e]veryone has the right

to a standard of living adequate for the health and well-being of himself and of his family, including... medical care and necessary social services... and the right to security in the event of... sickness, disability,... old age or other lack of livelihood in circumstances beyond his control.”<sup>1</sup> Impassioned supporters of Article 25 never entertain the possibility that the strong universal claims made by the United Nations could be incorrect, nor do they consider the possibility that inequality in the distribution of medical resources may not necessarily entail a violation of the human right to health care. In this paper, I intend to uncover the moral and practical implications of accepting Article 25. It is not my intention, however, to add yet another paper to the burgeoning literature on whether or not there exist human rights to social goods. My motivating assumption is that there exists, in some meta-ethically mysterious manner that shall be addressed, a human right to health care. From this starting point, I shall investigate what it really means for the individual to hold universal rights in general, and more specifically, to hold a universal right to the social good of health care. This paper is also fundamentally concerned with the many moral and practical problems that arise when such a weighty obligation is imposed on society. The implications of health care for the individual and for society is a topic that was discussed extensively during the United States’ many attempts at health reforms throughout the 1980s and 1990s, but the disputation was largely inconclusive and has fallen from philosophical attention. Since those times, particularly in the United States of America, I maintain that the moral situation has degraded; now more than ever must this debate over universal rights to health care be taken up in a thoroughgoing manner.

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<sup>1</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

To better understand the subject matter, I begin this paper with a descriptive assessment of human rights. It is my hypothesis in Chapter One that the right to health care can only be defined in terms of the right's justified claim on societal resources; or in other words, the right's moral force is in direct proportion to the fiscal realities of society. Article 25 provides the citizen with no real guarantee that they will receive health care as a matter of moral course, despite international consensus that all humans possess an inalienable right to receive medical attention. I argue that this is because the majority of human rights can be over-ruled by sufficiently high social benefits or a considered prioritisation of competing social norms. Under exceptional circumstances, a government's obligation to satisfy the universal right to health care could be so weak that citizens are not justified in receiving any medical attention whatsoever. Furthermore, I conclude that due to the weakened nature of the majority of human rights, this forfeit of care does not constitute a violation of the rights of humans.

Owing to the constitutional importance many societies place on human rights, a coherent rights theory requires strong theoretical foundations supported by even stronger arguments. Rights supporters draw their motivation and passion for defending human rights from a somewhat inherent sense that what they are doing is right and just. It takes, however, a great deal of intellectual labour to philosophically demonstrate human rights to be the self-evident and self-fulfilling moral prophecy they are so often supposed to be. In Chapter Two, I shall attempt to uncover the ethical foundations of the human right to health care. A coherent foundational theory is not only interesting for the sake of philosophy itself, but clarity of analysis has the practical advantage of improving solidarity amongst different campaign groups by



creating a clear common purpose. Foundational appeals can create a long-term commitment to the rights cause, and can significantly improve the exercise of rights by allowing activists to draw on only the most compelling arguments for action. As Michael Freeman succinctly declares:

Rights without reasons are vulnerable to denial and abuse.... Evading the task of finding the best grounding for human rights, in the face of philosophical sceptics and political opponents, demonstrates a lack of intellectual responsibility.<sup>2</sup>

I shall scrutinize three plausible foundations for human rights: theism, human dignity, and basic human needs or interests. This foundational investigation aims to support claims of universality and inalienability, and ultimately provide reasoning for the human right to health care that goes beyond mere appeals to relative culture.

While the right to health care draws our attention to important human needs that must be addressed, merely asserting human rights does not deal with the issue of just health care in a proper manner. The main problem with human rights charters is that they read like a child's Christmas wish list; the representative level of resources chosen by the authors of the United Nations Declarations was too high to successfully protect all the interests it addresses. As such, provision of universal health care is an impossible goal for many societies, and a blind pursuit of universal health care has dangerous potential for absorbing the resources of even the most affluent governments, reducing society to a level of poverty. This is compounded by the fact that Article 25 provides no practical definition or guidance for its fulfilment. The right to health care, then, cannot and must not be affirmed in the same manner as

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<sup>2</sup> Michael Freeman, *The Philosophical Foundations of Human Rights*, *Human Rights Quarterly* 16:3:1994:491-514, p. 493

many other fundamental liberties, such as freedom of speech or the right to own property. Chapter Three and Chapter Four shall address the topic of practical implementation of the right to health care in contemporary societies, discussing ways to distribute scarce medical resources amongst society's needy in an equitable manner, given limited resources. If not all people can be treated equally, which groups must miss out?

It is the main hypothesis of Chapters Three and Four that satisfying the right to health care is a responsibility of social justice, rather than merely beneficent public policy. I intend to assess the long-standing debate over whether health care is a social institution of special importance that is justified in consuming a disproportionate share of society's resources. I shall also assess the morality of inequalities in health care distribution amongst the sick and needy, appraising the inherent justice of current rationing techniques. Moving towards my conclusion, four distributive principles shall be analysed: a utilitarian maximisation of the greatest good, distribution in accordance with income and wealth, distribution in order to produce a strict equality of health levels, and Rawlsian justice as fairness. These largely abstract distributive theories shall be given practical consideration, being analysed in light of a case study that I have carried out on health care distribution in the United States of America.

In short, this paper shall include: (1) a descriptive assessment of the way human rights interact with one another in creating varying degrees of respondent obligation, (2) a foundational assessment so to understand why human rights ought to be obeyed and duties fulfilled as a matter of moral course. I shall then proceed (3) to criticise utilitarian and laissez-faire distribution, then discuss (4) distribution by strict

egalitarianism and Rawlsian justice as fairness. This assessment shall conclude with my own personal suggestions for an acceptable theory of medical distribution, which illustrates the fairest way of satisfying the human right to health care, given real world situations of resource scarcity.

## **Chapter One: Descriptive Analysis of Human Rights**

### **1: Introduction**

Throughout the history of moral rights theory there have been three very similar labels commonly used to address the subject: natural rights, the rights of man, and human rights. The changing name identifies a three-phase transition throughout the history of rights theory, each reflecting very subtle changes in the concept. The term “natural rights” comes from the Enlightenment philosophers, notably the work of John Locke, and serves to connect rights with natural law theory – a system that stretches as far back as Aristotelian teleology. The second term “rights of man” comes from revolutionary France. Heavily influenced by and almost identical in form to natural rights, these emphasise “man” as being naturally in possession of a god-given rational mind and universal moral nature from which universal rights can be deduced. The political philosophy of Montesquieu and Rousseau inspired revolutionary change within France and popularised the idea of man’s equal rights, the rejection of the divine right of kings, and the creation of legitimate governors in accordance with the will of the populace. “Human rights” is a contemporary term that has come into common usage as recently as the establishment of the United Nations in 1945. This term envisages rights as originating in human dignity, more specifically, in the maintenance of human moral inclinations. All three labels tend to refer to the same moral system of entitlements and prohibitions held by virtue of being human; however, the first two terms have some negative connotations as natural rights attach themselves to the controversial and rather obscure notion of natural law, and the rights of man have easily exaggerated sexist overtones. The label human rights is possibly

the least flawed of the three and as such is the term used by the majority of contemporary rights theorists.

Human rights are essentially extralegal. Confused people sometimes observe that legal rights are held by humans, as are contractual rights, so they all must fall into the category of human rights; however, what distinguishes these rights is the origin of their binding force. While legal rights derive their force from the pages of law irrespective of morality, and contractual rights derive from legally and sometimes morally binding agreements, human rights are morally binding irrespective of law. They derive from moral sources that are said to be above the law of any particular country and as such can be used to evaluate the actions of governments, institutions and individuals.

Chapter One is intended to be a descriptive analysis only, therefore it does not contain any proof that these entities actually exist or give reasoning for why we ought to accept their moral dictates. In an attempt to understand what exactly the human right to health care entails I shall first describe the nature of human rights, continuing in Chapter Two to justify these prescriptions.

Section (1a) of this essay shall begin by distinguishing three generations of human rights; the individualistic first generation, the socio-economic second generation, and the non-individualised third generation. Having positioned the right to health care within the second generation of human rights, Section (1b) of this essay shall propose the idea that the right to health care is logically untidy in its imposition of obligation on respondents. Due to the vast array of services provided by the health care institution and the definitional inadequacy of Article 25, the right to health care imposes an obligation of response on health care providers that varies in strength. This strength depends on the nature of the individual's medical need, financial and

technological availability, and other competing norms such as the greater public good and conflicting rights to other social goods. In some cases, the right to health care imposes a strong correlative obligation to provide medical care, while in many cases the obligation to provide medical care is weak. Section (1c) of this essay shall go on to reject the idea that the right to health care is a negative right of omission that is absolutely applicable. What is more, due to the vast array of services provided by the health care institution and the fact that the right sometimes imposes a weak obligation of response, I shall also reject the notion of the right to health care being one of positive assistance. This section shall conclude that the right to health care is a prima facie right, regularly conflicting and requiring trade-offs with competing norms, and imposes obligations of both positive assistance *and* negative omission. Armed with the above distinctions, in Section (1d) I shall refute the proposition that there is no intelligible right to health care, only a human right to health. I conclude that the right to health is merely a negative prima facie right to non-interference that excludes others from interfering in personal health matters; therefore, it is practically worthless as a means towards the moral end of protecting health interests and satisfying medical need.

### **1a: The Content of Human Rights**

It will be helpful first to identify the three different genres of rights content: first generation, second generation and third generation rights. It is arguable that they are named chronologically as to the order they appeared in philosophical history, whereas it could also be said that the ranking is an implication of importance, with the first generation rights being fundamentally prior for the successful exercise of the second and third. This is a contention discussed further in the proceeding pages.

The content of first generation rights are those traditional liberties of self-mastery which initially found expression in the medieval writings of Gersonides and William Ockham. Great philosophers such as Thomas Jefferson, John Stuart Mill and John Dewey have pioneered our modern understanding. The category of first generation rights constitute Articles 2-21 of the Universal Declaration of Human Rights (UDHR)<sup>3</sup> and as a general rule of thumb can best be understood to contain negative “freedoms from X” rather than positive “rights to X”. Although the very nature of liberty as a political concept is essentially contested and perennially open to debate, first generation rights are defended by liberal thinkers as a way of formally providing every person their moral due by securing individual freedom and protection from oppressive forces. The freedoms that comprise these rights are numerous, including freedom from unjust interference in holding property; various freedoms of conscience, expression, and religious practice; and the freedom to live a life and act in a manner desired. First generation rights are generally understood to formally grant a person the freedom to act as he or she wish without interference by others, so long as this action does not impinge on another person’s freedom. A person suffers a violation of first generation rights if he or she is unable to pursue a desired activity that does not conflict with another person’s similar system of rights. Of course, as Isaiah Berlin points out, I cannot declare that my freedom has been violated merely because I have the frustrated will to jump more than ten feet in the air, cannot read because I am blind or cannot understand the darker pages of Hegel.<sup>4</sup> In such cases of frustration there is no interference by others in my sphere of action and it is simply untrue that

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<sup>3</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>4</sup> Isaiah Berlin, *Two Concepts of Liberty*, In: *Four Essays on Liberty: New Edition* (London: Oxford University Press, 2002) p. 122

my lack of ability equates to coercion unless others have made malevolent arrangements to secure such inability. In this sense, my individual freedom is *secured* by the recognition of first generation rights because people must not interfere with my will to act, while simultaneously inappropriate freedoms are *restricted* as I must respect the similar system of rights possessed by others. As Mill once said, “each should be bound to observe a certain line of conduct towards the rest. This conduct consists, first, in not injuring the interests of one another; or rather certain interests which, either by express legal provision or by tacit understanding, ought to be considered as rights.”<sup>5</sup>

Second generation rights or so-called “welfare rights” find their origin in the socialist tradition of socio-economic arrangements designed to secure access to important institutions such as education, housing, employment and health care. Rights of this generation are essentially claims for those goods that act as social safety nets, and are embodied in Articles 22 – 27 of the UDHR.<sup>6</sup> The second generation is generally described as “rights to a substantive good X” rather than “freedoms from X”, although some provide insubstantial benefits such as Article 27:1, the right to participate in the cultural life of the community. Second generation rights secure access to those goods that enhance and protect individual well being, provided on a large scale by the government or similar institution. They are similar to first generation rights in the sense that they are inherently individualistic; however, they require more of an interventionist ethic to justify. An interventionist ethic means that in order to provide welfare institutions of health care, education, unemployment

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<sup>5</sup> John Stuart Mill, *On Liberty*, In: John Gray (ed.) *On Liberty and Other Essays* (Oxford: Oxford University Press, 1991) p. 83

<sup>6</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhcr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.



benefits and the like, the state must tax its citizens and, depending on your beliefs about the legitimacy of taxation, this may constitute an unjust violation of the first generation right to legitimately hold property free from coercion by others (Article 17, UDHR).<sup>7</sup>

It is important to note that although some philosophers attempt to justify the existence of second generation rights by reference to first generation rights, second generation rights are not necessarily justified by the previous generation despite the fact that they are named in such a serial manner. A referential justification for second generation rights, as the name suggests, shows similarities between the readily accepted first generation and the more controversial second. Such an argument points out that first generation rights are valued because they secure personal liberty, and since personal liberty can be infringed not only by political and social oppression but by malnutrition and disease, then rights to welfare goods such as health care are necessary entities as they enable a person to exercise those freedoms that first generation rights protect. Institutions such as the health care system *facilitate* the exercise of liberty, therefore second generation rights to health care must go hand in hand with those first generation rights that *protect* liberty. Henry Shue proposed such a referential argument, stating that “no one can fully, if at all, enjoy any right that is supposedly protected by society if he or she lacks the essentials for a reasonably active and healthy life.”<sup>8</sup> Other successful arguments concede nothing to the previous generation by appealing directly to the importance of the second generation itself. Many prominent philosophers and rights activists declare health care to be equally

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<sup>7</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>8</sup> Henry Shue, *Basic Rights: Subsistence, Affluence and U.S. Foreign Policy*, (Princeton: Princeton University Press, 1980) p. 24

important to an individual's freedom and well-being as the classical liberties secured by the first generation. It was this position the New Zealand political philosopher Jeremy Waldron had in mind when he wrote: "death, disease, malnutrition and exposure are as much matters of concern as any denials of political or civil liberty. Where such predicaments are avoidable, a refusal to address them is an evident insult to human dignity and a failure to take seriously the unconditional worth of each person."<sup>9</sup>

Third generation rights are intended to secure goods not for individual people but for the entire community, usually on an international scale. They take on a mixture of the individualistic and non-individualistic, being mostly first and second generation rights that have been redirected and re-conceptualised to impact on groups of people. The third generation are supported by the largely uninformative Article 28 of the UDHR, which states that "[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this declaration can be fully realised."<sup>10</sup> Article 28 is supplemented by the extensive 1986 Declaration on the Right to Development.<sup>11</sup> Burns Weston summarises Article 28 and the subsequent 1986 declaration into six general classes of rights: "the right to political, economic, social, and cultural self-determination; the right to economic and social development; and the right to participate in and benefit from 'the common heritage of mankind' ... the right to peace, the right to a healthy and balanced environment, and the right to humanitarian disaster relief".<sup>12</sup> These "solidarity rights"<sup>13</sup> are best understood as first

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<sup>9</sup> Jeremy Waldron, *Rights*, In: R. Goodin and P. Pettit (eds.) *A Companion to Contemporary Philosophy* (Massachusetts: Blackwell Malden, 1998) p. 579

<sup>10</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhcr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>11</sup> The Office of the High Commissioner for Human Rights, *Declaration on the Right to Development*, <<http://www.unhcr.ch/html/menu3/b/74.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 2.

<sup>12</sup> Burns Weston, *Human Rights*, *Human Rights Quarterly* 6:3:1984:257-283, p.266

and second generation rights that have been reoriented to ensure the self-determination of collective entities. The content of this generation suggests that these rights derive, not from liberal or socialist concerns, but from the recognition of the possible failure of the nation-state (hence the rights to peace, a clean environment, and humanitarian aid) and also the emergence of third world nationalism (hence the rights to self-determination, development, and participation).

Because they are non-individualistic rights that secure goods enjoyed collectively by groups, third generation rights cannot be justified by reference to a previous generation as they have no liberal provenance. It is hard to put forward a convincing argument grounded in individual liberty for non-individualistic public goods such as collective self-determination. A more likely solution is to appeal to the idea of group or community rights; however, the debate over whether or not groups can be relevant moral entities is unresolved, particularly in the arena of rectificatory justice.<sup>14</sup>

All liberal theorists will grant the legitimate existence of first generation rights, some non-libertarians recognise second generation rights, but the justification of third generation rights is heavily contested and many rights theorists consider the third generation as stretching the concept of rights too far. “[T]he new claims represent a degradation of the currency of rights,” Waldron objects, “a hijacking of the concept by ideologies who are very little concerned with its liberal provenance.”<sup>15</sup>

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<sup>13</sup> B. Weston, (1984), p. 266

<sup>14</sup> Joseph L. Cowan, Inverse Discrimination, *Analysis* 33:1:1972:10-12, and Michael D. Bayles, Reparations to Wronged Groups, *Analysis* 33:6:1973:182-184 are a good summary of the arguments involved. A serious logistical problem involved with group rights is that we can only secure third generation rights for a group of people by granting entitlements to each *individual* member of the group. Because groups are nothing more than a collection of individuals they cannot have a well-being independent from that of their members. In this way, third generation rights which are devised specifically for groups are reduced to the second or first generation.

<sup>15</sup> J. Waldron, (1998), p 578

Owing to constraints on space I must leave the issue of the legitimacy of third generation rights unresolved here. This paper is concerned primarily with the second generation right to health care, a topic that does not stray too far from the safety of established liberal tenets but “hijacks” the concepts just enough to make for an interesting and controversial discussion.

### **1b: Rights and Obligations**

Rights that do not flow from duty well performed are not worth having.  
Mahatma Gandhi

Investigation of a rights-based approach to political morality raises the question of what is meant when it is stated that P has a right to X. Today this expression is bandied around by almost any person out to promote their own interests – people demand a right to more parking in town, a right to keep a dangerous animal as a pet or a right to yell profanities from a soap box in the town square – but, as Beauchamp and Faden point out, “it is not sufficient grounding for a rights claim that one can argue forcefully that one ought to receive a good or service.... Even if there are strong arguments to favour publicly funded health programs, it does not follow that anyone has a right to health care through these programs because of these arguments.”<sup>16</sup>

A person having a right to receive certain goods does not necessarily mean that they will receive these goods in full, every time they are requested. Rights are only a part of a more general account that stakes out a valid claim, so in order to construct a complete rights theory there must also be a workable theory of respondent

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<sup>16</sup> Tom L. Beauchamp and Richard R. Faden, The Right to Health and the Right to Health Care, *Journal of Medicine and Philosophy* 4:2:1979:118-131, p. 119

obligation; a theory that states the strength of the obligation imposed on others in response to human rights. Assuming second generation rights to health care do exist inalienably within us all and assuming that claims can be legitimately made for a slice of governmental assistance, I shall now demonstrate how a respondent may legitimately refuse goods and services despite there being human rights to those goods. In other words, I shall investigate instances where the human right to health care does not strictly create or impose an obligation for society to provide a standard of health care.

Traditionally it is held that there exists a strict logical rule stating that rights and obligations are necessarily co-existent. Neither the right nor obligation can arise without the other, and when one is given up the other vanishes; a relation which David Lyons called “conceptual correlatives”.<sup>17</sup> An example of this strict logical correlation is if Alvin were to exercise his right to be free from non-consensual medical procedures, then the obligation not to medicate Alvin is created in all possible respondents by logical necessity. If either aspect of the correlation is missing – if a person holds a right without any identifiable respondent or if there is a respondent obligation without corresponding rights<sup>18</sup> – the remaining counterpart is made redundant or becomes “practically superfluous”.<sup>19</sup> It is nonsensical to exercise a right to be free from non-consensual medical procedures without there being anyone around to administer such procedures. The right is made practically superfluous without an identifiable respondent to interact with. *Vice versa*, it makes no sense to be

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<sup>17</sup> David Lyons, The Correlativity of Rights and Duties, *Nous* 4:1:1970:45-55, p. 47

<sup>18</sup> It goes without saying that it is possible to have moral obligation without rights, such as an obligation of charity, where we are not obliged to practice that virtue towards any particular person. The rule of conceptual correlativity is not intended to cover duty that one merely ought to do, in this weaker sense of ought. Interest lies only with the strict relation between rights and the respondent obligation rights are supposed to create.

<sup>19</sup> David Braybrooke, Abstract of Comments, *Nous* 4:1:1970:56-57, p. 57

obliged (in the strictest sense of the term) to omit medical procedures on unconsenting agents if there is nobody around to treat in such a manner. The obligation becomes practically superfluous without a rights-subject to interact with. Although people still possess the right (owing to its inalienable nature), the rule of conceptual correlatives maintains that the right/obligation becomes practically superfluous whenever it lacks a strict logical correlation with its corresponding obligation/right.

It is important to also keep in mind that the concepts of right and obligation necessarily have content – in this example non-consensual medical treatment – and just as there is a formal rule of correlativity connecting the concepts of right and obligation, the content too must match up according to that rule. An agent's right to be free from *non-consensual medical treatment* must correlate to a respondent obligation not to administer *non-consensual medical treatment*. According to Lyons, the traditional rule of strict conceptual correlatives says that “rights imply duties (even if not all duties imply rights) and also that claims of individual rights need not be recognised unless backed by proof that corresponding obligations obtain.”<sup>20</sup>

Lyons argues that while these strict conceptual correlatives are quite common and familiar in cases of promise keeping and contracts, wrongful injuries that require reparations, and parent-child and student-teacher relationships, the correlation is not as all-encompassing as initially proposed because some rights do not strictly correlate to an obligation. He accepts cases of strict correlativity where rights and obligations are necessarily co-existent, but conceptual correlatives do not exhaust all possible relations, since a large number of important rights impose obligations on respondents in a fitful manner. Just as many obligations do not necessarily entail rights, there exist rights that do not necessarily entail moral obligations.

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<sup>20</sup> D. Lyons, (1970), p. 45

Consider another example of Alvin who is now exercising his right to stand in front of a crowd and protest against the Vietnam War. This is what Lyons calls an “active right”;<sup>21</sup> a right to actively do something (to be contrasted with Alvin receiving ten dollars from a debt, which is a passive right). If the conceptual correlative rule holds, it is a direct logical result that all those present at Alvin’s speech have an obligation of non-interference placed upon them purely by virtue of Alvin exercising his right: they necessarily have what is called a “passive obligation”<sup>22</sup> imposed on them by the speech-making (in contrast to active obligation). The audience are obliged to refrain from killing, kidnapping, assaulting, coercing or blackmailing Alvin for the duration of his speechmaking because to act in such an offensive way would, amongst other things, violate his right to free speech. The problem with the conceptual correlativity thesis in this case is that all those present at the rally have the passive obligation not to interfere with Alvin *regardless* of Alvin exercising his right to express himself. If these passive obligations of non-interference truly are a strict conceptual correlative of Alvin’s right to free speech, they must necessarily be coexistent with the right, tied to the act of speechmaking, and become waived once the right to free speech is no longer exercised and speechmaking is concluded. These obligations of non-interference are not extinguished. In fact, these restrictions are placed on all people regardless of Alvin’s speechmaking; therefore, Alvin’s right to free speech does not impose a logically corresponding and necessarily coexistent obligation of non-interference on respondents. Moreover, the correlative rule maintains that the content of the right must match up to the content of the obligation, so the active right to *free speech* must

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<sup>21</sup> D. Lyons, (1970), p. 48

<sup>22</sup> D. Lyons, (1970), p. 48

create a passive obligation of non-interference in *free speech*; however, in this counter-example the content is mismatched. The content of the obligation is a general non-interference in the affairs of others, while the content of Alvin's active right is specifically to free speech.<sup>23</sup> Even if Alvin were completely unjustified in his speech making and had no right to do so, for example if he were inciting violence in an angry mob, there is still an overwhelming obligation not kill, kidnap, assault, coerce, or blackmail Alvin. The only recourse of the crowd would be to call the authorities and let them, with their extended powers of persuasion, pursue such avenues.

This counter-example, as devised by Lyons, drives a wedge between the right and obligation, rejecting any logical connection and necessary co-existence the two were supposed to possess. Alvin possesses the right all the time, and the crowd are constantly obliged to act in certain ways around Alvin, but the two are not logically connected and definitely not necessarily co-existent. As a result, Lyons has demonstrated that there exist situations where a particular right does not necessarily invoke respondent obligation. Lyons concludes that:

Since others are prohibited in general from (e.g.) assaulting, threatening coercing and forcibly restraining Alvin... [i]t may seem as if these obligations follow from, are 'part' of or 'correlate' with Alvin's right. But once we see that these obligations apply generally, whether or not Alvin acts within his rights, and that this is what makes it seem as if they follow from Alvin's right, we should no longer be tempted to say that they follow.<sup>24</sup>

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<sup>23</sup> It is imperative to this counter-example to keep in mind that, just as the right correlates to the obligation, the content of the two must also logically correlate, with the active right to free speech directly invoking a passive obligation not to interfere in the speech. "The rule is that the expression of the content of the right is related to the expression of the content of the obligation as the passive is related to the active voice." D. Lyons, (1970), p. 48

<sup>24</sup> D. Lyons, (1970), p. 53



Braybrooke points out that although Lyons' line of argument may successfully sever the logical connection between active rights and passive obligation (or in his words, makes rights and obligations "logically superfluous"<sup>25</sup>), this does not make rights meaningless or redundant (or in his words, "superfluous practically"<sup>26</sup>). Rights are inalienable and exist within human-kind even when they are not being exercised or imposing obligation on others. Despite lacking a strict logical correlativity with obligation, the right is still completely intelligible as a moral entity. Braybrooke asserts that:

Both an active right and the associated implication (i.e. the obligation) could exist even though logically superfluous. Their being logically superfluous would not, moreover, imply their being superfluous practically. Nor would it follow from (the right) being superfluous practically (the obligation being heeded anyway) that [the right] does not exist.<sup>27</sup>

A number of human rights are ambiguous in their formulation. This is particularly true of second and third generation rights, which are designed to be equally applicable to a variety of international institutions. Where I call rights "ambiguous", Braybrooke gives perhaps a more appropriate label, claiming that rights have an "open texture".<sup>28</sup> By this he simply means that rights can be interpreted in a variety of different ways depending on the situations surrounding their exercise. It follows from this open texture that the degree of obligation imposed on health care providers will fluctuate in strength, depending on the particular interpretation and institutional arrangements surrounding the exercise of the right. Article 25 of the UDHR is clearly inadequately worded to impose a definitive and

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<sup>25</sup> D. Braybrooke, (1970), p. 57

<sup>26</sup> D. Braybrooke, (1970), p. 57

<sup>27</sup> D. Braybrooke, (1970), p. 57

<sup>28</sup> David Braybrooke, *The Firm but Untidy Correlativity of Rights and Obligations*, *Canadian Journal of Philosophy* 1:3:1972:351-363, p. 360

uniform respondent obligation: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care.” As a result, the obligation imposed on Malawian or Haitian health care systems will be completely different –weaker and less demanding – than the obligation imposed on the more affluent systems of New Zealand, the United States and the Netherlands.

The conclusion that may be draw from this discussion of rights and obligation is; primarily, that the rule of conceptual correlativity holds in limited cases. Some obligations are strict conceptual correlatives, being necessarily co-existent with rights. The prime example is Alvin exercising his right to be free from non-consensual medical treatment and all others being necessarily obliged to respect this. Secondly, sometimes a right implies a subtle relation to an obligation. Lyons demonstrated that while this is not the strict logical relation evidenced above, it is a relation nonetheless that Braybrooke best describes as an “implication to the obligation from [Alvin’s] right”.<sup>29</sup> Lyon was right in saying that the crowd is generally obliged not to interfere with Alvin at all times, not specifically because he is in the process of speaking. However, if someone were to shoot Alvin mid-speech then surely this would violate not only his general right to integrity of person but also his specific right to free speech; so, although the contents do not logically correlate, it can be seen how the specific right to free speech does loosely imply a general obligation of non-interference. Finally, some cases would require extended debate about the relevant connection between right and obligation because there exists no obvious logical correlation *and* no subtle relation. Flying a skywriting plane overhead or turning the thermostat up to 35 degrees is questionable interference in Alvin’s right and as a

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<sup>29</sup> D. Braybrooke, (1972), p. 361

result, a duty of non-interference may not be broken. Individual cases with blurry relations such as these are best debated on a case-by-case basis in a court of law or philosophy class, with novel cases becoming precedents to clarify future transgression. “Clearly, the situation with respect to the obligation, so viewed, not to interfere with [Alvin’s] speaking publicly is *logically untidy*”<sup>30</sup>; therefore, it is now agreed amongst the philosophical community that there is a “firm but untidy correlation between rights and obligation”<sup>31</sup>, with the strict conceptual correlative and subtle implicit duties being morally binding to varying degrees depending on their strength of relation to the right. It can even be maintained that some rights have questionable loose “duties” that carry no morally binding force as they may hold no relation whatsoever to the right.<sup>32</sup> This firm but untidy correlation is reiterated by prominent rights theorist, Alan Gewirth:

The idea, then, is that when duties are correlative with rights, fulfilment of the duties is morally required, as against loose duties whose b[e]neficiaries are also individuals but without the correlativity with rights or the accompanying modality of requirement. It is in connection with the latter duties that potential beneficiaries may have to ‘beg or entreat’, not because of the *psychological* recalcitrance of potential duty-bearers but rather because, as a matter of normative modality, fulfilment of such duties is not morally required.<sup>33</sup>

Strong arguments can be made that the right to health care is a strict conceptual correlative of the obligation to provide only the most important medical care, obliging the state to devote resources in limited cases; for example, controlling a

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<sup>30</sup> D. Braybrooke, (1972), p. 360

<sup>31</sup> D. Braybrooke, (1972), p. 351

<sup>32</sup> Just because the duty does not relate to human rights this is not to say that they cannot be morally binding in other ways. It has been argued by Libertarian theorists who oppose the concept of positive rights that a morally binding duty to provide health care could derive from other concerns, such as charity. Utilitarian considerations may also come to similar conclusions out of concern for the greater good.

<sup>33</sup> Alan Gewirth, *Rights and Duties*, *Mind* 97:387:1988:441-445, p. 443

highly infectious and dangerous disease or providing clean drinking water and adequate waste disposal. Sometimes the right does not correlate strongly to an obligation and as a result there is only a loose implication. In such cases, the state will only have to provide restricted or selective treatment, meeting the rights holder halfway. The piecemeal funding of pharmaceuticals seems to exemplify this implicit relation as there is no strict obligation on the state to provide a comprehensive array of treatment options, only an acceptable minimum. At other times, there is no obvious correlation or implication at all between the right and the obligation and therefore the state is not morally obligated to respond to the right holder. Non-restorative cosmetic surgery is provided by the same medical establishment as restorative treatments, yet the health care institution is not obliged to fund such procedures in response to any purported right to health care. In this manner, the right to health care seems to be the prime example of an open textured right that fitfully imposes obligation on respondent institutions according to no hard or fast rule of correlation, depending heavily on situational context.

Not all cases of exercising a right to health care will necessitate a response from health care providers. When combined with the prima facie nature of rights, the effective exercise of the right to health care is weakened by variable factors such as the availability of resources, society's level of technological development, the moral importance of competing social projects, and the demands of the greater good. Depending on how these factors play against the implementation of a health care system, the respondent obligation imposed by the right could easily fall far short of a strict logical correlation or even loose implication.

### **1c: Negative Absolutes and Positive Prima Facie Rights**

Genuine tragedies in the world are not conflicts between right and wrong. They are conflicts between two rights.

Georg Wilhelm Friedrich Hegel

The language of rights is a powerful tool that expresses more than a desire to satisfy self-interest, but a morally or legally forceful claim that an action X is the right (or wrong)<sup>34</sup> thing to do and therefore others are morally obliged not to interfere with P doing X. What is more, P having a right to X may entail some further obligation apart from mere non-interference; it could place an obligation of assistance on others to actively promote P's interest in achieving X.

In the case of the first generation right to be free from non-consensual medical treatment, the obligation is one of *negative* omissions. This is not an obligation that is relative to any particular respondent, as all imaginable respondents are morally obliged to withhold medical procedures from the unconsenting rights holder. What is more, since an act of omission is generally cheap and easy to perform, it is logically possible for all right holders to exercise this negative right simultaneously an endless number of times and have it respected. On the other hand, with the second generation right to health care, the obligation generated is to render *positive* assistance. A very laudable but expensive obligation to provide goods and services is imposed on respondents by the rights holder. If a right is *absolute*, this refers to the unlimited exercise of that right, for example the way in which negative acts of omission can be infinitely performed without draining resources or requiring the prioritisation of norms. A *prima facie* right means that norms must be balanced and traded against one

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<sup>34</sup> Jeremy Waldron, A Right to do Wrong, *Ethics* 92:1:1981:21-39

another owing to the regrettable fact that not all conditions can be simultaneously satisfied. For example, it is not logistically possible to positively provide unlimited health care services to every person in the world without diverting funds from and ultimately trading-off between other goods such as education or civil defence.

Based on many similar observations, theorists have generalised that first generation rights are all negative omissions and absolute rights, as they can be exercised simultaneously without contradiction. Second generation rights are positive prima facie rights, constantly coming into conflict and having to be traded off against one another whenever exercised simultaneously. The contested third generation rights merit a passing mention if only for the fact that they do not fit this mould at all, being either positive or negative depending on the context. In reference to the previous section, this distinction between positive prima facie and negative absolutes is complemented by Lyons' distinction between active and passive voices.<sup>35</sup> Alvin can have a passive positive right to receive ten dollars a week from the state, a passive negative right to be born free and equal, an active positive right to seek health care at a hospital, and an active negative right to travel freely around the country.

This way of categorising first generation as negative and the second generation as positive rights is at best a tentative rule of thumb, once it is understood that some first generation rights require substantial positive assistance. On voting day people would be unable to exercise their first generation right to vote in a democratic election unless some authority provides a secure and very expensive voting apparatus staffed by diligent officials. The first generation right to hold property free from interference of others also requires substantial positive assistance in the form of a police force to uphold and enforce property laws. Moreover, second generation rights

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<sup>35</sup> D. Lyons, (1970), p. 48

may contain negative and positive elements, for example in medical cases of preventive care or quarantine where the best medicinal course available is a largely inexpensive act of omission. It may therefore be concluded that the right to health care is a second generation right that contains elements of negative duties of omission and positive duties of assistance. Furthermore, I believe it is a misunderstanding to categorically call the first generation absolute rights and second generation prima facie rights. Ronald Dworkin<sup>36</sup> clearly points out that few rights are absolute because the legitimate exercise of a right must be always be weighed against many other considerations such as cost, expected benefit, likelihood of success, and the greater good of society. Dworkin grants rights the magnificent power to “trump”<sup>37</sup> claims of utility; however, he qualifies this, saying that on special occasions, if the greater social good is significantly greater, then rights claims do not have this power of veto.

Dworkin writes:

Someone who claims that citizens have a right against the government need not go so far as to say the state is *never* justified in overriding that right. He might say, for example, that although citizens have a right to free speech, the government may override that right when necessary to protect the rights of others, or to prevent a catastrophe, or even to obtain a clear and major public benefit.<sup>38</sup>

In the above passage, Dworkin picks out a prime example of a first generation negative right that can be exercised infinitely free of cost, and clearly states three situations in which this so-called “absolute” right can be overruled. On occasion, rights may trump utility considerations, while at other times a sufficiently high utility gain can prevail. This is reasonably standard concession amongst rights theorists.

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<sup>36</sup> Ronald Dworkin, *Taking Rights Seriously*, (Cambridge: Harvard University Press, 1977)

<sup>37</sup> Ronald Dworkin, *Hard Cases*, *Harvard Law Review*, 88:6:1975:1057-1109, p. 1069

<sup>38</sup> R. Dworkin, (1977), p. 191

Rights not only come into conflict with other considerations of social justice such as the greater social good, but also conflict with one another. As a result, there are hardly any recognisable absolute rights, apart perhaps from the fundamental Article 1 “All human beings are born free and equal in dignity and rights.”<sup>39</sup> It is not possible to fully realise second generation rights to public goods such as health care, education, roading and housing, owing to the fact that in a system of limited resources rights must be traded off against each other and resource distribution skewed amongst groups in society. As Beauchamp and Faden poetically point out, there cannot be multiple absolutes without contradiction: “virtually all agree that no right always has the right of way when rights themselves come into conflicting traffic.”<sup>40</sup>

Talk of absolutes is often confused with talk of inalienability, a misconception that results in people mistaking actions are not unjust for human rights violations. In some transcendent and mysteriously metaphysical manner that is explained in Chapter Two, rights adhere to humankind by virtue of being human. This is what the charters and declarations call the inalienable existence of human rights; it is not possible to voluntarily give up or forfeit an inalienable right, since the only condition for possession is simply being human. Inalienable rights are also said to be trans-historical as neither the possession of humanity nor the adhering rights change over time. Even if a society cannot afford a health care system, does not engage in paid employment, or even has no concept of property or religion, the inalienability thesis still insists that there exists full human rights to health care, employment, and associated freedoms and protections. One could even go so far as to say that, within a pre-literate hunter-gather society, there exist full sets of human rights identical to

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<sup>39</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>40</sup> T. Beauchamp and R. Faden, (1979), p. 122



those held by a modern Western liberal society, the only difference between the two being that the former cannot exercise their rights while the latter can. If a pre-literate hunter-gather society was provided with a comprehensive acute care emergency ward they will be just as entitled to service by way of human rights as members of a developed society. The arguable point here is that all rights from any generation *inalienably exist* within humankind; but, owing to resource scarcity, period of historical development, or other considerations of social justice, the majority of these inalienable rights cannot be *absolutely exercised* and must be traded off against one another.

It seems that if there are no resources available to fund a health care system, or if some alternative concerns such as civil defence or the greater public good trump the prima facie right to health care, then the correlation between the right and the obligation weaken to the point that state-funded health care becomes a questionable loose implication lacking moral requirement. This does not mean that the right itself is alienated by not being fulfilled; it simply means that due to the prima facie nature of the right the respondent obligation is not morally binding on that particular occasion.

### **1d: A Human Right to Health**

In health there is freedom. Health is the first of all liberties.

**Henri Frederic Amiel**

To understand the exact nature of a moral right it helps to understand the obligation that the particular right generates; however, rights charters are intended to be to be a moral blueprint for the arrangement of almost any society and as a result tend to leave the finer details of respondent obligation and practical implementation for the society

in question to define. It has been said that the language of human rights is restrictively inflexible and intractable when dealing with important “big ticket” goods such as national health care, and the right itself as stated is extremely uninformative as to how a state must go about realising this great ideal. Article 25 of The Universal Declaration of Human Rights ensures “the right to security in the event of sickness, disability... old age or other lack of livelihood in circumstances beyond his control”<sup>41</sup>, but this fails to justify the sprawling health systems evident in the world today. In the following quotation, Norman Daniels demonstrates the large leap that is taken from the human right, as minimally defined above, to the extensive modern health system, which the right is supposed to support:

I include here our system of high-technology hospital and clinic based medicine, the training institutions for physicians, nurses and allied professionals, and the research and development institutions supporting these forms of health care services. Less visible and less glamorous, but extremely important in their effect on collective health status, are the various public health agencies concerned with preventive programs. I include here the laws and agencies responsible for the control of infectious diseases, nutrition and health education, drug and food protection, consumer product safety, and the regulation of health hazards in the environment, including the provision for clean water and for proper sanitation and other waste disposal. The health care system also involves institutions responsible for social support and personal care services needed by the mentally and physically disabled or the chronically ill.<sup>42</sup>

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<sup>41</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>42</sup> Norman Daniels, *Just Health Care*, (Cambridge: Cambridge University Press, 1985), p. 2

Owing to the open texture of this mysterious moral entity named health care it is hard to see how such a vast array of respondent obligation's can correlate to this nondescript and uninformative 25<sup>th</sup> Article. It is questionable whether goods and services such as educational programs or consumer safety programs can be comprehensively ensured by the somewhat limited right to security in the event of sickness, disability, old age or other lack of livelihood in circumstances beyond one's control. All rights are intended to be held equally, but it is disputable how this ideal pertains to the facets of health care. If the state is (ideally) obliged to provide all persons with equal *amounts* of health care, then the sick would have too little care and the healthy too much; equality with regard to cost, quality, access, and allocation of the resources are likewise troublesome to define and realise. Other human rights such as "Article 4: No one shall be held in slavery or servitude"<sup>43</sup> seem rather self-explanatory as it may be easily determined which practices constitute slavery and servitude and practical methods of realising this ideal may be envisaged; on the other hand, health care seems an ambiguous entitlement that varies dramatically between countries. A small third world African nation will be obliged to implement a radically different health care plan from that of a first world European nation, while an ageing population warrants an entirely different plan from that of a youthful population. As a result, it is a common criticism that "[a] right to health care should not exist because the concept is sufficiently ambiguous that it is impossible to specify precisely what claims it would warrant."<sup>44</sup>

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<sup>43</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhchr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.

<sup>44</sup> Michael Siegler, *Right to Health Care: Ambiguity, Professional Responsibility, and Patient Liberty*, *Journal of Medicine and Philosophy* 4:2:1979:148-157, p. 149

Siegler points out that owing to the ambiguity associated with defining health care and because every society requires different plans for realising the ideal, it makes better sense to have a right to the outcome of a process, namely health, rather than have a right to the ambiguous process itself. Siegler argues by analogy, showing how it is a relatively unquestioned assumption that all humans hold an equal right to education. Education is not valued because it gives teachers a job or because society requires thirteen years of free babysitting while all the adults are all at work during the day; it is valued because it is important to have an informed, literate and socialised society. The act of education is simply a process that has a far less value than the outcome of that process. If we were to set in stone a relatively universal moral necessity such as a human right to education, surely the subject of that right would be a desired outcome, not simply a right to go through the process. By analogy, health care is a process that has health as its end – the colossus that is the health care system does not exist as an incredibly expensive hospice, it exists for the simple purpose of bringing people as close to “health” as is possible. In Siegler’s words, “[h]ealth care is claimed and desired only as a means toward some other good, and that good is health”<sup>45</sup>, so it makes some sense for humankind to possess a universal right to health. If a right to health is to be taken seriously within the framework outlined in the previous sections, I shall now address the question: what kind of right would it be?

There is no way the right to health could be a positive absolute, as this would create what is commonly referred to in medical circles as “medical black holes”. If the right to health had a positive nature, then terminally ill patients would require endless aid and resources to be poured into their ailments, in an expensively futile attempt to bring about slight improvements in their health. The right to health is simply

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<sup>45</sup> M. Siegler, (1979), p. 152

impossible to maintain if it is understood as absolute, because any patient who dies under medical supervision would technically have their inalienable human right to health violated. This constitutes an inevitable, frequent and unacceptable disregard of moral entitlement. Moreover, life-saving medical procedures are exceedingly costly, so if a state were to attempt to realise a positive absolute right to health then medical black holes would divert funds from many other public services, such as education and defence forces, resulting in further rights violations. Any attempts to realise a positive absolute right to health would simply suck society dry of funds and result in numerous undesirable violations of human rights.

Because of the black hole problems associated with a positive right to health and owing to the fact that hardly any rights can be absolute, the right to health must be a negative *prima facie*. To start with, the *prima facie* aspect seems correct because, as I have previously pointed out, it must be possible for one's right to health to be overridden by competing rights or sufficiently high utility considerations. This negative aspect implies that people have a right to their present state of health, whatever that state may be, and that state of health can only be interfered with given sufficiently good reason. This is not a claim to good health, only to health as I currently have it. The idea of a negative right to health is similar to the negative right to hold property; it does not guarantee that a person attain good property or indeed hold any property at all, only that they can retain property free from unjust interference once in their possession.

It is a rather severe implication of the negative right to health that if an individual is born with debilitating illness, contracts a disease, or becomes otherwise disabled and no one can be identified as the cause of the interference, then the state is not obliged to provide restorative care. Genetic disease, birth deformity, pandemics

and accidents of general misfortune will not violate one's negative right to health and hence will not oblige restitution – no one has interfered so there is no identifiable respondent obligation. On the other hand, there will be a strict respondent obligation to cure those ailments caused by others – from assault, car crashes or second-hand smoking related illnesses – although as Bell points out, it can be argued that in these cases rectification is not a moral obligation imposed on the health care system, but an obligation imposed on the perpetrator of the crime. Consider the analogy to property once more, as portrayed by Nora Bell:

Our moral intuitions are that theft and mugging are wrong – that they violate the victim's rights. But the 'right' to be free from mugging and theft is more an interest to be weighted against other interests in the allocation of funds than it is an absolute right... [N]ot only is the 'right' to police protection only one of a number of competing interests, but it is not something legitimately claimed against the state for the state has not violated the right – the mugger has.<sup>46</sup>

While ambiguity is a justified complaint of the right to health care, it appears that the right to health is likewise so to a devastating degree. The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>47</sup>, but the right to health is only intelligible as a negative prima facie right that fails spectacularly in achieving its purpose of returning people to this healthy state. It fails in this task because it rests on the arguable empirical assumption that the majority of disease is socially caused and therefore excludes disease and disability derived from the natural lottery, only concerning itself with disease and disability produced by the interference of others.

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<sup>46</sup> Nora K. Bell, *The Scarcity of Medical Resources: Are There Rights to Health Care?*, *Journal of Medicine and Philosophy* 4:2:1979:158-169, p. 161

<sup>47</sup> World Health Organization Regional Office for South-East Asia, *Constitution of the World Health Organization*, <<http://www.searo.who.int/EN/Section898/Section1441.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 3

Genetic disease, ailments associated with aging, pandemics of influenza, and even devastation from earthquakes and floods will not be covered under the human right to health. As if this did not restrict the class of treatable ailments enough, it is hard to see exactly who is obligated to remedy the right bearer's loss. A case of intentional assault will obligate the assailant to provide health care. This hardly seems plausible. What we need is for the state to be obligated to provide care in a range of cases; however, "on this view [of a negative right to health] society is *not* obligated to *initiate* legislation or programs for the maintenance of my health, nor is it clear that it ought to be."<sup>48</sup>

A *prima facie* right to *good* health seems to be what is required, as this obligates the state to aid in the entire spectrum of disability we intuitively think a health care plan must cover. A right to good health is, of course, a right to positive assistance, which equates to the *prima facie* positive right to health care.

Coming full circle now, Siegler may be correct that this is a right to health care is a right to a mere process, rather than an outcome. It may also be true that "health care" is a rather ambiguous term that requires definition before we can attempt to implement it as a moral standard. Nonetheless, I contend that these are relatively minor issues that pale in comparison to the problems associated with its closest competitor – the negative right to health. Definitions are easily devised for practical purposes and, once formulated, definitions are best assumed simply for the sake of argument. All the right to health care seems to require is some philosophical tidying-up in defining the content of health care, whereas the negative right to health requires far more work than mere definition; it seems fundamentally unworkable and impractical. One may object that this is a rather parasitic defence of the right to health

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<sup>48</sup> N. K. Bell, (1979), p. 161

care (one that feeds off its competitor's weakness). Nevertheless, we possess human rights in order to protect fundamental human interests, and in this case the ill-defined right to health care succeeds at restoring and maintaining human health, autonomy and freedom far better than the practically ineffective and restrictive right to health.

### **1e: Summary and Conclusions of Descriptive section**

Human rights in general are essentially extra-legal entities designed to work as an independent blueprint for assessing the moral appropriateness of governmental action, social institutions, and individual action, irrespective of cultural or political differences.

The right to health care itself is a second generation socio-economic human right held inalienably by all and exercised as a method of ensuring both a moral due of negative omissions and positive allocation of goods and services from institutional arrangements. This human right imposes varying degrees of obligation on health care providers depending on the strength of the logical correlation between the entitlement and the respondent obligation. The health care institution provides some services that are moral necessities in society due to a strict conceptual correlation with the right, for instance the immediate quarantine of all seriously infectious diseases. Other services are loosely implied by the right and carry a weaker moral imperative because full implementation of service is subject to contingencies such as funding constraints and technological availability. The subsidisation and distribution of some pharmaceuticals is an example of a weakened correlation from right to obligation. Other times, there can be no implication from the obligation to the right, so the performance of some health care services is best described as supererogatory.



Article 25 provides us with no informative guidance as to the services included for entitlement and no guidelines as to the level of service a state is obliged to provide, leaving health care ill-defined and impractically broad in definition. What is more, theoretically the prima facie nature of the right leaves us no guarantee that we will receive any health care as a matter of moral course despite international consensus that humans possess an inalienable right to receive it. This is because the majority of human rights can be over-ruled by sufficiently high social benefits or a considered balancing of competing norms; this is especially so for second generation rights to goods and services.

No system can incorporate multiple absolutes without irreconcilable conflict, so to call the successful exercise of health care rights “conditional” seems to be an understatement. As more social programs compete against each other for society’s limited resources and as these programs become exceedingly more complicated and expensive, the societal obligation to set such programs in place becomes weakened and difficult to achieve. As a result, the right to health care is not as clean cut as many rights activists propose. If there are no available resources, or if utility trumps the consideration, or if it is considered that competing interests demand moral priority, then the correlation from the right to the obligation is weakened becoming a loose or questionable implication. Therefore, by its very nature the right to health care is exercised conditionally, being dependent on numerous factors such as the health provider’s fiscal competency, the moral priority of other competing entitlements, the pressures of the greater social good, and the technological or logistical availability of health services.

## **Chapter Two: Conceptual Foundations for a Right to Health Care**

In every country, we should be teaching our children the scientific method and the reasons for a Bill of Rights. With it comes a certain decency, humility and community spirit. In the demon-haunted world that we inhabit by virtue of being human, this may be all that stands between us and the enveloping darkness.

Carl Sagan

### **2: Introduction: Relative vs. Universal**

Philosophy is not always allied with rights activism. Cultural relativism is a philosophy employed by social scientists to counter the inevitable ethnocentrism that plagues inter-cultural analysis. Cultural relativity essentially states a rule that is fundamental to the social sciences of anthropology and sociology; that one must not judge the behaviour of other people by the standards of one's own culture or ethnic background. While cultural relativism is essential for the anthropological battle against ethnocentric bias, this philosophy is defective when applied to ethical analysis, as it often fuels an ideology endorsed by malevolent tyrants and dictators – the idea that it is best for the state to have moral sovereignty over the populace. Many rogue states tend to subscribe to moral relativist ideology, viewing human rights as a liberal democratic invention applicable only to Western democratic society.

Acceptance of this relativist position means that any state can decide for itself those practices that are morally legitimate and illegitimate, making it impossible for others to persuade a government that what it is doing is inappropriate. Human rights are designed to be used as a moral blueprint or objective standard that can be held up against any given state in order to track discrepancy. If the central tenet of radical cultural relativism is applied to ethics – that outsiders are not competent to dictate

moral law to another culture – then the entire concept of international human rights is undermined.

Moral cultural relativists would say that slavery is wrong because society disapproves of slavery, but this goes against a commonsense understanding of justice and morality; most people would argue the other way, stating that society disapproves of slavery because slavery is wrong. Along with offending commonsense, relativism commits the same error as that in the descriptive analysis of third generation group rights; namely, it makes the questionable ontological assumption that entities such as “state”, “community”, or “culture” can possess a moral status. Norms such as human rights are traditionally based on uniform observations about the individual, while moral relativists attempt to base moral rule making uniform observations about culture. This picture of cultural systems as being clearly defined and united entities is incorrect, because in reality the boundary of any culture is practically unidentifiable. Even if some uniform similarities can be identified which to attach the uniting label “culture”, within that culture there are further sub-groups that may hold belief systems diametric to the state defined morality. What is more, a person may belong to more than one group or culture resulting in a further concoction of beliefs. In essence, the moral cultural relativist argument contradicts itself; it claims that since there exists variation *between* cultures it would be improper to impose some external moral standard that applies to all, but then goes on to support an internal moral standard that completely ignores the huge variation that is present *within* the culture.

One alternative to this defective position is to ascribe *universality* and *inalienability* to human rights. Inalienability means a right exists by virtue of the right holder’s existence and cannot be taken away or forfeited. Universality follows from

inalienability, as all humans possess moral rights equally, irrespective of cultural differences. One important distinction is central to universal theories of human rights, which was discussed in Section 1c; human rights exist necessarily as universal and inalienable entities in all people, but, depending on the strength of the respondent obligation, it is possible (and sometimes legitimate) for them to not to be realised. This is because human rights are largely *prima facie* in nature and context-sensitive. Whether rights can be realised or successfully exercised is dependent on the particular society in question and its ability to fulfil the right. It is futile for the activist to campaign for the enjoyment of a right to work, a right to health care, or a right to hold property if a society has no jobs, doctors, or land. Although rights inalienably exist within all citizens, rights are not being illegitimately violated or ignored if they are impossible to realise in a particular context. Illegitimate or immoral violation comes about when it is logistically possible for a state to realise a particular human right, but the right is still ignored.

Chapter One provided a descriptive assessment of human rights by making the assumption that these universal and inalienable entities exist; however, up until now I have provided no proof in the strictest sense of the term that human rights are anything more than a relativist social convention or an empty tool for social progress. Chapter Two shall now proceed to address the issue of why human rights possess this moral authority, demonstrating why we all must abide by their universal and inalienable dictates. The theories investigated commonly hold that the good is prior to the right – they hold that a universal good such as god or human nature, when combined with the power of reason, can produce and justify an itemised list of human rights. I shall investigate three plausible foundations for human rights; theism, human

dignity, and basic human needs or interests. In the order presented these theories represent one “radically universal” position and two “relatively strong universal” positions. This foundational investigation buttresses claims of universality and inalienability, ultimately providing reasoning for human rights that goes beyond mere appeals to relative culture.

## **2a: Theism**

Work on human rights during the Enlightenment attempted to explain and justify the existence of universal and inalienable rights by viewing them, not as a product of the rule and law of any particular society, but as a product of the rule and law of the natural world. Natural Law theory dates back to Plato and Aristotle, and over time has amounted to a large body of complicated literature concerning politics, religion, civil law and ethics. In this brief discussion of Natural Law, I analyse the paradigmatic theory set out by Thomas Aquinas and adopted for use in John Locke’s political philosophy, which holds the following basic tenets:

(1) The natural law is given by god; (2) it is naturally authoritative over all human beings; and (3) it is naturally knowable by all human beings. Further, it holds that (4) the good is prior to the right, that (5) right action is action that responds non-defectively to the good, that (6) there are a variety of ways in which action can be defective with respect to the good, and that (7) some of these ways can be captured and formulated as general rules.<sup>49</sup>

Natural law theory states that, in addition to the culturally relative and ever-changing political (positive) law, there is an objective law that applies to all people irrespective of where they live, their beliefs, historical situation or their political

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<sup>49</sup> Mark Murphy, [The Natural Law Tradition in Ethics](http://plato.stanford.edu/archives/win2002/entries/natural-law-ethics/), In: Edward N. Zalta (ed.) *The Stanford Encyclopedia of Philosophy: Winter 2002 Edition* <<http://plato.stanford.edu/archives/win2002/entries/natural-law-ethics/>> (15<sup>th</sup> of January, 2007)

agreements. Natural law is a product of the “good”. This good is not merely any contingent item that one may deem to be good for life, such as happiness or friendship, but if I were to put together a very long list of all the goods imaginable and somehow rank them in order of their goodness, the good which would be placed at the top of the list would be known as the highest good. Natural law is a product of the highest good, meaning that if one reflects on the attributes and demands of this highest good – be it God (Locke, Aquinas), self-preservation (Hobbes), completion (Aristotle), or whatever else you wish to argue<sup>50</sup> – the “right” or moral rule follows from the good as a conclusion of reason.

Great advances in natural rights theory during the Enlightenment took place against a backdrop of revolution and political instability. In fact, John Locke’s respected *Treatise of Civil Government* is often described as a defence of the “Glorious Revolution” of 1688, when the British government invited the Dutch Prince William of Orange to overthrow King James II, marking the end of absolutism and the beginning of constitutional government in England. By looking at some of the rights charters written during this era and noting the heavy emphasis on theistic and rationalistic justification for the rights listed, the influence of natural law theory on the formulation of famous declarations is evident. The French Declaration of the Rights of Man and Citizen (1789) “set[s] forth in a solemn declaration the natural, unalienable and sacred rights of man... [and] recognizes and proclaims, in the presence and under the auspices of the Supreme Being, the... rights of man and of the

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<sup>50</sup> Not all natural law theorists rely on god as the highest good. While this section is founding natural rights on theistic grounds, it is worth noting that many modern natural law theorists, such as Robert Nozick, use a secular grounding.

citizen.”<sup>51</sup> Another famous example is the United States Declaration of Independence (1776) which reads; “[w]e hold these truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness.”<sup>52</sup>

This natural law is to be distinguished further from what Locke and Aquinas called divine law; the latter being the word of God laid down via mediums or prophets to apply to specific groups of people, and the former being word of God procurable by any rational mind. For instance, Locke considered large sections of the Old Testament, including parts of the Ten Commandments, to be divine law applicable only to the people of Israel.<sup>53</sup> In contrast, natural rights were considered by Locke to be inalienable rules owing to their divine providence and universal because no human being can enjoy rationality and not be bound by its great universal law:

The state of nature has a law of nature to govern it, which obliges every one; and reason, which is that law, teaches all mankind who will but consult it, that, being all equal and independent, no one ought to harm another in his life, health, liberty or possessions. For men being all the workmanship of one omnipotent and infinitely wise maker... they are his property, whose workmanship they are, made to last during his, not one another's, pleasure.<sup>54</sup>

As the above passage suggests, reflecting on natural law produces natural rights, the most important for Lockean civil society being natural property rights. Theistic foundations are evident, as Locke's famous property rights follow from the

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<sup>51</sup> Human and Constitutional Rights, *Declaration of the Rights of the Man and of the Citizen*, <<http://www.hrcr.org/docs/frenchdec.html>> (15<sup>th</sup> of January, 2007)

<sup>52</sup> The US Constitution Online, *The Declaration of Independence*, <<http://www.usconstitution.net/declar.html>> (15<sup>th</sup> of January, 2007)

<sup>53</sup> John Locke, *Works*, In: W. Yolton (ed.) *The Works of John Locke 1632-1704: 9<sup>th</sup> edition*, (London: Routledge, 1997), Sect. 6:37

<sup>54</sup> John Locke, *Second Treatise of Government*, In: J. W. Gough (ed.) *The Second Treatise of Government, and a Letter Concerning Toleration* (Oxford: Basil Blackwell, 1946), Sect. 6

similar idea that people are all the property of God, so all people have a duty to “preserve” themselves and a duty to “preserve the rest of mankind”<sup>55</sup> in a similar fashion. Because people have God given or natural status as equal and independent beings, reason defines the rights and responsibilities of humanity as non-interference in life, health, liberty or possessions. No man has the right to subordinate others (except for limited purposes of self-defence) and those who violate natural rights to non-interference defy the rule of reason and therefore subject themselves to punishment “to such a degree as may hinder [the rights] violation... preserve the innocent and restrain offenders.”<sup>56</sup> For Locke, political society exists when men agree to surrender their natural powers of punishment to some authority, so the purpose of government is simply to protect and ensure those natural rights found in a state of nature.

## **2a. (i): Objections to Theistic Foundations**

*God gave us the gift of life; it is up to us to give ourselves the gift of living well.*  
**Voltaire**

For a long time this theistic interpretation of natural law was acceptable as philosophical foundations for universal and inalienable human rights to non-interference from others; however, in contemporary debates philosophers can no longer justify the existence of universal human rights by simply invoking the good of god. One famous rejection of divine command theory comes from the ancient dialogues of Plato, where Socrates asked the religious expert Euthyphro “whether the pious or holy is beloved by the gods because it is holy, or holy because it is beloved

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<sup>55</sup> J. Locke, (1946), Sect. 6

<sup>56</sup> J. Locke, (1946), Sect. 7



of the gods.”<sup>57</sup> If morality is commanded by god because god recognises such acts as being right, then this implies that god is not the ultimate authority on morality – there is a standard of goodness independent of god which god is referring to in law-making. If divine command theorists reject this unacceptable conclusion, then by default they fall on the second horn of the dilemma, concluding that moral law is right because it is commanded by god. This conclusion is also unacceptable for two reasons: first, the word of god becomes arbitrary as god could have commanded lying and stealing to be virtuous and they would be so. Second, to use descriptive facts (god said “do not steal”) to justify a prescription (do not steal) commits a logical fallacy by arguing from an “is” to an “ought”. Since Augustine and Aquinas understood God as being the exhaustive authority on goodness in the universe, for them it is simply not possible for there to be a supremely good entity independent of God. These thinkers preferred to fall on the first horn of the dilemma, claiming that God must always look inwards to Himself for guidance on the right and the good; He theoretically could demand “immoral” acts as moral, but would never do so as He is essentially good.

Kai Nielsen neatly pointed out a central problem for theistic natural law: “If there is no god... the classical natural law theory is absurd”.<sup>58</sup> I interpret this statement in two ways: the burden of proof is put on those who wish to refute theistic natural law as they must disprove god’s existence and providence; and conversely, apologists face the insurmountable task of arguing that god exists and promulgates natural law. Both of these are contested positions not easily vindicated, to say the least; therefore, the argument reaches stalemate.

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<sup>57</sup> Plato, *Euthyphro*, In: H. Tredennick and H. Tarrant (eds.) *The Last Days of Socrates* (London: Penguin, 1993) 10a

<sup>58</sup> Kai Nielsen, *The myth of natural law*, In: S. Hook (ed.) *Law and Philosophy* (New York: New York University Press, 1964) p. 129

Michael Moore notably sidesteps the problem by applying a technique reminiscent of Ockham's razor. He claims that, because respectable inquiry demands the omission of unnecessary entities when giving explanations, "[i]f non-theistic grounds for the belief in moral objectivity are fully sufficient, then theistic grounds are not necessary."<sup>59</sup> Nielsen points out that there seems to be no hope of refuting the theistic natural law theory by attacking its fundamental premises and disproving either the existence of god or his purported involvement in natural law. It seems, therefore, that Moore is correct in suggesting that the most likely recourse is to argue an acceptable account of objective morality that does not involve god. Even then, if the assumption that god exists is allowed, god's position as the good from which the right derives is made redundant – god is an unnecessary entity in a universe of objective morals not of theistic providence and can be removed from an assessment of natural rights.

Having said this, it is important to keep in mind that there is no way to conclude convincingly that either side of the debate is correct. It makes sense to talk of natural human rights outside a theistic frame, if only for the benefit of avoiding this intractable ontological debate. I believe the final word must go to John Finnis, who views the debate between the faithful defenders and religious sceptics as a circular task of futility; stating that even if non-theistic universal foundations for morality are accepted, this in no way disproves the premise that a creator god could be responsible for those non-theistic foundations:

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<sup>59</sup> Michael Moore, *Good without god*, In: R. P. George (ed.) *Natural Law, Liberalism, and Morality* (Oxford: Clarendon Press, 1996), p. 225

[T]he fact that natural law can be understood, assented to, applied and reflectively analysed without adverting to the question of the existence of god does not of itself entail either (i) that no further explanation is required for the fact that there are objective standards of good and bad and principles of reasonableness (right and wrong), or (ii) that no such further explanation is available, or (iii) that the existence and nature of god is not that explanation.<sup>60</sup>

## **2b: Human Dignity**

Jack Donnelly believes that it is a mistake to view rights strictly as gifts from god, relative entities born of society, or as strictly universal facts of human nature. He makes the motivating observation that nowhere in any contemporary rights bill does it seriously suggest that human rights are founded on theistic goods or relative culture; in fact, the preamble of the International Covenant on Economic, Social and Cultural Rights (1966) makes the positive claim that “these rights derive from the inherent dignity of the human person”.<sup>61</sup> This claim is worth investigation, not only so I can discuss the insights of such an eminent rights theorist, but also because Donnelly’s argument is a logical expansion on the United Nations claim that rights derive from the inherent dignity of man. As such, discussion may prove that the United Nations itself is incorrect in this foundational opinion of human rights, having based global charters on the misguided conception of dignity for the past sixty years.

According to Donnelly, a thoroughgoing moral universalism such as the one portrayed by Locke gives “absolute priority to the demands of the cosmopolitan moral community over all the (‘lower’) moral communities”.<sup>62</sup> This amounts to an intolerable denial of national moral autonomy. What is more, the radically universal

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<sup>60</sup> John Finnis, *Natural Law and Natural Rights* (Oxford: Clarendon Press, 1980), p. 49

<sup>61</sup> The Office of the High Commissioner for Human Rights, *International Covenant on Economic, Social and Cultural Rights*, <[http://www.unhchr.ch/html/menu3/b/a\\_cescr.htm](http://www.unhchr.ch/html/menu3/b/a_cescr.htm)> (15<sup>th</sup> of January, 2007), See: Appendix 4

<sup>62</sup> Jack Donnelly, *Cultural Relativism and Universal Human Rights*, *Human Rights Quarterly* 6:4:1984:400-419, p. 402

position is said to be based on an ethnocentric bias as it ignores the empirical fact that there once existed, and may still exist, traditional African, Chinese, Indian cultures that do not possess concepts integral to rights theory, such as “human”, “individual”, and “equality”. The defender of radical universalism may reply that, in much the same way as individuals can be harmed without their knowing it, these concepts can still apply to some cultures even if the people concerned do not understand them. These cultures that lack the concept of equality may unwittingly be morally defective. In spite of this, Donnelly blindly maintains the cultural relativist defence that pockets of conceptual exclusion not only exist, but a few societies even hold ideological convictions that are entirely incompatible with the exercise of “universal” human rights. Therefore, radically universal human rights are unintelligible and inapplicable to those cultures that do not attach any moral significance to, or do not even possess, the necessary concepts of individuality and equality. As Donnelly puts it, “autonomous individuals are easily viewed as essentially equal. Basic equality, however, is likely to be an incoherent or incomprehensible notion when people are defined, as they usually are in traditional society, by ascriptive characteristics such as birth, age or sex.”<sup>63</sup>

It is Donnelly’s fundamental premise that, “as a matter of historical fact... most non-western cultural and political traditions lack not only the practice of human rights but the very concept”.<sup>64</sup> On this reading one could be forgiven for thinking him a radical cultural relativist; however, he qualifies this position by saying that moral rule is derived from a “relatively universal”<sup>65</sup> human nature. He accepts a universal

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<sup>63</sup> J. Donnelly, (1984), p. 415

<sup>64</sup> Jack Donnelly, Human Rights and Human Dignity: An Analytic Critique of Non-Western Conceptions of Human Rights *The American Political Science Review* 76:2:1982:303-316, p. 303

<sup>65</sup> J. Donnelly, (1984), p. 402

core of human nature only as far as saying that all human beings exist within certain fixed boundaries – we all share a common humanity defined by fixed psychological and biological limits. However, within this universal psychological and biological frame, humans have a tremendous potential to grow spiritually, culturally, and politically into beings that can be quite unfamiliar, repulsive, and even frightening to other humans. Donnelly emphasises the many differences *and* similarities that exist within the common humanity, taking them to be evidence of a relatively universal core of human nature: a fixed physiological and psychological framework reflects the universal aspect of human nature, while an essential relativity is retained owing to a potential for growth into markedly different people.

Because humans all share in this relatively universal human nature, people also share similar fundamental interests that originate from this core, which Donnelly calls “central moral aspirations”.<sup>66</sup> Donnelly takes human rights to be the most effective way a society can protect the fundamental interests or moral aspirations of the populace. When these basic interests are sufficiently protected, the people are said to lead a life that is worthy of humankind, or in Donnelly’s words, the people lead a “life of dignity”. Donnelly gives examples of central moral aspirations: “life, social order, protection from arbitrary rule, prohibition of inhumane and degrading treatment, the guarantee of a place in the life of a community, and access to an equitable share of the means of subsistence.”<sup>67</sup>

Since moral aspiration is derived from a relatively universal human nature, it follows that these basic interests will also be socially relative, with different societies subscribing to different sets of aspirations. Moreover, because a life of dignity is

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<sup>66</sup> J. Donnelly, (1982), p. 303

<sup>67</sup> J. Donnelly, (1984), p. 414-415

nothing more than a life of secured aspiration, conceptions of dignity are also relative to societies. In liberal democratic societies the concept of a life of dignity is protected and maintained by human rights, whereas in traditional Islamic African, Confucian Chinese, and Hindu Indian communities where the concept of human rights is purportedly unintelligible, dignity is protected and maintained by a diverse range of alternative institutional agreements such as religion, social hierarchies and family. These traditional societal practices are neither derivative nor correlative to rights, so this is why some traditional cultures appear to violate enumerated United Nations human rights, such as women's rights to vote, while at the same time maintaining their own concept of female dignity through other means.<sup>68</sup>

## **2b. (i): Enumerating a Human Rights List**

Typically, in order to catalogue and defend any particular list of human rights, philosophers must first identify and defend a particular conception of human nature to work with. Philosophers then proceed to show exactly how a chosen conception of human nature supports a chosen list of human rights. For example, to follow Immanuel Kant's philosophy is to defend the Kantian self-governing individual as a model of human nature and explain how this nature reveals the "categorical imperative" or moral right. Alternatively, to accept a Hobbesian nature of self-preservation requires proof as to how this nature reveals a negative formulation of "the golden rule". In the following quotation, Donnelly refuses to adopt and defend

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<sup>68</sup> It is noted by Donnelly that although these traditional practices protect dignity to some level, the liberal democratic human rights strategy is as effective, if not more effective at achieving a life of dignity as defined by the traditional community itself. He gives no evidence as to the truth of this statement and does not explain why it may be so. J. Donnelly, (1984), p. 314

any comprehensive theory of human nature. As a result, he cannot directly defend a substantive rights list:

[F]ew issues in moral and political philosophy are more contentious or intractable than theories of human nature. There are many well-developed and widely accepted philosophical anthropologies [and]... [e]ach of us probably has a favourite that, up to a certain point, we would defend. But there are few moral issues where discussion typically proves less conclusive. I doubt there is much really new that can be said in defence of any particular theory of human nature. I am certain that I have nothing significant to add.<sup>69</sup>

Defence of an acceptable theory of human nature and defence of the manner in which human nature bestows and enumerates moral aspirations is an issue not taken up by Donnelly because he views such details of philosophical anthropology as beyond his role as a rights theorist. He does say that the human nature underlying his theory is “plausible and attractive”,<sup>70</sup> but fails to provide specific details of how this is so. Owing to his ambiguity, there is no theoretical way of telling what aspirations man’s moral nature demands and no direct way for Donnelly to enumerate a workable list of human rights.

In order to gain content for his theory, Donnelly acknowledges a comprehensive list of prima facie “universal” human rights, namely the various United Nations covenants and bills, which he indirectly adopts as content on the grounds that they are accepted and assented to by a majority of the global community. It must be understood that Donnelly does not expect these rights to range over all societies in all cases. He includes only those societies whose moral aspirations are similar enough to the Western Democratic tradition to have their particular conception

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<sup>69</sup> Jack Donnelly, *Universal Human Rights: In Theory and Practice: 2<sup>nd</sup> Edition* (London: Cornell University Press, 2003), p. 16-17

<sup>70</sup> Jack Donnelly, *Universal Human Rights in Theory and Practice* (London: Cornell University Press, 1989), p. 21

of dignity sufficiently protected by the charters. This relatively universal interpretation of human rights allows limited local exceptions to international rights charters because of traditional ideologies that exclude the practice of human rights, while simultaneously maintaining human dignity in their own “less effective”<sup>71</sup> fashion.

Donnelly contends that leaving the argument from dignity vague and insubstantial (or “empty” as he calls it) is “one of its great attractions”.<sup>72</sup> This is because it leaves his position consistent with most theories of human nature, so long as they are compatible with human rights, without allying with any one particular theory and engaging in irresolvable debates on philosophical anthropology. Donnelly states that “[the argument from dignity] is thus able to provide (relatively) ‘neutral’ theoretical insight and guidance across (or within) a considerable range of positions.”<sup>73</sup> Nonetheless, I must object that the theory is weakened by its inability to directly produce a rights list. After all, there is no point in providing a philosophical foundation of human rights if the argument fundamentally cannot say what rights those foundations support.

## **2b. (ii): Objections to Human Dignity**

There is circularity in the argument from dignity that springs, not surprisingly, from Donnelly’s ill defined and poorly defended conception of human nature. Michael Freeman criticises the way Donnelly utilises an undefined and undefended theory of human nature to produce moral aspiration and dignity. Because of this flaw Donnelly is unable to derive a specific list of such aspirations and, in turn, is unable to produce

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<sup>71</sup> J. Donnelly, (1984), p. 314

<sup>72</sup> J. Donnelly, (1989), p. 23

<sup>73</sup> J. Donnelly, (2003), p. 17



a list of rights designed specifically to protect these human interests. Donnelly does not find this to be a problem, because there is an almost universal consensus on the best way to protect dignity – United Nations rights charters – which his theory can indirectly adopt. For Donnelly, the only reason that this consensus could possibly exist is because it derived from an almost universally accepted theory of human nature, which is undefined and under defended. Freeman concludes that “[t]he consensus is based on the theory. The theory is not defensible, but, to Donnelly, this is not a defect because there is a consensus. The circularity of this argument is vicious because Donnelly himself admits that both consensus and theory are weak.”<sup>74</sup> The entire argument from dignity rests on the moral posit of human dignity while simultaneously refusing to acknowledge any account of man’s moral nature, so, as a result, his moral posit is neither justified nor adequately explained.

In response to this objection, Donnelly emphasises that his argument is merely a description of human rights, as they are understood in the world today. He intends to answer the question “how do rights function in political and linguistic contexts?” not “how are human rights moral entities?” These are two entirely separate tasks. If the project is merely an analysis of how rights work he does not need to philosophically defend a theory of human nature. The above objection is sidestepped. If I allow that the project was intended as descriptive from the beginning, it is permissible to use a theory of human nature in the manner Donnelly does – more like an assumed axiom than an argued premise. As a result, however, his argument from dignity is non-normative and cannot justify moral human rights. This change of tack is inconsistent to the great lengths he takes to argue the foundational importance of human dignity.

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<sup>74</sup> M. Freeman, (1994), p. 503

If this argument is designed truly as a descriptive argument, the argument from dignity cannot provide any reason as to why dignity is morally important and founds human rights, let alone explain why rights must be accepted as moral rule. As far as the indirect adoption of the United Nations content goes, Donnelly seems to think that a strong consensus in favour of a rule adds moral force to that rule, but this is against the entire point of human rights which have traditionally protected the individual against tyranny of the majority. On a descriptive account, just because there exists a list of rights that are accepted by a majority does not mean that those lists have moral force. Donnelly provides no consistent account of his own project and what he wishes to achieve. There are many passages in his text that explain his project as descriptive assessment of how rights work, but then he proceeds to give prescriptive arguments that attempt to found human rights in man's relatively universal moral nature. If his goal were to formulate the argument from dignity in order to normatively justify human rights, then he has failed because he does not adequately explain and defend what he means by man's moral nature. As a result, the argument from dignity is weak because it is impossible for him to directly give rights content. Any attempt to save the theory by reference to indirect content is circular. On the other hand, if he wishes to provide a merely descriptive account of the workings of human rights then he avoids the circularity problem because this analytic project does not require a full account of human moral nature. However, this evasion generates new problems as it provides no moral reason for the adoption of the United Nations lists and undermines his claim that dignity is the foundation of human rights. If his project is a descriptive account, in order to accept the reasoning that dignity founds moral rights he must show how those United Nations lists have moral force beyond consensus.

Without an appropriate understanding of human nature, Donnelly's attempt to base rights in the recognition of human dignity fails. It seems that in some respects references to dignity are an attempt to emotively persuade the reader that rights are a noble cause worth upholding; a proverbial tug at the heart strings. If he intends dignity to be taken seriously as a foundation for human rights, a more rigorous defence is needed. I do, however, approve of Donnelly's middle path of relatively weak universalism as a platform from which to view human rights. Rights are a social practice that the majority of humanity recognises, but there can still be legitimate exceptions. Out of a need to respect the ideologies of those "lower" moral communities who do not share the same moral aspirations of the Western Liberal Democratic tradition, human rights must be *prima facie* universal entities that allow these societies a strictly limited level of moral autonomy. In societies where a level of respect for human beings is maintained through alternative means such as religion or social hierarchy, it must be accepted that these rules can perform identical functions and achieve the same beneficial goals as human rights. The final theory I shall address is best understood from the philosophical standpoint of relatively weak universalism. In my opinion, the following needs based theory is one of the more successful attempts as it is a normative theory for the foundations of human rights which finds support in empirical science and evolutionary theory. Although it is proposed by the theorist in the flawed language of radical universalism, it is not incompatible with my favoured philosophical position of relatively weak universalism.

## **2c: Human Needs**

A man will fight harder for his interests than for his rights.

Napoleon Bonaparte

John O'Manique adopts a needs-based approach to found human rights, claiming that "[a] human right is a person's moral claim to that which is needed for his or her development".<sup>75</sup> Many theorists in the past have taken a needs-based approach to morality by founding human rights directly on recognised need: Christian Bay, for example, claims that "needs establish human rights"<sup>76</sup> and Reginald Green states that "need logically gives rise to a right".<sup>77</sup> The famous psychologist Abraham Maslow devised a hierarchical pyramid of need that ranked security of health as one of the most powerful categories of instinctive human need, second only to breathing, eating and sleeping. While reflecting on such basic needs, Maslow maintains that "it is legitimate and fruitful to regard instinctoid basic needs... as rights".<sup>78</sup>

It is necessary to carefully define what is meant by the term "need", in order to exclude trivial claims that could be better described as "wants" or "preferences". This is because the majority of needs cited by people are either not the type of needs that concern justice and morality, or do not translate successfully into the language of rights. An example could be if "X needs a flu vaccination", then this could correlate to "X has a right to a flu vaccination". On the other hand, "X needs a car" does not translate to "X has a right to a car", in spite the fact that X finds himself in urgent

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<sup>75</sup> John O'Manique, Universal and Inalienable Rights: A Search for Foundations, *Human Rights Quarterly* 12:4:1990:465-285, p. 476

<sup>76</sup> Christian Bay, Self Respect as a Human Right: Thoughts on the Dialectics of Wants and Needs in the Struggle for Human Community, *Human Rights Quarterly* 4:1:1982:53-75, p. 67

<sup>77</sup> Reginald Green, Basic Human Rights/Needs: Some Problems of Categorical Translation and Unification, *Review of the International Commission of Jurists* 27:1981:53-58, p. 55

<sup>78</sup> Abraham Maslow, *Motivation and Personality: 2<sup>nd</sup> Edition*, (New York: Harper and Row, 1970), p. xiii

need of transport. Norman Daniels calls for a “truncated” or “selective”<sup>79</sup> needs criterion; meaning simply that all needs are not created equal and, as such, the criterion used for judging needs must be weighted to favour those that are morally relevant. In one well-anthologised paper, Thomas Scanlon suggests a distinction between subjective and objective needs, favouring only those needs that are objectively identifiable and objectively ascribable:

“By an *objective* criterion I mean a criterion that provides a basis of appraisal of a person’s level of well-being which is independent of that person’s tastes and interests, thus allowing for the possibility that such an appraisal could be correct even though conflicted with the preferences of the individual in question”.<sup>80</sup>

An objective criterion seems to be required to form a truncated scale of need; however, not all objective needs weigh equally with respect to justice. The need for a flu vaccination may be objectively ascribable to all people, but having said this, the needs of some immune-deficient groups such as the elderly will receive moral priority over younger, more flu-resistant groups. To decide a correct weighting of objective needs, Scanlon considers people’s motives and their “urgency” for needing such things – for comfort and status or health and protection against injury. Judging by motive and urgency, needs find their prioritised place on a truncated scale of need satisfaction.<sup>81</sup> On a scale which is truncated to rank health needs, needs for flu vaccination are objectively more urgent than needs for fast cars, while vaccination of the frail elderly is objectively more urgent than vaccination of the strong and youthful.

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<sup>79</sup> N. Daniels, (1985), p. 25

<sup>80</sup> Thomas M. Scanlon, *Preference and Urgency*, *Journal of Philosophy* 72:19:1975:655-669, p. 658

<sup>81</sup> T. M. Scanlon, (1975), p. 660-661

Having concluded with Scanlon that it is proper to only consider objectively ascribable and objectively important needs, the needs theorist must now decide on an itemised list of such needs and place each need on a truncated scale according to urgency. One way of creating a truncated needs list is to appeal to empirical science to determine exactly what constitutes legitimate human need. This has resulted in lists with content such as “minimum quantities of protein, water, carbohydrates, heat, etc”,<sup>82</sup> which is an empirically identifiable content that correlates to rights to those basic goods necessary for the maintenance of life. In contrast to the un-truncated needs criterion, this scientific criterion has the problem that it is far too restrictive to create a satisfactory needs list successfully. While those who propose the scientific needs criterion have no trouble in determining basic necessities for a minimum maintenance of life, using science in this way simply does not go far enough in determining the necessary conditions for a dignified life. If every human being secured minimum quantities of protein, water, carbohydrates, heat and so on, this still would be a far cry from providing a life that is worthy of a human being. Donnelly laments that “‘human needs’ is almost as obscure and controversial a notion as ‘human nature’. Science reveals a list of empirically validated needs that will not generate anything even approaching an adequate list of human rights.”<sup>83</sup> This concern is even echoed by one of the primary advocates of needs-based theories, Christian Bay, who agrees with Donnelly that “it is premature to speak of any empirically established needs beyond sustenance and safety”.<sup>84</sup>

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<sup>82</sup> J. O’Manique, (1990), p. 475

<sup>83</sup> J. Donnelly, (2003), p. 13

<sup>84</sup> Christian Bay, *Human Needs and Political Education*, In: R. Fitzgerald (ed.) *Human Needs and Politics* (Rushcutters Bay: Pergamon Press, 1977), p. 17

### 2c. (i): Survival and Development Needs

The underlying problem with needs-based approaches is that they directly correlate a need to a human right, acknowledging objective need as a necessary and sufficient condition for human rights. Leaving the needs list un-truncated creates an over-inflated rights list, while attempts to truncate the needs list by utilising a scientific needs criterion generates a human rights list that is too limited to secure a life worthy of a human being. O'Manique provides a novel twist to needs-based theories, arguing that only those needs which pertain to human survival and development can found rights. This approach recognises rights that fulfil scientifically ascertainable *survival* needs, such as a minimum quantity of essential nutrients, and also expands the criterion to include *developmental* needs, such as freedoms of expression, association, religious practice, and non-interference.

Investigations into human rights conducted by governments, the United Nations, and assorted human rights scholars often connect the two concepts of human development and human rights. Development is described by the United Nations as both a process one may undergo while under the protection of rights and as a highly desirable goal and a right in itself. O'Manique states that “[development] is to change from what is to what is believed (by the individual or community) ought to be the case”;<sup>85</sup> and elsewhere he defines development as “a process (of individual or community) of actualising what is believed... to be good.”<sup>86</sup>

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<sup>85</sup> J. O'Manique, (1990), p. 466 fn.

<sup>86</sup> John O'Manique, Human Rights and Development, *Human Rights Quarterly* 14:1:1992:78-103, p. 81

This is similar in formulation to the definition used in the United Nations 1986

Declaration on the Right to Development, which states that:

“[D]evelopment is a comprehensive economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom.”<sup>87</sup>

The health care system can easily be understood as an institution concerned with helping people survive. What is more, modern health care institutions are also intimately concerned with the development of patients and even the development of members of the wider healthy community. Medical practitioners not only help people to survive physiologically by treating debilitating ailments, but also provide rehabilitative, educational and social working services that aid people in their psychological, social and even spiritual development.

By using this survival-development needs criterion, O’Manique finds no trouble in enumerating human needs and formulating a comprehensive and legitimate list of human rights similar, if not identical, to the United Nations declarations.<sup>88</sup> He claims that this is because “all real needs, including those that relate to [development], are, at least in principle, empirically testable or can be inferred from empirically confirmed premises.”<sup>89</sup> Basic requirements for the maintenance of life can easily be determined through biology, and human developmental needs can be ascertained through psychology and the social sciences. If a human need for haemodialysis,

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<sup>87</sup> The Office of the High Commissioner for Human Rights, *Declaration on the Right to Development*, <<http://www.unhcr.ch/html/menu3/b/74.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 2

<sup>88</sup> J. O’Manique, (1992), p. 84

<sup>89</sup> J. O’Manique, (1990), p. 476



primary education, or non-interference in life and liberty can be empirically determined to be necessary for survival and development, then, according to O'Manique, that particular survival and development need correlates to a basic human right.

## **2c. (ii): Evading Logical Fallacy**

O'Manique recognises that many philosophers who have attempted to ground human rights have encountered problems in their attempts to make descriptions logically entail prescriptions.<sup>90</sup> As a result, he does not attempt to make needs logically entail rights, but still provides an empirical formula for identifying valid rights claims. In keeping with the law of David Hume that it is a logical fallacy to deduce an “ought” from “is”, O'Manique is not trying to prove that normative rights claims can be logically deduced from empirical survival and development needs. O'Manique goes to great lengths to point out that “[t]his is not one more useless attempt to derive ought from is; there is no logical connection here.”<sup>91</sup> The truth of a rights claim cannot be proven nor denied in any empirical sense, nor deduced logically from the existence of needs. Whether a person possesses survival or development needs is a

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<sup>90</sup> Most notably see Alan Gewirth's *Reason and Morality* (Chicago: University of Chicago Press, 1978) for his attempt to ground a universal moral principle – “Act in accord with the generic rights of your recipients as well as of yourself” p.135 – in necessary descriptive features of human action. This attempt fails, primarily because while there may be forceful reasons for acting in accordance with ones own generic rights, Gewirth cannot logically universalise these reasons so they apply with equal force to the generic rights of others. My reasons are good reasons for me to act in accordance with my rights and your reasons are good reasons for you to act in accordance with your rights, but it is not logically possible to get beyond this egocentric or prudential reasoning and discover impartial reasons as to why we must respect the rights of others. Therefore, an impartial prescriptive morality fails to be logically induced from prudential descriptive facts. For example, if “Y is a good” and “I ought to have X as it is necessary for my having Y” and “A ought to have X as it is necessary for his having Y”; in spite of Gewirth's insistence, this does not logically entail a moral obligation for me to aid or refrain from hindering A's accrument of X.

<sup>91</sup> J. O'Manique, (1990), p. 475

matter best established empirically, independently of any considerations of human rights. In this way, the acceptability of any entry into human rights lists can be tested by correlating it to a need; normative claims for goods are valid as long as the claim (right to health care) corresponds to empirically determinable developmental or survival needs (need for health care). As O'Manique correctly points out in the following quotation, throughout his theory normative assumptions remain logically distinct from any empirical considerations:

Since a right corresponds to a need whose validity can be tested empirically, any statement that identifies the object of a right is empirical. The assertion that I have a right is normative, but the statement that the right is to do or have X is empirical. The validity of entries on a list of rights can be empirically tested. If no such test can be conceived, at least in principle, then it would follow that the claim is not justified.<sup>92</sup>

### **2c. (iii): Objections and Qualifications**

This is the most cogent argument so far presented as it is simple to follow, avoids the pitfalls of the previous theories, and does not over-expand the realm of valid rights claims beyond that already accepted by the United Nations. The theory has generated a minimal amount of peer criticism and I find that only one minor objection warrants discussion. I shall conclude by discussing some sceptical concerns about foundations.

O'Manique claims to be basing a theory of universal and inalienable human rights on the good of survival and development and explicitly states that he is adopting the radically universal position that "all humans have rights in the same way and to the same extent regardless of their race, culture, political system or any other

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<sup>92</sup> J. O'Manique, (1990), p. 477

distinction.”<sup>93</sup> If this is his position, then the theory is open to Donnelly’s objection that radically universal human rights deny the ethical autonomy of some non-western cultures. What is more, it is arguable that the theory is contradictory in thinking that rights claims can be made by cultures which do not understand fundamental concepts necessary for the making of such claims. As stated in the above argument from dignity, I find these objections damning to the radically universal position; however, I am unsure as to whether O’Manique’s theory is truly radically universal. This is because radically universal human rights must be based on a radically universal good – which O’Manique identifies as survival and development needs – but he then goes on to contradict his previous statement by claiming that this need is not strictly universal: “The belief that survival is good is *virtually* universal[;]... found, explicitly or implicitly, in *almost* all human beings.”<sup>94</sup> He then goes on to explain how there exist exceptions to this so-called “universal” need for survival, such as “[t]hose who sacrifice their own lives for the lives of others, or for a ‘higher life’ in a religious context.”<sup>95</sup> This is not the language of a radical universalist; in fact, this is exactly the language used by Donnelly when he described his own position of relatively strong universalism. It is clear that O’Manique is confused as to the degree of universality his foundations possess. I suggest, however, that in order to answer Donnelly’s objection that rights are unintelligible to limited non-western cultures, O’Manique must revert to the weaker position of relatively strong universalism. In this way, the theory can continue reasonably unscathed, allowing limited traditional societies their own methods of ensuring that survival and development needs are fulfilled, while the Western world can adopt a rights-based approach to need satisfaction.

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<sup>93</sup> J. O’Manique, (1990), p. 477

<sup>94</sup> J. O’Manique, (1990), p. 473, Italics mine.

<sup>95</sup> J. O’Manique, (1990), p. 473

O'Manique succeeds where others fail as he utilises a needs-based criterion rather than adopting a highly contested theory of human nature to derive content, while at the same time including the notion of development. Development provides a criterion of need that avoids giving too small a claim on goods and avoids an over-inflation of relevant needs. In his 1992 paper, he compiles a list of human rights produced solely on the basis of this theory that is identical, bar one or two articles, to the UDHR charter.<sup>96</sup> One rather important benefit of this theory is that it does not attempt to bridge the is-ought gap, but still provides a means of validating the "ought" conclusion by "is" considerations. As a result, the existence of human rights is not logically linked to empirical science, but there still is convincing reason for accepting their moral conclusion. As theoretical misunderstanding can easily spill over into problematic practical implementation, high standards such as human rights require strong foundations supported by even stronger argument. For some, nothing short of direct logical proof will justify the high moral standard imposed by human rights; however, this search for strictly logical foundations will always result in *aporia* so long as fundamental terms such as "human nature", "universality" or even "equality" are contentious. Even if convincing moral arguments can be put forward as to how humans ought to act, as a study of Donnelly and O'Manique has shown, lists of human rights can only be indirectly supported by empirical argument owing to "Hume's Guillotine". I believe the best philosophers can hope for are arguments that indirectly produce some consent as to why rights must be respected, but which provide no logical proof exactly why dictates of human rights must be accepted. As a result, the theoretical disputation is inconclusive and many human rights activists or governments may be left without solid reasons for why they act as they do.

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<sup>96</sup> J. O'Manique, (1992), p. 84

There are some non-foundational philosophers who hold that, owing to the chimerical nature of foundational appeals, the entire quest is paradoxical and results in infinite regress. Their argument is similar to the “first cause” or “unmoved mover” argument found in the philosophy of religion. Foundationalists operate on the premise that every theory or practice has a foundation, but once they discover what appears to be the ultimate foundation of the practice in question, they completely drop this motivating assumption and assume that there exist no further reasons beyond this “ultimate” principle. In order to be consistent, the motivating assumption that “all principles have foundations” must be retained, resulting in a futile search of infinite regress. There is another variation of this objection, which argues that the foundationalist’s task is self-defeating. Hypothetically, if foundationalism ever succeeds in discovering an ultimate Foundation (F) of a practice, this means that foundationalists are accepting the rule that there exist principles in the world, namely F, that do not require foundations. If this rule is applicable to F, then it must also apply to the initial practice they are trying to found, that is, human rights. Therefore, by accepting the possibility of an ultimate foundation for human rights, philosophers are also accepting the possibility that rights themselves do not require a foundation. These objections are so clever that they can even be turned against the non-foundationalist. If there are no ultimate foundations, then there are no good reasons for accepting any principles whatsoever, even those principles held by the non-foundationalist. Therefore, no good reason exists for accepting the non-foundationalist position in preference to the foundationalist position.

Non-foundationalist objections can be taken in two ways. Either there exists human rights, but there is no method of proving or explaining their dictates beyond

morally arbitrary social convention or unsupported belief; or, as the nihilistic Alasdair MacIntyre maintains in the following quotation, there are no reasons for following human rights because there are no such entities:

[F]or the truth is plain: there are no such rights, and belief in them is one with belief in witches and in unicorns. The best reason for asserting so bluntly that there are no such rights is indeed of precisely the same type as the best reason which we possess for asserting that there are no witches and the best reason which we possess for asserting that there are no unicorns: every attempt to give good reasons for believing that there *are* such rights has failed.... Natural or human rights then are fictions – just as is utility – but fictions with highly specific properties.<sup>97</sup>

It is problematic for human rights theory that no foundation can be absolutely, objectively, or logically true; however, philosophers definitely possess a good deal of descriptive knowledge about human rights, fictitious or not. When human practices correspond to these descriptions and countries are run according to their dictates, it is an understatement to say that the “highly specific properties” of human rights promote a great amount of good and prosperity by thwarting the designs of villainy. It is for this reason that the human rights cause is not abandoned, in spite of foundational troubles.

## **2d: Summary and Conclusions of the Foundational Section**

In this chapter I have demonstrated a general normative framework, balanced in part by empirical considerations, of what a successful foundational theory may look like. god and culture are not readily available as moral sources, so the initial orientation for

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<sup>97</sup> Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, (London: Duckworth, 1981), p. 67

theorising about human rights must not be radically universal or radically relative. Donnelly's position of relatively strong universalism serves my purpose well as it avoids the respective problems of moral nihilism and Western moral imperialism over cultures. Donnelly seems correct in saying that any rights theory that relies on a particular conception of human nature often becomes bogged down with "intractable" and "inconclusive"<sup>98</sup> discussion. In order to derive an acceptable content of human rights I feel it is best to avoid speculation about human nature, arguing instead that correct lists correlate to the fulfilment of survival and development needs. Although I am not rejecting the possibility of ever bridging Hume's logical gap, philosophers must be wary of attempts to justify prescriptive conclusions with descriptive premises. A successful theory requires normative premises to give human rights their moral force. These premises must be supported by, yet are logically independent of, empirical considerations. O'Manique succeeds in achieving this, as he provides a foundational theory that is purely prescriptive, yet supported independently by biology and the social sciences. O'Manique has even gone so far as to use his theory to formulate a list of survival and development needs that match almost identically the various United Nations rights charters. This means that the theory will be in keeping with Donnelly's requirement of a relatively universal consensus on both the existence of human rights and their enumeration in international law. None of what I have said so far is incompatible with the current expression and wording of the United Nations Rights charters, as the fulfilment of survival and development needs will satisfactorily protect and maintain the inherent dignity of humankind.

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<sup>98</sup> J. Donnelly, (2003), p 16-17

## **Chapter Three: Distributing Health Care**

### **3: Introduction: The Role of Distributive Justice**

Protecting the rights of even the least individual among us is basically the only  
excuse the government has for even existing.

**Ronald Reagan**

As discussed in the previous chapter, philosophers who strive to uncover foundations for human rights work with premises that attempt to explain the inherent value of a norm. Although this allows an understanding of why rights are significant entities, these principles are unable to direct public policy because they are concerned primarily with individuals, lacking the specifics needed to deal with larger societies. If a society were to distribute resources according to O'Manique's moral dictate to satisfy human survival and development needs, needs for health care, education, civil defence, and housing will all come into irreconcilable competition with one another. Human needs are often prohibitively expensive to satisfy when demanded simultaneously as positive rights, so it follows that not all of them can be maximally realised within a society beset by resource scarcity. The prima facie nature of positive rights allows the legitimate trade off of one right against the other, satisfying those "more important" rights first. What is more, some situations may even require a trade-off between human rights and the greater public good, and because foundational theories always give an overriding priority to human needs, foundational theorists are unable to decide which particular needs are to be sacrificed or "trumped"<sup>99</sup> for a large gain in utility.

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<sup>99</sup> Ronald Dworkin's influential rights thesis states that individual principles such as rights are "political trumps" over collective goals; however, an extremely high gain in public good, or in



Foundational theories inform us that satisfying needs by way of rights is morally important, but they provide no way of telling which particular rights are to receive priority given real world situations of conflict and scarcity. Tristram Engelhardt, former editor of *The Journal of Medicine and Philosophy*, laments that the concept of an inalienable and universal human right to health care is reduced to a cliché, although an important one.<sup>100</sup> He goes on to say that the interesting theoretical question is not so much whether there exists a universal and inalienable right to health care or how this right is founded within moral systems, but what limits are there on the obligation to provide health care? It is arguable that people are justified in claiming a right to health care only if it can be harvested from an acceptable theory of distributive justice; because, if there are no substantial mechanisms to allocate medical care, then the right to receive medical care is reduced to impractical rhetoric. Some philosophers have even gone so far as to argue that a right to health care is unintelligible, even as abstract theory, without a particular distributive framework in which to view it.<sup>101</sup> Issues of distributive justice are present even if the existence of positive human rights is denied. So long as there is a general recognition that services such as health care are good for a society, a theory of distributive justice is required to explain how they can best be achieved. It is for these reasons that an investigation into human rights must not only explain why rights are morally important, but also provide an acceptable theory of distribution that illustrates the fairest method of maximally satisfying restrictively expensive human needs.

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Dworkin's words "a goal of special urgency", can overrule rights on occasion. See: Hard Cases, *Harvard Law Review*, 88:6:1975:1057-1109, p. 1069 and *Taking Rights Seriously*, (London: Duckworth, 1977), p. xi-xii

<sup>100</sup> Tristram Engelhardt jr., Rights to Health Care: A Critical Appraisal, *Journal of Medicine and Philosophy*, 4:2:1979:113-117, p. 113

<sup>101</sup> N. K. Bell, (1979), pp. 158-169

It is helpful to first make a distinction between macro-allocation and micro-allocation, as discussed by Norman Daniels.<sup>102</sup> Micro-allocation decides appropriate funding between competing treatments or facilities within the health care institution. Macro-allocation, on the other hand, is more complicated; deciding which institutional services should be available in a society, who can access the services and on what basis, and deciding who should pay for the services. I shall begin by arguing in favour of a mechanism for micro-allocation that is currently in use across the globe; distribution by Quality Adjusted Life Years. Following this, a discussion of Macro-allocation health policy leads to the rejection of utility maximisation and the rejection of a preponderant reliance on privatised insurance markets. These approaches are rejected because neither one ensures an efficient access to the health care institution for all who require it, also neither of these mechanisms distribute with an aim to satisfy objectively defined medical needs.<sup>103</sup> This paper shall then proceed in Chapter Four to address two, more promising, theories of distributive justice that are compatible with the needs-based foundation of rights; egalitarianism and justice as fairness. Given the associated drawbacks of all four theories discussed, I shall conclude by suggesting a two tier blend of private marketplace and governmental egalitarian allocation, designed by me to create a fair and equal distribution of health care in a community.

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<sup>102</sup> N. Daniels, (1985), p. 2

<sup>103</sup> Utilitarianism will meet basic human interests if and only if doing so will achieve the primary goal of utility maximisation, while a laissez-faire market distributes in accordance with personal income and wealth.

### **3a: Utilitarianism**

It seems natural to begin with an assessment of utilitarian distribution since this is already a surprisingly dominant principle for medical distribution in medical systems in the developed world. Generally speaking, a utilitarian health policy will state that justice demands the maximisation of the greatest good for the greatest number.

Society has the strict obligation to prevent and treat ailments because doing so brings about a greater balance of benefits when weighed against the costs of providing a health care system, or the costs associated with ignoring the health concerns of society. Since it is a serious problem that many positive rights are too expensive to realise fully, a cost-benefit assessment such as this seems ideally situated to allocate resources and maximally satisfy rights in the most efficient manner.

As seen above, it is arguable that the right to health care exists as a means of satisfying basic human needs. Utilitarian calculations do not strictly run in accordance with this right because the entire point of a utilitarian medical system is to promote the greatest good to the greatest number, not specifically to satisfy medical needs. If overriding utility could be gained by sending funds elsewhere, then a utilitarian system would not satisfy medical survival and development needs. In fact, if enough utility could be produced by acting otherwise, it would be *unjust* to distribute resources in order to satisfy these needs. Nevertheless, in the vast majority of situations, the satisfaction of medical needs is a utility maximising activity, so the theory will be most likely to advocate a health care system; not directly for the end of satisfying medical needs, but indirectly for the end of utility maximisation. In this way, rule-utilitarianism supports, or is at least is compatible with, the human right to health care because the recognition of this right is often a utility promoting activity.

Particularly in the United States, on a micro-allocative level, the cost-benefit measure is institutionalised rule: medical decisions are regularly made after a complicated balancing of benefits and costs. This is because health care economists can easily compare similar surgical procedures or pharmaceutical options by looking at the numerical dollar value versus the number of people positively affected. It is possible to see utility-type calculations in use in health care distribution within the military. Frontline paramedics in the heat of battle are instructed to treat the slightly wounded before the critically wounded, because limited medical resources are better spent turning around five lightly wounded soldiers who will return to combat, rather than hospitalising one who will never fight again.<sup>104</sup> The same policy applies to treatment in the event of nuclear catastrophe; a policy of the greatest good for the greatest number means treating those with a higher chance of survival in preference to treating the seriously injured, or even allowing surgeons of high social utility into the bomb shelter before tobacconists.<sup>105</sup> A simple case of utilitarian number crunching occurred when the UK health board distributed resources for a steroid contraceptive pill estimated to cause embolisms in 14 users for every million. The drug was distributed on the grounds that deaths resulting from childbirth were 228 per million pregnancies; a number the pill would ultimately reduce at a fraction of the cost.<sup>106</sup>

There is a notorious objection to the utility approach that it requires a comparative figure to be placed on the numerous costs and benefits associated with weighing moral decisions. It is easy in theory to say “60 utility units outweigh 40 disutility units, therefore the benefits outweigh the costs”, but such ethical arithmetic

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<sup>104</sup> Joseph Fletcher, *Ethics and Health Care Delivery: Computers and Distributive Justice*, In: R. Veatch and R. Branson (eds.) *Ethics and Health Policy*, (Cambridge: Ballinger Publishing Co., 1976) p. 105

<sup>105</sup> J. Fletcher, (1976), p. 105

<sup>106</sup> J. Fletcher, (1976), p. 106

does not easily translate to real life situations. For example, in times of scarcity it is uncertain whether it is a disutility to redirect funds from chemotherapy to improve radiotherapy facilities. Furthermore, any predictions made about future costs and benefits, and the consequences of action in general, are often inaccurate and vary according to the outlook of the person who predicts. In response to these troubles, authorities have formulated admittedly rough calculations for “quantifying qualities”<sup>107</sup> on both the micro-allocative and macro-allocative level.

### **3a. (i): Utilitarian Micro-allocation**

On the level of micro-allocation, the main criterion used to assess the benefits of medical procedures is the metric of the Quality Adjusted Life Year (QALY). This takes the estimated number of years a medical procedure will bring to a patient and multiplies by a quality assessment of those years to produce a QALY number. One year at full quality is 1.0, one year at less than full quality ranges from 0.9 to 0.1, and death or an equivalent state equals 0.0. On this scale, for example, a year of mild angina receives a 0.9, insulin dependent diabetes is 0.58, while being blind, deaf or dumb is 0.39.<sup>108</sup> The QALY figure for any particular ailment is established by surveying those people affected by the medical condition and averaging their subjective assessment of quality of life. Subjective assessments such as these eliminate problems associated with classical utilitarianism, concerning the accuracy and legitimacy of evaluating future consequences. Moreover, the QALY metric looks at a patient’s post-treatment prospects as a way of assessing the cost-effectiveness of

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<sup>107</sup> J. Fletcher, (1976), p. 106

<sup>108</sup> Andrew J. Wang, Key Concepts in Evaluating Outcomes of A.T.P. Funding of Medical Technologies *Journal of Technology Transfer* 23:2:1998:61-65; also at The National Institute of Standards and Technology, “Key Concepts in Evaluating Outcomes of A.T.P. Funding of Medical Technologies” <<http://www.atp.nist.gov/eao/jtt/wang.htm>> (15<sup>th</sup> of January, 2007)

competing treatments, not to prioritise between the specific needs of competing individuals. If two cancer patients are awaiting treatment, the number of QALYs will decide between chemotherapy (which could give 3 years at 0.36 QALYs) and radiotherapy (giving 4 years at 0.3 QALYs). The metric does not decide which of the two patients will be treated. It is therefore strongly impersonal and mitigates the influence of morally arbitrary factors such as age, social class, race or religion on resource distribution. Having a medical need qualifies a patient to enter the medical system and then the QALY calculation decides the most cost-effective treatment for the patient.

The post-treatment QALY benefits are compared to the costs associated with the medical procedure. Costs are ideally considered broadly, such as the impact on family or community, but unfortunately are too often narrowly assessed according to the dollar value of treatment. Before a comparison of financial costs versus QALY benefits can take place, the numerical QALY figure must be converted into monetary terms; or in other words, health economists must discover how much money one year at 1.0 quality, or part thereof, is worth. It may sound cold and callous, but in order to achieve this economists first calculate the dollar value that a particular society places on an entire human life of full quality. A hypothetical situation is proposed to a sample community of 100,000 people, in which they are told that one individual from within the group faces immediate death. The identity of this person is left anonymous: it is explained to group members that this person could be their neighbour, a family member, a complete stranger or even themselves. The sample group is then surveyed as to how much money each individual is willing to pay in order to save the life of the unidentified person. If the population responds that they will spend on average \$50 each to reduce the chance of death in the community by 1 in 100,000, then this is

statistically equivalent to one person spending \$50 to reduce their own chance of death by 1 in 100,000. Therefore, if each person in the community is on average willing to pay \$50 for a 1 in 100,000 reduction in the risk of death over his or her lifetime, then this means that the dollar value this particular community places on a full human life at 1.0 QALY is  $\$50 \times 100,000 = \$5$  million. When an otherwise healthy forty-year-old man goes in for an operation that will enable him to live a full life to the male average of 76 years old, the procedure is creating a benefit of 36 years at 1.0 QALYs. With a full quality complete life valued at \$5 million, each year of the man's life that is created has the monetary value of  $\$5 \text{ million} \div 36 = \$139,000$ . Keeping in mind that QALYs are not designed to prioritise patients, but rather the funding of treatments, if the cost of this operation is more than \$139,000, then this means the resources can be used more efficiently pursuing other treatment options.<sup>109</sup>

### **3a. (ii): Objections to a Utilitarian Micro-allocation**

I do not mean to over-simplify the issue. Although this approach is frequently used, the accuracy and appropriateness of QALYs is heavily debated and intimately tied to long-standing dilemmas of the classical utilitarian calculus.<sup>110</sup> Andrew Edgar describes a hypothetical situation where there are two competing procedures, with funds either being allocated to a treatment that keeps patients alive for sixty years at a very low figure of 0.1, or a treatment that keeps patients alive for five years at 0.9.

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<sup>109</sup> A. J. Wang, (1998) p. 65

<sup>110</sup> For my analysis I follow: Andrew Edgar, Sam Salek, Darren Shickle and David Cohen, *The Ethical QALY: Ethical Issues in Healthcare Resource Allocation*, (Haslemere, U.K.: Euromed Communications, 1998); however, the main arguments are replicated almost identically in most other publications concerning QALYs. For similar discussions see: Michael Lockwood, Quality of life and Resource Allocation, In: J. Bell and S. Mendus (eds.), *Philosophy and Medical Welfare*, (New York: Cambridge University Press, 1988); and John McKie, Jeff Richardson, Peter Singer and Helga Kuhse, *The Allocation of Health Care Resources: An Ethical Evaluation of the Q.A.L.Y Approach*, (Aldershot: Ashgate, 1998).

Because the QALY metric rules in favour of treatments which maximise life years multiplied by quality, the multiplication of these fractions results in the former treatment receiving priority. This means that, according to the QALY approach, an extremely long life in a vegetative coma is preferable to a shorter life as a fully-productive member of society. This conclusion is repugnant, since all would agree that being in a vegetative coma is undesirable compared with being a fully-functioning and productive member of society, regardless of the amount of time spent in either condition. This discussion is similar to Mill's argument of quality outweighing quantity considerations in a hedonistic utilitarian calculus:

Few human creatures would consent to be changed into any of the lower animals for a promise of the fullest allowance of a beast's pleasures; no intelligent human being would consent to be a fool, no instructed person would be an ignoramus... It is better to be a human being dissatisfied than a pig satisfied; better to be Socrates dissatisfied than a fool satisfied.<sup>111</sup>

Just as no quantity of animalistic pleasure outweighs the higher quality of being human, no quantity of comatose years will outweigh the higher quality of a fully-functioning life, regardless of its length. "Superficially at least," Edgar argues, "QALYs do not appear to be designed to make the sort of discriminations required in order to decide the point of discontinuity between biographical [with a life plan] and merely biological life."<sup>112</sup> In keeping with the public consultation theme inherent in QALYs, as a partial solution Edgar suggests that the public decide which conditions constitute a biographical or merely biological existence. As a guideline, if no amount of money spent on a condition will ever return the patient to a positive quality of life, then the public must assign the condition a low score that ranges, for example, from

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<sup>111</sup> John Stuart Mill, *Utilitarianism*, In: G. Sher (ed) (Indianapolis: Hackett, 1979), pp. 9-10

<sup>112</sup> A. Edgar *et al*, (1998), p. 72



0.0 to 0.15. This serves as a point of discontinuity, with so-called “death-like-states” below a quality threshold of 0.15 not warranting continued treatment or arguably life-support, regardless of the number of years that could be spent at this level. Quality levels above this threshold will justify treatment. According to the QALY scale suitably revised, a long life at low quality will no longer be preferable to a short life at high quality.

There are, however, other objections that are not as easily answered by a reference to public opinion. If faced with the funding of two treatments that cost the same – one that brings a person back to full health, or another that treats ten people to 1/10<sup>th</sup> health – the multiplication of values becomes equal with no numerical difference between the two. Because QALYs cater to the utilitarian notion that the healthier life will produce a richer array of experiences and utility than could ever be achieved by the ten unhealthy lives, the advocates of the QALYs system will sacrifice ten lower quality lives to save one superior quality life. The same can be said of competing procedures that, all other things being equal, either treats ten people to survive for one year each, or treats one person to survive for 10 years. Utilitarians will deem this sacrifice of the majority a necessary outcome of maximisation and a demand of justice. It seems to be a correct objection that the QALYs approach fails to show adequate reverence for human life, lacking a respect for sanctity of life that must be inherent in any just distribution of health care.<sup>113</sup>

Finally, it is a valid complaint that QALYs have an inbuilt bias towards funding treatments for younger people. This is because the funding of treatments for 20 year olds will clearly produce more QALYs than treatments for 80 year olds; or, *reductio ad absurdum*, treatments for a 19 year old will create more QALYs than

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<sup>113</sup> A. Edgar *et al*, (1998), p. 66

treatment for a 20 year old.<sup>114</sup> It is, however, a convincing reply that, when scarce medical resources are being allocated, it is not necessarily unjust to give preference to the younger generation, considering the fact that the elderly have already had their so-called “fair-innings”<sup>115</sup> of years. Lewis, Charney and Farrow<sup>116</sup> cite a study where respondents were asked to distribute medical care between two patients with identical ailments, one aged 5 and another 70 years. 94% responded that they would give the child priority. When the ages were brought closer together, distributing to a 35-year-old or a 60-year-old, 80% gave preference to the younger patient. The closer the ages became the harder it was for respondents to decide, with a majority of 46% being unable to choose between a 2 year old and an 8 year old. Based on this study, it can be concluded that rationing to the younger generation out of respect for fair-innings is commonsense morality, supported by a majority of the public.

It has been argued in the past that any favouritism when rationing medical resources wrongs the unfavoured group, simply because they are denied access to medical resources.<sup>117</sup> For those who subscribe to the above position, QALYs will inevitably wrong patients because it is a rationing technique; however, QALY’s favouring of the young only wrongs the elderly once, while if it were to favour the elderly it would wrong the younger generation twice. In other words, if we do not favour the younger generation, not only will the young be wronged by a system that denies them access to medical care, but also they will be wronged a second time by

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<sup>114</sup> Because QALYs are designed to compare treatment options, not individuals, this reduction to absurdity can only work if we are choosing between two treatments, one designed specifically for 19 year olds and another designed specifically for 20 year olds. While it is true that there is an inbuilt age bias, the reduction is correct iff we grant the existence of these unlikely treatment options.

<sup>115</sup> A. Edgar *et al*, (1998), p. 67

<sup>116</sup> M. C. Charney, P.A. Lewis and S. C. Farrow, Choosing Who Shall Not be Treated in the NHS, *Social Science and Medicine*, 28:12:1989:1331-1338, pp. 1333-1336

<sup>117</sup> Robert Veatch is a proponent of this view, arguing that rationing techniques such as waiting lists and lotteries violate an individual’s right to equal treatment. Robert Veatch, What is a “Just” Health Care Delivery?, In: R. Veatch and R. Branson (eds.), *Ethics and Health Policy*, (Cambridge: Ballinger Publishing Co., 1976), p. 141

being deprived of a fair innings. Because the elderly have already enjoyed their fair innings, they will only receive the single injustice of being denied access to medical care. If we are in a position where we must choose between two competing treatments, QALY's favouritism towards the younger generation allows youth the same opportunities that the elderly have already enjoyed. What is more, to go against this commonsense position may serve a double-injustice to the younger generation.

Regrettably, owing to constraints of space I can only scratch the surface of this debate which has roots spanning over two and a half centuries. I must conclude that the QALYs approach is theoretically defensible and a useful tool for conducting cost-benefit assessments of micro-allocation; however, by itself it is by no means a solution to controlling the expensive costs that obstruct fair and just health care distribution. Particularly in the USA, the price of health care has skyrocketed owing to corruption and fraud within the system. There is also an artificial inflation of the price of health care because of a large reliance on privatised insurance markets. A constant fear of malpractice lawsuits forces doctors to practise so-called "defensive medicine"; needlessly duplicating expensive tests and treatments. What is more, competing hospitals perceive a need to keep up with the latest "big-ticket" technology, replacing satisfactory equipment with the latest model each year. Such issues surrounding the uncontrollable costs of health care are discussed in detail in the following section on free-market allocation; suffice to say, these are largely problems of macro-allocation that the micro-allocation assessment of QALYs cannot resolve on its own. I endorse the QALY assessment within micro-allocation spheres, and as such, the remaining bulk of this paper shall discuss the wider sphere of macro-allocation.

### **3a. (iii): Utilitarian Macro-allocation**

On the larger scale utilitarian macro-allocation, the benefits of spending X amount on the health care institution are weighed against the costs of not spending X on alternative goods such as civil defence or education, or the costs to society's health of sending the funds elsewhere. Familiar problems with utility calculations concerning how moral mathematicians establish numbers are not necessarily relevant to the macro-allocation of health care, because most societies have readily available health statistics on all relevant indicators, such as infant mortality, average life expectancy, days of hospitalisation, and morbidity by disease. In this way, mathematical morality is less problematic in the realm of health care ethics than it is in other fields of morality, as difficult ethical problems can be solved in a formulaic manner. For example, a new hospital costs \$10,000,000 to install, \$850,000 per annum to operate, is accessible to 55% of the population, treats 50,000 patients per annum at an average cost of \$400 each, resulting in average QALYs of 0.75: these are familiar terms for health economists who devise complicated equations for finding the maximising moral course.

On face value, the utilitarian goal of maximising the health of the greatest number at the least cost is workable because cost benefit analysis such as this is currently implemented around the world, albeit with questionable success in achieving the goal of *maximal* coverage and quality. Having said that, public health policy is never pure utilitarian calculus but often a Frankenstein's monster of differing ideologies and distributional principles, so perhaps it is arguable that a more wholehearted adoption of the utilitarian calculus will provide more success in the realm of maximal coverage and quality. The famous situational ethicist, Joseph Fletcher, proposes that "somehow we must learn to program computers with

preference questions”<sup>118</sup>, suggesting a purely utilitarian macro-allocation health policy that will ideally be dictated by what can only be described as a maximisation machine; a super computer that will “quantify qualities”<sup>119</sup>, programmed with all the relevant distributional facts and societal health figures to calculate the most cost effective distribution of resources amongst the sick.<sup>120</sup>

Given the questionable assumption that such a hypothetical machine is workable and can successfully achieve a maximal distribution of quality health care to the greatest number, the issue of desirability is most telling. Egalitarian thinker Robert Veatch believes that utilitarian calculations are undesirable because a strict cost-benefit criterion will require caps on expenditure and limitations on services that will inevitably prevent many people from returning to a level of health equal to others. This allocation is incompatible with Veatch’s strict equality principle that “justice requires [that] everyone has a claim to health care needed to provide an opportunity for a level of health equal, as far as possible, to other persons’ health.”<sup>121</sup> Furthermore, just as utility calculations could deem it wasteful for a health care system to provide genetic therapy, nuclear powered hearts, or cryogenics, it is possible that a cost benefit calculation could deem it never cost-efficient to provide a health care system. This would dramatically increase the level of inequality within society. Libertarians such as Robert Nozick will also find utilitarian assessments undesirable as there is always the possibility that a calculation will restrict an individual’s freedom if there are sufficient gains to be made for society. Furthermore, Nozick would find it problematic that Peter Singer weighed up the benefits and

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<sup>118</sup> J. Fletcher, (1976), p. 104

<sup>119</sup> J. Fletcher, (1976), p. 106

<sup>120</sup> J. Fletcher, (1976), p. 104 and p. 108

<sup>121</sup> R. M. Veatch, (1976), p. 134

drawbacks of a medical marketplace – a non-patterned distributive mechanism favoured by Nozick – and compared it to the patterned alternative of a taxpayer-funded national health plan, with the result that the latter system produced a greater balance of benefits over costs for the community.<sup>122</sup> Although these are not strictly objections against utilitarianism, it is worth noting that these positions are not compatible with one another, as the institution favoured by Singer’s reasoning puts utilitarianism at odds with libertarianism, and the toleration of unhealthy citizens defies Veatch’s egalitarian thinking.

### **3a. (iv): Objections to a Utilitarian Macro-allocation**

Utilitarian health policy is susceptible to the old objection that calculations demand the intuitively undesirable sacrifice of an individual or group of individuals if a sufficiently high gain can be made to offset the sacrifice. Robert Veatch considers a hypothetical board of utilitarian public planners who feed all the relevant health data into Fletcher’s maximisation machine. In this hypothetical society, there exists a small underclass (0.1% of society) of poor, unemployed, uneducated, brain-damaged and chronically unhealthy citizens who consume a disproportionately large slice of taxpayer-funded health care. The maximisation computer will propose the policy of cutting service to these people, with the inevitable result of killing off sections of the underclass, thus improving statistics in the social measures of health (morbidity not mortality). The health plan also involves identifying the healthiest 10% of society and encouraging them to reproduce, further improving morbidity statistics. Veatch contends that “the harm of death is critical and must be added to the calculation of

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<sup>122</sup> Peter Singer, *Freedoms and Utilities in the Distribution of Health Care*, In: R. Veatch and R. Branson (eds.), *Ethics and Health Policy*, (Cambridge: Ballinger Publishing Co., 1976), pp. 175-193

goods and harms. Non-health harms also might have to be taken into account, such as social malaise or rebellion”.<sup>123</sup> The harm of a rights violation could even be included, since rule-utilitarianism endorses the right to protection from arbitrary loss of life and liberty. Nevertheless, it is possible to imagine a system that produces huge benefits and to imagine similar ways of reducing the harms: aside from the obvious financial gains from restricting treatment, organs of the deceased underclass could be transplanted to those in need, or the system could be organised so the majority of those banned would be vicious criminals sentenced to death. “It is conceivable”, Veatch concludes, “that even after these [harms] are added in, banning of the one in a thousand still turns out to be utility maximising”<sup>124</sup>

Even if the system were carefully formulated to produce utility, this discriminatory and semi-genocidal health plan would not sit well with my intuitive sense of justice. In fact, according to utilitarian health policy it would be an injustice to *include* poverty-stricken and unhealthy people in a national health system. Rule-utilitarianism is endorsed primarily because it is able to account for important moral rules such as human rights, but it is problematic that all rules are justified by the amount of utility they produce. If greater utility can be produced by adopting an alternative set of rules; for example, swapping the rule “respect the human rights of underclass murderers” for “ban underclass murderers from health care and transplant their organs”, then this maximising course must be adopted. In this sense, rights make absolutely no difference to the moral course because ultimately the issue rests on utility. David Lyons makes this point in a different illustration: “Mary is fully justified in exercising her legal rights only when she can promote human welfare to the

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<sup>123</sup> R. M. Veatch, (1976), p. 132

<sup>124</sup> R. M. Veatch, (1976), p. 132

maximum degree possible, and others are fully justified in encroaching on Mary's rights in the same sort of circumstances and for the same sort of reasons."<sup>125</sup> Rule-utilitarianism fails to account adequately for the moral force of rights, allowing them to be "trumped" too easily by inhumane and clearly immoral maximising public policy. The true motivation for not adopting such a despicable health care policy is separate from the fact that a disutility is produced; genocidal public policy is a disutility because it is wrong, not wrong because it is a disutility. I must side with Veatch and Lyons that, once the programmatic implications of utilitarian macro-allocation are drawn out, the resulting health care plan is flawed: it is perversely counter-intuitive, it promotes as just a health policy that is clearly undesirable for any society, and it fails to take seriously the moral force of human rights.

Cost benefit calculations are necessary within medicine to avoid sending funds down medical black holes; however, the important weighing of costs against benefits must not be blown out of proportion into an all-encompassing maximisation of the greater good for the greatest number. As I have shown with micro-allocation by QALYs, cost-benefit analysis can be a simple economic tool that is acceptable from a variety of ethical perspectives, while utilitarian macro-allocation is a misguided ethical theory that promotes undesirable and counter-intuitive social policy. What is more, because I am searching for a distributive theory that is compatible with human rights, I must not favour a macro-allocative theory that disregards an individual's medical needs or the medical needs of a morally notable section of society. Keeping in mind the financial and social costs of any public policy is important when planning under scarcity and any normative vision of health care should allocate maximally

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<sup>125</sup> David Lyons, *Rights, Welfare, and Mill's Moral Theory*, (New York: Oxford University Press, 1994) p. 156



within the technological and financial limitations of society. Nonetheless, when society is dealing with life-saving medical technology, I feel a single-minded utility calculus does not exhaust the notion of ethical macro-allocation.

### **3b: Macro-allocation by Laissez-Faire Insurance Markets**

The macro-allocation of health care on the free-market is another method that, on face value, disregards human survival and development needs. This is because there is no taxation to support health care goods and service provision, leaving distribution primarily in accordance with an individual's own level of income and wealth. A free-market approach to health care accentuates individual freedom to such a degree that it leaves no room for social intervention into health care matters, with a basic minimum supported by charity for indigent individuals. In spite of how it appears, this approach does not entirely reject O'Manique's survival and development needs criterion, but changes the focus from an objective to a subjective assessment of need. Supporters of a more socialistic system could refer to the satisfaction of objective needs of citizens and provide health care out of respect for rights, whereas supporters of a laissez-faire system could cite individuals' free choice to satisfy their own subjectively defined needs, distributing health care via the market in accordance with income and wealth.<sup>126</sup>

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<sup>126</sup> A fair share of income and wealth will be regulated by separate principles of justice. While I do not need to take a detailed stand on these principles, a possible laissez-faire principle for income distribution could be "to each according to his contribution in satisfying whatever is freely desired by others in the open marketplace of supply and demand." (See: Gene Outka, Social Justice and Equal Access to Health Care, *Journal of Religious Ethics*, 2:1974:11-32, p. 19) Ideally, all will achieve a fair share of income and wealth in accordance with this income principle, and therefore all shall be in a position to purchase market goods and satisfy their subjective health care needs. Charity plays the part of picking up those who fall through the gaps of this idealized system.

Robert Sade attacks a program of nationalised health care provision in favour of a medical marketplace, on the grounds that people have a right to select their own ends, determine their own methods of goal realisation, and execute and dispose of their goals without coercion from others.<sup>127</sup> In short, Sade argues that the market provides a freedom of choice that is not possible with a nationalised distribution. He draws an analogy between the doctor and the baker,<sup>128</sup> pointing out that it is immoral to appropriate bread from the baker without paying for it. Sade claims that any coercive interference by the state into the business of health care providers constitutes a similar injustice, going on to conclude that “medical care is neither a right nor a privilege: it is a service that is provided by doctors and others to people who wish to purchase it.”<sup>129</sup> Those who oppose the reformation of the medical marketplace in

A often do so by appealing to the reduction in consumer choice and provider freedom that results from nationalisation, so Sade appears to articulate an argument central to the privatisation camp. In this section, I shall side with Sade and others in the opinion that medical insurance markets play a vital role in the creation of a just distribution of health care. However, my point of difference is that I believe markets do not create a just health care system unaccompanied. While the free-market may increase consumer choice, freedom, and arguably increase service quality, it is an inefficient distributor that is unable to establish comprehensive access and, as such, must be supplemented by a government controlled health care system.

Privatisation of industry is said to have increased efficiency and quality of service; its advocates often emphasise the inefficient nature of extensive government,

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<sup>127</sup> Robert M. Sade, Medical Care as a Right: A Refutation, *The New England Journal of Medicine*, 285:1971:1288-1292

<sup>128</sup> Or, perhaps I should say, Sade draws a mis-analogy. A baker does not rely on millions of taxpayer dollars to finance the training, research and development of the baking profession. This is a fundamental and morally relevant difference.

<sup>129</sup> R. M. Sade, (1971), p. 1280

half-joking that a national health care system loses human lives as a national postal service loses letters. Privatisation is also said to have the supreme benefit of maximising choice, because health care providers have significant freedom from interference in the pricing, diagnosis and treatment of patients. Without state economists regulating department expenditure, the only restriction on a medical specialist is the affluence and ailment of the patient. Moreover, because a state will not subsidise their training, specialists owe no special debt to society, meaning that providers have complete freedom to set up shop wherever and in whatever speciality they like. Patients therefore have the option of choosing medical practitioners of their liking from a variety of specialist backgrounds in any location that suits; patients may choose an inexpensive doctor who performs minimal services or an expensive doctor who over-prescribes and caters to the hypochondriac. There is no need for centralised cost control or waste control measures since health care will receive as much or as little funding as citizens wish to give, in accordance with their subjectively defined needs. Most importantly, taxation is not required to fund social projects. Aiding the medically worst-off is transformed from a legal and moral necessity to a strictly moral matter: citizens have the free choice of either aiding the impoverished sick or ignoring any possible duty without fear of legal retribution.

There is truth behind the criticism that the majority of health care is priced beyond the reach of healthy employed citizens, let alone sick unemployable citizens relying on charity. The extreme pricing often reflects the high cost of production that goes into the research and development of new medical procedures. If citizens cannot afford to purchase care, then it is not right to say the price will simply drop; the treatment or product will be removed entirely from the market. Cost sharing practices such as insurance markets attempt to solve this problem by taking infrequent and

unpredictable events of prohibitively expensive cost and averaging them over a larger population so they become statistically regular and affordable. In this way, people prepay and share the excessive price tag of most medicine with a comparatively small premium that is ideally affordable, even for those who are poverty-stricken.

The USA is a prime example of insurance-based medical markets of this kind. While not one hundred percent privatised, with around seventy percent of Americans utilising some form of private insurance, no other system in the world even comes close to the massive dependence the USA has on its legion of private health insurance providers. As a way of assessing what role the private sector must play in the just distribution of health care, I shall now discuss the inherent advantages and disadvantages present in a highly privatised insurance system like that of the USA.

### **3b. (i): Medical Markets in the United States of America: A Case Study**

*America's health care system is neither healthy, caring, nor a system.*  
**Walter Cronkite**

Established in the 1930s the Blue Cross Blue Shield Association (BCBSA) is a dominating force in the medical marketplace, made up of 39 regional insurance companies across the USA. They are unashamedly proud of the fact that one in three Americans carries either a Blue Cross or a Blue Shield membership card. A variety of customised packages is available and, like all insurance plans, the more people pay, the more coverage they should receive. Blue Cross is a prepay hospital plan that can cost anywhere from US\$50 to US\$500 (NZ\$72 to NZ\$720) a month for a set amount of hospitalisation days (regardless of how sick the individual actually is at the end of that period) and Blue Shield provides prepaid pharmaceuticals and doctor services up

to a certain dollar value. Out-of-pocket payments make up the difference. Other options include compensation according to the amount a person has already paid into the system or a set limit on physician visits, such as eight per year, and even “catastrophic coverage” with a lifetime maximum limit of five million dollars.<sup>130</sup>

Another popular insurance practice in the USA was born out of the worker shortages of World War Two, when government legislated against the practice of competing for labour by offering exorbitant salary incentives, as this would unfairly disadvantage smaller companies. As a way around these restrictions on salary incentives, the workers would bargain with their employer for competitive retirement packages, health and dental insurance. Employers will either pay for the workers’ health care within certain price limits, or work as an agent for BCBSA, providing various blue plans at subsidised rates. In 2005, 60 per cent of employers offered some type of health insurance to their workers, a figure that is lower than previous years. Employers are also progressively charging more for their health packages: average premium rates increased 73 per cent from 2000 to 2005.<sup>131</sup>

Medicare is probably the most infamous provider of American health insurance, with around 14 per cent of citizens subscribing in 2005.<sup>132</sup> Established mid-1960s, the plan comprises two independent schemes that can be purchased from the government. Part A is hospital insurance for citizens aged 65+ and Part B provides subsidies on doctor and pharmaceutical bills for people with specific ailments. In 2005 it cost US\$78 (NZ\$112) per month for part B, so is generally cheaper than other market options, but eligibility is severely restricted as is the array of illness and

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<sup>130</sup> Blue Cross and Blue Shield Association, *Homepage*, <<http://www.bcbs.com/>> (15<sup>th</sup> January, 2007)

<sup>131</sup> US Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States*, <<http://www.census.gov/prod/2006pubs/p60-231.pdf>> (15<sup>th</sup> of January, 2007)

<sup>132</sup> US Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States*, <<http://www.census.gov/prod/2006pubs/p60-231.pdf>> (15<sup>th</sup> of January, 2007)

disability covered.<sup>133</sup> Health providers directly bill the patient, who then requests partial reimbursement from the government, so while this process allows the doctor considerable freedom in pricing, consumer autonomy is somewhat restricted as reimbursement is only valid if people are treated in a “Medicare approved facility”. What is more, Medicare only provides coverage if people have made a “deductible payment”; or in other words, if they have already paid over US\$110 (NZ\$158) of their own money on medical bills in the past 12 months.<sup>134</sup>

### **3b. (ii): Objections to the Medical Marketplace**

Despite this abundance of private health care providers, 47 million Americans were left without any kind of health care coverage in 2005 and this figure is increasing.<sup>135</sup>

There is much empirical evidence against the claim that insurance privatisation provides increased efficiency, quality, and choice. It is generally held within the literature that such laissez-faire distribution fails to score highly on *any* criteria of justice, with Allan Buchanan concluding that “the U.S. health care system is seriously ethically unjust.”<sup>136</sup>

An excessive burden is placed on the American public by this inefficient method of health care delivery. The US system in 2004 had the highest health

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<sup>133</sup> The US Department of Health and Human Services narrowly defines Medicare as insurance for “People 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).” US Department of Health and Human Services, *Glossary*, <<http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=M&Language=English>> (15<sup>th</sup> of January, 2007)

<sup>134</sup> U.S. Department of Health and Human Services, *Medicare Part B*, <[http://www.cms.hhs.gov/MedicareGenInfo/03\\_Part%20B.asp#TopOfPage](http://www.cms.hhs.gov/MedicareGenInfo/03_Part%20B.asp#TopOfPage)> (15<sup>th</sup> of January, 2007)

<sup>135</sup> U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States*, <<http://www.census.gov/prod/2006pubs/p60-231.pdf>> (15<sup>th</sup> of January, 2007)

<sup>136</sup> A. Buchanan, (1994), p. 729

expenditure in the world, consuming US\$5711 per person<sup>137</sup> compared with New Zealand's nationalised system costing US\$1893.<sup>138</sup> By the year 2013, the US figure is expected to rise to US\$10,709 per person.<sup>139</sup> Owing to the ever-rising price of US health care there has been a significant emphasis on cutting costs rather than improving coverage and quality for citizens. Insurance companies frequently adopt self-interested policy that actually *decreases* access to care; designing packages guaranteed to maximise profit and avoid the costs of carrying the sick. While Medicare was established as an affordable alternative to other non-federal insurance plans, increasing deductibles and restricted eligibility clauses leave many clients under-insured, thinking that they have adequate coverage when in reality they possess only a dangerously limited plan. This places such a burden on consumers that medical costs are a factor in over half of all bankruptcies in the USA, and of these, 20% had private medical insurance but lost coverage over the course of their illness.<sup>140</sup> What is even more appalling, owing to the financial impoverishment of Medicare and the red tape associated with state bureaucracy, reimbursement rates are 40% lower than those of other insurance providers,<sup>141</sup> so many Medicare approved facilities often turn away patients "covered" by Medicare out of a very real fear of not being paid. If the efficiency of a health care system is measured by the level of access to service compared with the cost of provision, the USA has the most inefficient health care

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<sup>137</sup> The World Health Organisation, *Countries: USA*, <<http://www.who.int/countries/usa/en/>> (15<sup>th</sup> of January, 2007)

<sup>138</sup> The World Health Organisation, *Countries: New Zealand*, <<http://www.who.int/countries/nzl/en/>> (15<sup>th</sup> of January, 2007)

<sup>139</sup> US Department of Health and Human Services, *Effects of Health Care Spending on the US Economy*, <<http://aspe.hhs.gov/health/costgrowth/index.htm>> (15<sup>th</sup> of January, 2007)

<sup>140</sup> Blue Cross and Blue Shield Association, *Expanding Access to Care*, <[http://www.bcbs.com/betterknowledge/mcrg/chap5/uninsured/ch5\\_Slide\\_3.html](http://www.bcbs.com/betterknowledge/mcrg/chap5/uninsured/ch5_Slide_3.html)> (15<sup>th</sup> of January, 2007)

<sup>141</sup> A. Buchanan, (1994), p. 729

system in the world at the expense of those patients who have no other choice but to participate in it.

This only scratches the surface of criticism about how insurance privatisation is an utterly ineffective and wasteful mode of health care provision. The most telling study conducted from 1970-1982 was the RAND health insurance experiment, in which 6000 US families were randomly assigned to one of two groups: one which had relatively free health care (comparable to insurance coverage with affordable premiums) and the other who had to pay full-price for health care (comparable to being under/uninsured). The predictable outcome was that those given relatively free health care received one-third more medical attention.<sup>142</sup> However, a notable conclusion of the RAND study was that, at the end of five years, despite one group seeking substantially more care, “there was *no* significant difference between the groups’ levels of health”<sup>143</sup>, and the group that received relatively free care was estimated to have gained a statistically insignificant seven weeks of increased life. Based on this experiment, it seems that, when compared with paying full-price for medical care, the purchasing of private health insurance does nothing notable towards helping people to live a significantly longer or healthier life. To put it another way, the American government spends US\$765,000,000,000 per year<sup>144</sup> of taxpayer money on inefficient insurance schemes that extend the average life by less than 0.2 per cent.

The very nature of a medical free-market encourages waste and detrimental competition, contributing to its inefficiency. Privatisation promotes the attitude that

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<sup>142</sup> As measured in dollar-value, number of eye-glasses and dental work obtained, and “restricted activity days” where subjects could do nothing more but engage themselves in health care related issues.

<sup>143</sup> Robin D. Hanson, Why Health is not Special: Errors involved in Bioethics Intuitions, *Social Philosophy and Policy*, 19:2:2002:153-179, p. 162

<sup>144</sup> Total health expenditure was over 1.7 trillion USD, with government expenditure as a percent of total health expenditure at 45% (2003). Blue Cross and Blue Shield Association, *National Health Care Trends*, <<http://www.bcbs.com/betterknowledge/mcrg/chap1/>> (15<sup>th</sup> of January, 2007)



doctors are just another market commodity that can be brought, sold, and sued if they fail to live up to consumer expectations. The patient is made unsure of a doctor's motive for treatment (follow up treatment may be ordered just to boost the doctor's salary) and the doctor is made fearful of the patient's consumer right to sue. Aside from destroying the doctor-patient relationship, an increase in malpractice litigation forces fearful doctors to practise "defensive medicine". This involves ordering two or three rounds of tests rather than one, hospitalising patients rather than recommending they rest at home, and over-prescribing in order to carpet-bomb the ailment before a patient becomes too uncomfortable. Dan English maintains that this partially accounts for the huge cost of health care in the USA: "Financial estimates of these services yield a figure of [US] \$52 billion per year as the cost of 'defensive medicine' on the part of *surgeons* alone."<sup>145</sup> What is more, when medical practitioners are sued in the USA, this does not guarantee that the doctor will be banned from continuing to practise, so litigation in no way protects patients from any future malpractice. Privatisation also encourages competition between hospitals attempting to become more technologically advanced than their neighbours. Less expensive, yet equally effective, equipment and services are made redundant every year to make room for the newest upgrade. The Office of Technology Assessment of the US Congress maintains that this wasteful attitude towards "big ticket" technology is estimated to account for up to 40 per cent of all cost increases within hospitals. What is more, with such a high demand for goods, it is claimed that less than twenty percent of new upgrades have undergone any form of controlled clinical trial or systematic study.<sup>146</sup>

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<sup>145</sup> Dan English, *Bioethics: A Clinical Guide for Medical Students*, (New York: W. W. Norton, 1994), p. 138

<sup>146</sup> R. Bayer, D. Callahan, A. Caplan and B. Jennings, Towards Justice in Health Care, In: T. Beauchamp and L. Walters (eds.) *Contemporary Issues in Bioethics: 4<sup>th</sup> Edition*, (Belmont: Wadsworth Publishing Co., 1994), p. 713

Attaching health care to employment is a disastrous idea that seriously disadvantages the unemployed and unemployable, reducing consumer choice. It is a scheme guaranteed to sell health care only to those who are healthy, because presumably, people suffering from an illness requiring moderate long-term medical care will be unable to work full-time and therefore be ineligible for this form of insurance. Moreover, when people lose their jobs their stress levels increase, as does the likelihood of falling sick, at a time when they are unable to afford private coverage. In 1986 the Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed, granting all terminated employees the choice of purchasing continuing coverage with the firm at a competitive price.<sup>147</sup> In reality, the COBRA does nothing to improve consumer choice, because, unless a former employee walks straight into another job (in which case there would be no need for coverage), “competitive” private insurance packages are unaffordable for the unemployed. The failure of employer-based health insurance to provide adequate access to care is evidenced by the fact that more than two-thirds of uninsured adults belong to the labour force.<sup>148</sup>

In discussing the contention that privatisation of medical care promotes consumer choice, Peter Singer rightly points out that “[t]here can be no freedom without adequate information on which to make a choice.”<sup>149</sup> Access to health care in the USA is determined by the amount of coverage people buy, which is in turn determined by access to information about what plan best fits their needs. If, like Medicare, an insurance company is constantly on the brink of bankruptcy and has an

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<sup>147</sup> US Department of Labour, *FAQ about COBRA*, <[http://www.dol.gov/ebsa/faqs/faq\\_consumer\\_cobra.html](http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html)> (15<sup>th</sup> of January, 2007)

<sup>148</sup> Alain C. Enthoven and Richard Kronick, *A Consumer-Choice Health Plan for the 1990's: Universal Health Insurance in a System Designed to Promote Quality and Economy*, In: T. Beauchamp and L. Walters (eds.) *Contemporary Issues in Bioethics: 4<sup>th</sup> Edition*, (Belmont: Wadsworth Publishing Co., 1994) p. 719

<sup>149</sup> P. Singer, (1976), p. 180

unhealthy preoccupation with curbing its medical costs, an ideal legal way of minimising payouts while still receiving income from premiums is to restrict the flow of information to the public. The BCBSA echoes Singer's concern that there is a notable lack of clear health information available to the American public, with frequent misunderstandings over how to procure effective coverage and under what specific conditions a package will not pay out: "Ninety million adults in the U.S. have difficulty understanding and using health information, and there is a higher rate of hospitalization and use of emergency services among patients with limited health literacy."<sup>150</sup> A lack of health information among those most likely to be hospitalised means the insurance companies have to pay out less frequently to a high-risk group, but still receive regular premiums from these people. Federal and State attempts to restrict consumer understanding of health issues are not uncommon in the USA. In 1974, Ralph Nader's consumer research organisation attempted to compile a directory of doctors' fees, qualifications and office hours so the public could possess a clear and precise charter of health-related information, but the Maryland County Medical Society stopped the attempt by threatening sanctions against those doctors who participated in the survey.<sup>151</sup> For whatever reason, presumably because there is money to be made in maintaining the status-quo, there is evidence of active resistance to informing the American public about health insurance related issues. The US insurance community and its affiliates work to severely restrict the individual consumer's free-choice.

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<sup>150</sup> Blue Cross and Blue Shield Association, *Engaging Consumers*, <[http://www.bcbs.com/betterknowledge/mcrg/chap2/general/ch2\\_Slide\\_7.html](http://www.bcbs.com/betterknowledge/mcrg/chap2/general/ch2_Slide_7.html)> (15<sup>th</sup> of January, 2007)

<sup>151</sup> P. Singer, (1976), pp. 179-180

Pre-1992, before the health care industry perfected blood screening techniques, blood from US private blood banks was estimated to have a 55 per cent contamination rate of hepatitis C.<sup>152</sup> The threat of hepatitis C can be reduced to zero by simply interviewing potential donors about their health history and lifestyle preferences and turning away those with a high risk. However, if blood is sold for money, then potential donors have a very good reason to lie about their past health record. In this way, the privatization of blood banks directly promoted the likelihood of blood contamination, because those who are most in need of the meagre sum paid for blood are from a socio-economic class that is more likely to have hepatitis C. Presumably, if patients requiring a blood transfer had the choice between “blood A” that has a 55 per cent chance of contamination or receiving donated “blood B” that has a zero percent chance, any person would choose the latter. However, advocates of an entirely privatised health system deprived patients of the opportunity to access uncontaminated blood. Supporters of privatisation may reply that this is far fetched as no health care system would ever be so reckless as to intentionally increase infection rates by fifty-fold. Moreover, a laissez-faire distribution will allow the market to be supplemented by charity, so the patient truly does have a choice between “blood A” and “blood B”. However, Singer informs us otherwise:

[W]hen hospitals in Kansas City chose to obtain blood exclusively from a non-profit community blood bank rather than from either of two commercial banks operating in the city, the commercial banks complained to the federal trade commission. In due course the commission ruled that the community bank and the hospitals had illegally conspired together to restrain commerce in whole human blood, and ordered them to stop doing so – this despite testimony that the commercially obtained blood carried a greater risk of infecting the recipients with hepatitis.<sup>153</sup>

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<sup>152</sup> P. Singer, (1976), p. 187

<sup>153</sup> P. Singer, (1976), p. 182

Considering the numerous problems associated with privatisation of health care, the fundamental issue seems to be keeping the price affordable so all people can access the institution. However, controlling the rising price tag of care and increasing insurance coverage is not simple, because the privatisation problems listed above create a prisoner's dilemma whenever cost-cutting measures are introduced. To improve the health system, it is beneficial for all concerned to enter a cost-cutting pact. Such a pact cannot work if individuals defect from the agreement; however, owing to the mistaken assumption that an increased level of medical care equates to an increased level of health (disproved by the RAND experiment) it is rational for any individual to continue their uninhibited consumption. This is compounded by the fact that the national problem is so large that the detrimental effects of one person defecting from the pact are seen to be negligible. From the perspective of private health care providers, any attempt at cost cutting leaves them open to malpractice litigation and a severe reduction in personal income. Even if everybody acknowledges that cutting the costs of health care is necessary to increase health care coverage, reduce excessive burdens and create a more just system, the act of cutting costs encourages free-riders; therefore, costs will continue to rise.

It seems that when privatisation advocates are confronted on their own grounds, any claims of increased efficiency, choice and quality are contradicted by an over-abundance of cold US statistics pointing to the contrary. Privatisation of any industry encourages self-interested policy designed to increase income and reduce expenditure; health care practitioners and insurance companies in the medical marketplace are concerned with maximising returns rather than an ethical distribution of their goods and services. The competitive nature of the marketplace also increases rivalry between practitioners. This encourages a wasteful use of medical technology

and generates a fear of malpractice litigation, which destroys the sacred patient-doctor relationship and encourages the expensive practice of defensive medicine. Privatised health care systems are far from efficient, because the rising cost of national health care forces insurance companies to introduce cost-cutting measures that create excessive financial burdens on the medical consumer, reducing access to care. What is more, in an effort to reduce costs, the insurance industry ebbs the flow of health-related information to the consumer, actively restricting the individual's choice and opportunity for effective care. It is difficult to vindicate the claim that privatisation increases quality. While it may be true that in some underdeveloped countries the quality of private health care is generally better than the nationalised system, Allen Buchanan finds that "there is no good evidence that privately insured individuals in the US receive higher quality care".<sup>154</sup> Nonetheless, keeping in mind the adage that absence of evidence is not evidence of absence, I must declare that the debate over improved quality has yet to be decided.

### **3b. (iii): A Proposed Solution**

I suggest that many of the problems outlined above can be reduced or eliminated by having a taxpayer funded national health system working alongside private insurance markets.

The free-market is said to enhance individual choice; however, health care premiums continue to grow at several times the rate of inflation, leaving an astonishing number of people without the opportunity to access care. In the USA, charity-based free clinics are unable to keep up with the demands of the uninsured; consequently, multitudes of uninsured and underinsured people have severely limited

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<sup>154</sup> Allen Buchanan, *Privatisation and Just Health Care*, *Bioethics* 9:1995:220-239, p. 222

health care choices. Establishing a centralised governmental health care system alongside the private industry will relieve the stress placed on charity hospitals, maximising individual choice. The affluent will have four immediate choices: to pay for private care through insurance schemes, to receive care from the national health centres, to visit charity-based health centres, or even to omit medical care entirely. The indigent will have three choices: nationalised care, charity-based care, or no care. Furthermore, the example used earlier in Singer's discussion of contamination in private blood banks would not have arisen, as the affluent would have had the free choice of receiving either private or public care, and the indigent would have received public care, including uncontaminated blood.

The creation of a national health service means that health care access in the USA will no longer need to be attached to employment status. Apart from increasing efficiency and opportunity for access, detaching health care from employment also has the huge benefit of stimulating the economy by encouraging business growth. It is estimated that employers in the USA spend 58 per cent of after-tax profits on health care for their employees;<sup>155</sup> funds that employers could otherwise use to expand their business, offer staff pay-raises and create new positions.

The health care industry will no longer have to implement underhanded cost-cutting measures, because the financial burden of carrying the sick will be shared by three arrangements: private industry, public taxes, and charity. Private medical practitioners receive their primary income directly from patients, so have a significant financial incentive to order unnecessary repeat visits, tests or pharmaceuticals. On the other hand, public providers do not receive income directly from patients, so have no

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<sup>155</sup> Blue Cross and Blue Shield Association, *Employer and Insurance Trends*, <[http://www.bcbs.com/betterknowledge/mcrg/chap6/employer/ch6\\_Slide\\_2.html](http://www.bcbs.com/betterknowledge/mcrg/chap6/employer/ch6_Slide_2.html)> (15<sup>th</sup> of January, 2007)

incentive to practise such expensive and wasteful tactics. In this way, drawing patients away from the inefficient private industry to the more efficient public system is in itself a cost-cutting technique. Taking the majority of health care providers out of the marketplace will also improve efficiency by altering the consumer's view that medical practitioners are just another commodity that can be purchased, sold and sued. Incidences of malpractice litigation will be reduced, together with the practice of defensive medicine. Moreover, as is the case with other government-run agencies, public health care providers will be standardised across the county. This will reduce hospitals' wasteful attitude towards big-ticket technology and eliminate doubling-up on expensive procedures, specialists and equipment within regions.

Privatisation is also exceedingly inefficient on an administrative level and will benefit by working in partnership with a public system. When a patient receives treatment in the USA, the medical bill is passed from the doctor to the patient and then on to either the insurance company or the US government. Patients then receive a co-payment request and must prove that they have met the threshold of deductible payments for that year. Finally, payments are sent to the medical practitioner, with numerous supervisors and departments rubber-stamping approval on the paperwork at each stage. This process creates millions of dollars in red-tape formalities and staff overheads, which can be eliminated by keeping the majority of treatments and payments under the supervision of one centralised health agency. The unification of a fragmented administrative system will also make it harder for people to commit health care fraud; a crime that cost America US\$90 billion in 2004.<sup>156</sup> Moreover, in a privatised health care system a patient's medical records can often be spread out

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<sup>156</sup> Blue Cross and Blue Shield Association, *Increasing efficiency and Information Sharing*, <[http://www.bcbs.com/betterknowledge/mcrg/chap4/healthit/ch4\\_Slide\\_6.html](http://www.bcbs.com/betterknowledge/mcrg/chap4/healthit/ch4_Slide_6.html)> (15<sup>th</sup> of January, 2007)



amongst several doctors and insurance companies, creating duplicate paperwork and making it hard to establish a full medical history. These inefficiencies will be eliminated by keeping all health information in a centralised governmental store. Centralisation of records would also aid the medical community in tracking disease incidence; a collated store of medical data could be frequently analysed without difficulty, to monitor the rise and fall of disease demographics. Finally, in the USA many insured people who fall sick forgo doctor's visits because they cannot afford the co-payments and deductibles, or are reluctant to endure the excessive paperwork associated with insurance claims. A centralised provision of medical care will remove any such disincentive for visiting a medical professional. This shall result in an increase of inexpensive preventative medical care, such as routine physicals; disease will be discovered at an earlier stage, preventing the development of major disorders that require expensive treatment.

## **Chapter Four: Distributing Health Care: Part 2**

### **4a: Strict Egalitarianism**

The private sector of health care distribution can be suitably regulated by the distributional principle: to each according to their personal share of income and wealth. However, to fill the gaps in access left by the private sector I propose that nationalised health care distribution shall best be regulated by egalitarian principles of justice. The egalitarian understanding of justice, subject to certain important qualifications, is that all people over the course of their lifetime should have the opportunity to achieve an equal amount of net welfare. Earlier in this paper I mentioned Robert Veatch's formulation of an egalitarian principle for equal access: "Everyone has a claim to the amount of health care needed to provide a level of health equal to other persons' health."<sup>157</sup> I find this principle subject to three important clarifications.

The above egalitarian principle has a restrictive sense about it, practically forcing the sick to utilise health resources they may not desire in the name of making their health equal to others. Although freedom of choice is not a dominant ideal under egalitarianism, in any fair system a patient should be free to abstain from treatment or select ineffectual "treatment" if so inclined. The first half of the principle "every one has a claim to the amount of health care needed" must be understood as securing all people the opportunity to stake their claim, as well as the opportunity to abstain from accessing health care.

While the first half of the principle established the opportunity to reach a desired outcome, the second half of the principle defines this desired outcome as "a

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<sup>157</sup> R. M. Veatch, (1976), p. 133

level of health equal to other persons' health". It is important to note that Veatch is not advocating that an equal level of health care resources be allocated to all people and used at the patient's discretion as the need arises. To give people a strictly equal amount of health care resources in the form of dollar-limits or day-limits on service is a profligate distributional practice frequently employed by insurance companies; it results in those who live a healthy life receiving more resources than they need, while the chronically sick have inadequate resources to meet their needs. Different people obviously have diverse health needs of varying urgency and expense, so Veatch's desired outcome of an equal level of health can only be achieved by providing an unequal level of resources.

Although egalitarianism and utilitarianism are traditionally in diametric opposition to one another, Veatch's distributive principle is not contradicted by the current practice of QALYs. Egalitarianism can be used to justify the existence of the health care institution itself and therefore applies only to the macro-sphere, while QALYs are used to justify decisions made within the health care institution and pertain to the micro-sphere. This means that the egalitarian decree to take all necessary steps to restore an equal level of health does not conflict with a QALY decision to remove a patient's opportunity for equal health by withdrawing treatment; strict equality is an institutional ideal that is qualified in practise by the QALY rationing technique. The compatibility of these two principles prevents a situation where black hole patients drain unjustified amounts of resources in the name of equality.<sup>158</sup>

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<sup>158</sup> However, QALYs do not address the problem of the entire health care institution becoming a black hole itself, draining excessive resources away from other important institutions. This is an objection addressed in detail below.

Later in his writings, Veatch brings these clarifications to the fore in a reformulation of his strong equal access principle: “justice requires everyone has a claim to health care needed to provide an opportunity for a level of health equal, as far as possible, to other persons’ health.”<sup>159</sup> This principle secures what health planners often call equal access to health care, or in terms more familiar to the moral philosopher, provides all people with an equal opportunity to fulfil their medical needs. Veatch’s egalitarian approach is clearly compatible with founding a right to health care in the equal satisfaction of medical survival and development needs.

#### **4a. (i): Discontinuity as Justification for Equal Access**

It is important to note here that this egalitarian principle need not apply to society’s other goods, such as food, clothing, housing, and education. These societal goods are primarily distributed by free-market transactions, according to personal merit or societal contribution, with a minimum level of service supported by charity. Justice need not require that everyone should have a claim to a level of clothing that is equal, as far as possible, to that of other people, and the same can be said of food, housing, and education. If an individual cannot afford clothes, then that individual must turn to charity, so it stands to be explained why justice demands that health care be distributed on such a strict egalitarian principle when most other imaginable goods are not.

It has been proposed by Gene Outka that there is a strong discontinuity amongst society’s goods, and health care has special features that make it particularly unsuitable for distribution by any principle of justice other than equal access. Namely,

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<sup>159</sup> R. M. Veatch, (1976), p. 134

health care needs are “beyond our control or power to predict”<sup>160</sup> and possess an “overriding importance”<sup>161</sup> whenever they do occur. People may reasonably expect that tomorrow they will need clothes to wear and food to eat, or expect that at some stage they will need employment facilitated by some level of education. Not only are these needs predictable, but so is the cost of their satisfaction. People know that winter comes every year and also know they can buy an umbrella for under ten dollars, so they can plan to use their fair share of income and wealth (which is ensured by separate principles of justice) to satisfy these predictable needs. It is a grim thought, but no one knows when cancer or a runaway truck may strike them down. Moreover, the anti-cancer drug Herceptin costs over seventy thousand dollars per patient per year, so this is hardly something a person could pay for out-of-pocket, even if the occurrence of cancer were predictable. To compound this, the costs of health care are often shielded from the consumer and constitute specialist knowledge available only to the medical elite. One study cited by the BCBSA found that: “For higher cost health services, consumers consistently under estimate the actual costs by at least half. In comparison, one survey reveals that consumers, on average, can estimate the price of a new Honda Accord to within \$300.”<sup>162</sup>

The disparity between these two estimations is clearly because of the greater level of prime-time advertising used to promote the latest Honda, compared with the promotion of hip-replacement surgery; nevertheless, the point is that health consumers are completely unable to plan and save for medical eventualities. This is in discontinuity with the purchasing of food and education, raincoats and houses. In

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<sup>160</sup> Gene Outka, Social Justice and Equal Access to Health Care, *Journal of Religious Ethics*, 2:1974:11-32, p. 15

<sup>161</sup> G. Outka, (1974), p. 20

<sup>162</sup> Blue Cross and Blue Shield Association, *Engaging Consumers*, <[http://www.bcbs.com/betterknowledge/mcrg/chap2/general/ch2\\_Slide\\_4.html](http://www.bcbs.com/betterknowledge/mcrg/chap2/general/ch2_Slide_4.html)> (15<sup>th</sup> of January, 2007)

expounding his discontinuity thesis, Outka also maintains that health care needs have an overriding importance when they occur, being far more important to satisfy than the need for an umbrella when it rains or even a house to live in. Given twenty dollars and a rainy day, a person still has a choice between goods; to buy an umbrella or pay library fines, to take a taxi or save the money and walk. However; as Outka points out, “[w]hen lumps appear on someone’s neck, it usually makes little sense to talk of choosing whether to buy a doctor’s service rather than a colour television set. References to just trade-offs suddenly seem out of place. No compensation suffices, since the penalties may differ so much.”<sup>163</sup>

Distribution by meritarian principles, according to societal contribution, or according to what may be purchased with a fair share of wealth and income could very well be appropriate principles to satisfy needs for scholarships, clothing and housing, or outstanding citizen awards. However, taking into account the nature of health care needs – being uniquely undeserved, uniquely unpredictable, and possessing an overriding importance whenever they do occur – it seems that health care must be completely disassociated from such meritarian distributive principles. Outka takes discontinuity as sufficient reason for society to adopt two distributive principles: “to each according to his need”<sup>164</sup> and “similar treatment for similar cases”.<sup>165</sup> According to Outka, these two principles are equivalent to a policy of equal access to health care, which ensures that no person goes without access to the important institutional good and ensures that all medical needs are satisfied to an equal level.

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<sup>163</sup> G. Outka, (1974), p. 21

<sup>164</sup> G. Outka, (1974), p. 21

<sup>165</sup> G. Outka, (1974), p. 23

#### **4a. (ii): Rationing Under Equal Access**

Veatch and Outka differ in their opinions on how to implement a principle of equal access in times of scarcity. Outka accommodates for scarcity by rationing medical care through waiting lists or lotteries, or by the exclusion of certain types of disease. He argues that discriminatory measures such as waiting lists and lotteries unavoidably violate people's right to equal treatment; in the sense that medical needs will be satisfied at a different time and place to others with identical needs. Despite this, Outka maintains that rationing techniques do not violate the weightier right to be treated as an equal; in the sense that medical needs are not being arbitrarily ignored through rationing, nor being satisfied according to dubious inequalitarian principles such as, desert, wealth, or societal contribution. Outka maintains that "(1) if we accept the case for equal access, but (2) if we simply cannot, physically cannot, treat all those in need, it seems more just to discriminate by virtue of categories of illness, rather than between the rich and the poor ill."<sup>166</sup> Outka considers treatment as equals to be central to egalitarian rationing; whereas Veatch, with his stricter egalitarian concept, finds any policy that excludes the sick to be an unjust violation of equal treatment. For Veatch, rationing techniques of lottery, waiting lists, and disease prioritisation are "repulsive as well as gargantuan."<sup>167</sup> He downplays the problem of resource scarcity, claiming that as a society we are more than able to treat those medically worst-off by increasing revenue through graduated payroll taxation or by introducing a system of deductibles and co-payments for the rich, alongside a serious effort to eliminate waste within the system. In one article, Veatch makes the bold statement that:

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<sup>166</sup> G. Outka, (1974), p. 24

<sup>167</sup> R. Veatch, (1976), p. 141

[w]e have the capacity to provide available health care necessary to improve the health, insofar as possible of the medically least well off. In fact, we can probably work our way up the list of the worst diseases before the question of limits is even raised – if we approach the allocation of health care from this egalitarian perspective.<sup>168</sup>

#### **4a. (iii): Objections to Equal Access**

Perhaps this form of strict egalitarianism goes too far by placing health care on such a high moral pedestal. Allen Buchanan challenges discontinuity of the health care institution by pointing out that not all health services are special in the manner desired by Outka.<sup>169</sup> There exist health care goods and services that are resourced in a similar manner to other social goods and services, owing to their lack of urgency. In addition, many medical needs may be reasonably predicted or expected by those who lead an insalubrious life. There have even been movements to exclude some medical services not worthy of public subsidy from a national health system, or more commonly and perhaps more humanely, a huge tax on the cost of purchasing alcohol and cigarettes supplements the cost of treatment. Elsewhere, Veatch has gone so far as to demand additional health care taxes on those who voluntarily participate in dangerous recreational activities such as motor racing, rock climbing, and stunt flying; demonstrating how even he believes not all health needs are unpredictable, undeserved, and of overriding importance.<sup>170</sup> What is more, there are many wasteful

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<sup>168</sup> Veatch opposed the need for disease prioritisation when he said: “The task of ranking diseases from worst to most benign is rather repulsive as well as gargantuan. Fortunately much of the ranking is unnecessary.” However, he goes on to say: “we can probably work our way up the list of the worst diseases before the question of limits is even raised”. I find it to be a problem for Veatch as to how exactly he intends this “list of the worst diseases” to be generated if it is true that “ranking diseases from worst to most benign... is unnecessary”. It seems that to avoid such contradiction, if any health care system is to run efficiently by treating the worst diseases in society, then it must do so by implementing the necessary rationing technique of disease prioritisation. See: R. Veatch, (1976), p. 141

<sup>169</sup> Allen Buchanan, *An Ethical Evaluation of Health Care in the U.S.*, In: T. Beauchamp and L. Walters (eds.) *Contemporary issues in bioethics: 4<sup>th</sup> edition*, (Belmont: Wadsworth publishing co., 1994)

<sup>170</sup> Robert Veatch, *Who Should Pay for the Smokers Health Care?*, *Hastings Center Report*, 4:1974:8-9



health care procedures, from the “medically defensive” practise of ordering excessive tests and X-Rays, to unnecessary bureaucratic red tape and the needless duplication of specialist positions in a community. Much esoteric research and development subsumed under the health care umbrella is unnecessary and wasteful given the numerous benefits that could be gained from redirecting funds to services such as health education programmes, or even allocating funds to other institutions exterior to health care. This appears to falsify the discontinuity tenets that *all* facets of health care relate to needs that are undeserved, unpredictable, and of overriding importance.

James Childress<sup>171</sup> and Charles Fried<sup>172</sup> both object that Outka’s discontinuity thesis is impractical as it places such a high moral importance on the satisfaction of medical needs that the institution absorbs a dominant share of society’s resources, creating an intolerable burden on society. If health care needs possess an overriding importance, then the institution is justified in taking the largest possible slice of funding. In fact, it is an unintended result of the overriding importance of medical needs that any policy that funds other institutions above the level allocated to health care constitutes an unjust distribution. What is more, it is possible for other non-health related needs to possess an overriding importance; for example, the need for a defence force in a country that is facing imminent attack. While these defence needs are more important than health care, the unpredictability of health needs compared with the predictability of defence needs would make it unjust to finance this important military operation if the costs were above, or drew resources away from, the provision of equal access. Outka does not intend that all of society’s resources be dedicated to health

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<sup>171</sup> James F. Childress, *A Right to Health Care?*, *Journal of Medicine and Philosophy*, 4:2:1979:135-141

<sup>172</sup> Charles Fried, *Equality and Rights in Health Care*, *Hastings Centre Report*, 6:1976:29-34; and Charles Fried, *Right and Wrong*, (Cambridge: Harvard University Press, 1978).

care, but he does demand that health care be funded in a manner consistent with its unique nature. This has the impractical outcome that the only way other institutions can receive funding above that of health care is if those other interests are more important *and* more unpredictable *and* more undeserved than medical interests. This undermines the funding of all other social institutions and diminishes the importance of the human interests those institutions protect, burdening society unnecessarily.

Buchanan is right in criticising the sweeping claim that health care is special, at least for the reasons cited by Outka, because the discontinuity is based on an assumption of homogeneity within the medical institution that is contrary to fact. Even if Outka's discontinuity of all health needs is accepted, then Fried and Childress seem correct in their criticism that discontinuity does not accurately reflect our intuitions about the diminished importance health care has in situations such as military invasion. Either way, Norman Daniels points out that "[s]imply claiming that health care is of special importance, and that utilitarianism or meritarian distributions are too risky, does not generate an equality argument."<sup>173</sup> Citing differences between various human needs is a good first step that helps us to define exactly what a just allocation might entail, but Veatch and Outka appear to require more argument to vindicate equal access as a demand of medical justice.

Theoretical inadequacies of discontinuity aside, there are still three objections to implementing the strong equal access principle. First, the principle is incompatible with a medical marketplace. Second, the principle unfairly restricts patient and provider autonomy. And third, the equality demands are too strict to succeed within a society of limited resources, disadvantaging society's worst-off.

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<sup>173</sup> Norman Daniels, *Rights to Health Care and Distributive Justice: Programmatic Worries*, *Journal of Medicine and Philosophy*, 4:2:1979:174-191, p. 185

Under Veatch's principle, a morally desirable level of health for any person is a level that equals others, not necessarily a high or a good level of health. To achieve equal health levels and avoid an immoral levelling-down of the healthiest citizens, the best care that is available to any one person in society must be made available to all. This form of equality necessitates the creation of a single taxpayer-funded tier of the highest possible quality, and is incompatible with the existence of a medical marketplace. In a frequently cited article, Claudine McCreadie points out that a tax funded sector will always be second-best if it is put in direct competition with a medical marketplace, since "the balance of professional manpower, and hence of political strength, lies in the 'insurance' sector."<sup>174</sup> For example, it is often the case with health care and other similarly organised institutions such as education that the private sector will out-compete the national sector for scarce resources, such as skilled workers or equipment. A second tier will allow access to be influenced by income and wealth and, assuming that McCreadie is correct that the quality of the first tier is undermined by the existence of the second, this will result in unequal health levels influenced by income and wealth. Because Veatch's strict equal access principle will not allow inequality in health levels, there must be a complete prohibition on the provision and purchasing of additional care from a medical marketplace.

With no independently determined level of service, but instead a strict equality of access to whatever services the system can support, there will be a severe restriction on the autonomy of those doctors who wish to practise medicine privately. Doctorial restrictions will also hamper consumers who wish to spend their hard earned money on so-called "Cadillac care". Egalitarians often justify this lack of

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<sup>174</sup> Claudine McCreadie, Rawlsian Justice and the Financing of the National Health Service, *Journal of Social Policy*, 5:2:1976:113-130, p. 128

provider autonomy by stating that doctors owe a debt to society, because of the huge amount of public subsidies that go towards their training. Doctors must repay this debt over their career, with the price being a restriction on the range of opportunities for choosing an economically lucrative specialty or location. The lack of consumer choice is an unfortunate and, in my opinion, unacceptable side-effect of the doctoral restriction and the egalitarian quest for equal access.

Limiting the choice of consumers will force those people who in alternative systems would purchase health care from a second tier of private providers to draw on state resources against their will. Veatch argues that an elimination of the second tier will improve the position of the worst-off, as it forces the wealthy, powerful, and influential upper class with their expensive medical tastes into the same tier as the poor, provoking improvement in service and closing the gap between the classes.<sup>175</sup> Maximin arguments of this sort go beyond the rich having a mere right to participate in the single tier. Those well off have an *obligation* to participate in a national health care system, despite the fact that their higher level of health could suffer if they do so. Veatch's argument that the upper class will provoke improvements in service raises the question: How is society to pay for these substantial improvements in times of scarcity? I find it hard to believe that any state funded health care system could support the massive influx of patients that will come from subsuming a second tier, plus make improvements in quality to satisfy their expensive medical tastes. Including these people with their luxurious demands will only serve to lower the health levels of the upper class and increase the strain on an already impoverished medical institution; reducing, not improving, the level of health of society's worst-off. What is more, as evidenced many times in the past, any strict prohibition on desirable goods and

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<sup>175</sup> R. Veatch, (1976), p. 138

services results in the creation of black markets. Health care will be no exception; a strictly egalitarian single tier system will force providers to take matters into their own hands, developing an underground and dangerously unregulated second tier of illegal health care. A second tier of unregulated health care will not serve to benefit the worst-off in society as they simply cannot afford to pay the inflated prices of black market goods and services.

#### **4a. (iv): Concluding Remarks on Equal Access**

The egalitarian principle of justice that everyone must have the opportunity to access the health care needed to provide a level of health equal to other persons is flawed both theoretically and practically. Discontinuity, as portrayed by Outka, is understood to justify the egalitarian principle of health care distribution, while allowing non-egalitarian principles to regulate other institutions. However, this assumes homogeneity of function amongst health care services that is contrary to fact. Moreover, discontinuity makes health care primary amongst the institutions, skewing a distribution that runs against commonsense. Given that discontinuity fails, the exclusion of health care from regulation by principles of decent minimum, desert, or free-market distribution; or at least, the distribution of health care by egalitarian principles, becomes arbitrary.

When the principle is implemented practically it is incompatible with a medical marketplace because competition between the two tiers will lower the quality of national service. Those patients who can afford better quality will seek private care, creating an inequality in individual health levels that is directly influenced by personal income and wealth. Veatch's principle does not permit a medical marketplace;

however, without this second tier existing, provider and consumer choice is restricted and there will be an illicit trade in black market medicine.

As the first tier subsumes the patrons of the redundant second tier, the first tier must ensure that the best care that was available to any one person in the disestablished second tier be made available to all in the first. I believe that this will place an excessive burden on an already impoverished national system. I disagree with Veatch's unrealistic optimism that society can provide an array of treatment options at the highest level of quality for the majority of illnesses before the question of financial limits is raised, while simultaneously maintaining an equal access to service. If the principle of equal access is to survive practical implementation, the more fundamental right to treatment as equals must take priority over the right to equal treatment, allowing the rationing of health care via waiting lists or lottery of a restricted package of services. While this manoeuvre brings the theory in line with fiscal realities, it does not solve all problems, as any system that rations out services will be detrimental to the health of those patients whose treatment options are restricted. It seems to me that what is required is an egalitarian system that shares the cost of carrying the sick by accepting the existence of a medical marketplace, thus avoiding Veatch's most serious problems.

#### **4b: Justice as Fairness**

Rejecting the strong equal access principle allows the possibility of adding a second tier that allocates health care on the free-market, permitting income and wealth to influence distribution. Whereas Veatch would not consent to any inequality in health levels, the theory portrayed now allows inequality as long as it results from a fair process. The most successful development of this two tier philosophy has been

Norman Daniels' extensive analysis of health care from the Rawlsian perspective, which also draws on elements from Charles Fried's and Gene Outka's discontinuity debate. Since *A Theory of Justice* is one of the most studied and critiqued works of twentieth century political philosophy, I shall assume a relative familiarity with Rawls' framework, detailing only those aspects relevant to assimilating Rawls' theory to health care.

According to John Rawls, people living within society are contractors who agree to abide by various rules of engagement and receive the associated benefits of mutual co-operation. *A Theory of Justice* is subtitled "Justice as Fairness", as the Rawlsian principles that dictate society's basic structure are formulated in an "original position"<sup>176</sup> of complete impartiality. Readers are asked to imagine an initial society occupied by hypothetical contractors whose job it is to formulate guiding principles. A so-called "veil of ignorance"<sup>177</sup> enforces impartiality in the original position, blinding the hypothetical contractors to any personal factors or attributes that may pervert fair decision-making. When the veil is lifted, the hypothetical contractors may have to live out their lives as members of any social class, race, religion, gender, occupation or historical era, so, because they are averse to risk, it is in their own best interests that the principles of justice should not unfairly disadvantage any of society's representative individuals. Rawls states that human abilities and attributes and the social conditions into which people are born are contingent matters "that seem arbitrary from a moral point of view";<sup>178</sup> therefore, the first part of Rawls' theory is designed to eliminate all morally arbitrary contingencies from the establishment of fair and just institutions.

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<sup>176</sup> John Rawls, *A Theory of Justice*, (Cambridge: Harvard University Press, 1971), pp. 118-192

<sup>177</sup> J. Rawls, (1971), pp. 136-142

<sup>178</sup> J. Rawls, (1971), p. 15

According to Rawls, the principles of justice as formulated by original hypothetical contractors under conditions of complete impartiality, lexically prioritised and in accordance with an intuitive sense of what is right are as follows:

*First Principle*

Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar liberty for all.

*Second Principle*

Social and economic inequalities are to be arranged so that they are both:

- (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and
- (b) attached to offices and positions open to all under conditions of fair equality of opportunity.<sup>179</sup>

Rawls' first principle secures equal basic liberties that are constitutionally imbedded and cannot be traded for social and economic gains.<sup>180</sup> The second principle is the main focus of this investigation, as it determines a just distribution of resources amongst society's institutions and representative individuals.

Health, vigour, intelligence, and imagination are counted as *natural primary goods*<sup>181</sup> and not considered by Rawls to be indicators of social redistribution because, "although their possession is influenced by the basic structure, they are not so directly under its control."<sup>182</sup> Rawls uses an index of *primary social goods*<sup>183</sup> to constrain the

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<sup>179</sup> J. Rawls, (1971), p. 302

<sup>180</sup> This is called the special conception of justice. J. Rawls, (1971), pp. 151

<sup>181</sup> J. Rawls, (1971), p. 62

<sup>182</sup> J. Rawls, (1971), p. 62

<sup>183</sup> "We distinguish between five kinds of such goods: (i) The basic rights and liberties: freedom of thought and liberty of conscience, and the rest. These rights and liberties are essential institutional conditions required for the adequate development and full and informed exercise of the two moral powers (in the two fundamental cases). (ii) Freedom of movement and free choice of occupation against a background of diverse opportunities, which opportunities allow the pursuit of a variety of ends and give effect to the decisions to revise and alter them. (iii) Powers and prerogatives of offices and positions of authority and responsibility. (iv) Income and wealth, understood as all-purpose means (having an exchange value) generally needed to achieve a wide range of ends whatever they may be.



domain of issues relevant to social justice and to indicate those representative individuals who are subject to the second (difference) principle. These objectively ascribable goods are all-purpose means that people need to pursue their conception of the good, regardless of their aims. Primary social goods are influenced directly by the basic structure, so it is morally desirable to arrange society in such a way as to provide more rather than less primary social goods to the people. Clothing, food and shelter are objectively ascribable goods not explicitly considered by Rawls; nonetheless, Daniels correctly states that these goods are best regulated by their exchange value with income and wealth.<sup>184</sup> Daniels considers health care to be a “special”<sup>185</sup> social good that is discontinuous with those other institutions that distribute clothing, food and shelter. He finds it hard to believe that hypothetical contractors would choose a system that distributes health care based solely on its exchange value with income and wealth, owing to the importance of health and the inequity that results from privatisation. Unfortunately, Rawls is silent on the topic of health care allocation owing to his assumption of a “strict compliance” where “all citizens have physical and psychological capacities within a certain normal range”.<sup>186</sup>

Put simply, in an original position, the assumption is made that nobody falls sick, all are mutually disinterested, and no one defies the principles of justice; therefore, there is no immediate need for Rawls to consider health care distribution. Ronald Green believes that Rawls uses strict compliance to avoid health care issues because he simply did not have enough space in *A Theory of Justice* to consider such

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(v) The social bases of self-respect, understood as those aspects of basic institutions normally essential if citizens are to have a lively sense of their worth as persons and to be able to advance their ends with self-confidence.” John Rawls, *Justice as Fairness: A Restatement*, (Cambridge: Harvard university Press, 2001), p. 58-59

<sup>184</sup> N. Daniels, (1979), pp. 179-180

<sup>185</sup> N. Daniels, (1985), p. 19

<sup>186</sup> John Rawls, *Social Unity and Primary Goods*, In: A. Sen and B. Williams (eds.) *Utilitarianism and Beyond* (Cambridge: Cambridge University Press, 1982), p. 168

a large topic.<sup>187</sup> As it is a very narrowly defined book extensively concerned with the most fundamental questions of political justice, it keeps a notable silence on many other social issues, such as international law and society's duty to animals and nature, so there is no pressing motivation for health care to receive special mention. Norman Daniels speculates that Rawls excluded health care to maintain a clear and uncluttered view of the fundamental issues of social justice, but believes that Rawls also implicitly recognised the truth of Outka's discontinuity. It is Daniels' conjecture that Rawls would not have desired health care to be influenced by income and wealth and proposed strict compliance primarily as a way around the problem.<sup>188</sup> It is important to realise that Rawls' silence does not mean that such social goods are not subjects of distributive justice, or that justice as fairness cannot be extended to cover these goods. Once acceptable principles of justice are selected under conditions of strict compliance and society moves gradually out of the original position, philosophers are allowed to modify the theory for situations of imperfect compliance. Daniels suggests that theorists can even invent entirely new principles of justice concerning health care, on the strict condition that Rawls' hypothetical contractors will accept the revision:

It is not a methodological requirement of his that a few such principles will apply to all situations. All that is required is that the special health care principles be suitably adjusted to other principles from the perspective of the original position, yielding a system with sufficient unity.<sup>189</sup>

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<sup>187</sup> Ronald Green, Health Care and Justice in Contract Theory Perspective, In: R. Veatch and R. Branson (eds.) *Ethics and Health policy*, (Cambridge, M.A.: Ballinger Publishing Company, 1976), pp. 112-113

<sup>188</sup> N. Daniels, (1979), p. 181

<sup>189</sup> N. Daniels, (1979), p. 181fn.

Once this hypothetical society has moved out of the original position and away from strict compliance, if the original contractors have not devised any mechanism for dealing with health care, justice as fairness will fail as there will be members of society who are blatantly worse off with no remedy for their disadvantaged position. To illustrate this, Kenneth Arrow compares two representative individuals: one with a full set of primary social goods and perfect health record and another with a full set of primary social goods but who suffers from haemophilia and requires four thousand dollars worth of coagulant treatment per year.<sup>190</sup> Both would come up equal on Rawls' primary goods index, and allocation by the difference principle would not favour one over the other, despite the debilitating health care needs of the latter.

#### **4b. (i): Health Care as a Primary Social Good**

One simple and rather obvious way in which health care needs can be accounted for is to include health care in the index of primary social goods. Norman Daniels elucidates this approach; not as a serious way of including health care in Rawls' theory, but more as a way of explaining the difficulties involved with such attempts. If health care is included as a primary social good, Daniels explains that "the index measures one's share of primary social goods plus the share of health services needed to satisfy some objective measure of health."<sup>191</sup> When society attempts to redistribute goods in favour of those worst-off groups in accordance with the difference principle, re-allocation raises the level of those with the lowest objective measure of rights and liberties, opportunities and powers, income and wealth, social bases of self-respect, and provides a level of health care services needed. By altering the list in such a way,

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<sup>190</sup> Kenneth Arrow, *Some Ordinalist-Utilitarian Notes on Rawls' Theory of Justice*, *Journal of Philosophy*, 70:9:1973:245-263, p. 254

<sup>191</sup> N. Daniels, (1979), p. 181

the subjects of maximin are not only those generally worst-off in society, but also those medically worst-off.

#### **4b. (ii): Objections to Health Care as a Primary Social Good**

Immediately this approach seems problematic. By definition, primary social goods are features of citizens' political and social circumstances, and as such must be directly under the influence of the basic societal structure. It is a questionable empirical assumption that all health services will fit neatly into this socio-political index. To clarify this objection, it is helpful to talk about Ronald Dworkin's distinction between brute luck and option luck.<sup>192</sup> Dworkin states that the latter type of luck is a "matter of how deliberate and calculated gambles turn out – whether someone gains or loses through accepting an isolated risk he or she would have anticipated and might have declined",<sup>193</sup> while the former is the antithesis, being beyond an individual's ability to anticipate. Reputable egalitarians<sup>194</sup> maintain that social justice requires the nullification of the effects of bad brute luck, and does *not* require the mitigation of the effects of bad option luck. Injuries caused by second hand smoking, unprovoked assault, genetic disease, and environmental pollution are matters of bad brute luck; therefore, it is unfortunate and unfair for people to suffer from these ailments. Justice as fairness demands rectification of their disadvantaged position. On the other hand, it is questionable to say that ailments resulting from a person's free choice, through alcohol and cigarette abuse or reckless participation in dangerous recreational activities, are unfortunate and unfair matters that demand rectification by the basic

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<sup>192</sup> Ronald Dworkin, What is Equality? Part 2: Equality of Resources, *Philosophy and Public Affairs* 10:3:1981:283-345

<sup>193</sup> R. Dworkin, (1981), p. 293

<sup>194</sup> Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality*, (Cambridge, M.A.: Harvard University Press, 2000), p. 73; and, Gerald A. Cohen, On the Currency of Egalitarian Justice, *Ethics* 99:1989:906-944, p. 908.

structure. If the role of justice as fairness is to mitigate injustice that results from bad brute luck in the natural and social lotteries, then health services that treat option luck ailments are technically not a concern of social justice. This may even be another reason why Rawls assumed ideal compliance and excluded health care from his schema – perhaps he realised that not all medical ailments are a matter of social justice, and therefore not all health care services are fit for inclusion into the primary social goods list.

Philosophical contributions by Peter Vallentyne,<sup>195</sup> Michael Otsuka,<sup>196</sup> and Marc Fleurbaey<sup>197</sup> all express doubts about the adequacy of Dworkin's distinction between option luck and brute luck. Fleurbaey advocates a different interpretation of luck egalitarianism, which incorporates the simple idea that justice requires compensation for some, but not all, instances of bad option luck. Fleurbaey finds it more helpful to account for individual responsibility by distinguishing between socially relevant and private matters, rather than between option and brute luck.<sup>198</sup> For example, Dworkin and Fleurbaey both agree that society need not rectify the loss of a drunken gambler who chooses to make a series of bad bets. This case of option luck is purely a private matter. On the other hand, if a drunk chooses to drive his or her car and is seriously hurt in a crash, then this is an instance of socially relevant option luck. This is socially relevant because it would be immoral and unjust for the driver to languish in agony while doctors withhold treatment. As far as medical care goes, if society has the capacity to treat an option luck ailment, but ignores the medical need on the grounds of its being a result of bad option luck, an injustice is created through

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<sup>195</sup> Peter Vallentyne, Brute Luck, Option Luck, and Equality of Initial Opportunities, *Ethics* 112:3:2002:529-559

<sup>196</sup> Michael Otsuka, Luck, Insurance, and Equality, *Ethics* 113:1:2002:40-56

<sup>197</sup> Marc Fleurbaey, Equal opportunity for Equal Social Outcome, *Economics and Philosophy* 11:1995:25-55, pp. 40-41

<sup>198</sup> Marc Fleurbaey, Egalitarian Opportunities, *Law and Philosophy* 20:5:2001:499-530, p. 500

this blatant neglect of medical need. On Fleurbaey's reinterpretation of luck egalitarianism, all health matters are a concern of social justice, whether or not they are a result of brute luck or option luck. I find Fleurbaey's interpretation preferable to Dworkin's, as the former better reflects commonsense intuitions about the diminished role individual responsibility plays in the basic structure's obligation to rectify medical needs. In answer to the objection that the majority of medical ailments, and therefore medical treatments, are not a concern of social justice; on this revised conception of individual responsibility the satisfaction of all medical needs is the responsibility of the medical establishment. If primary social goods are defined as socially controlled factors that citizens use to criticise and revise their conceptions of the good, then the amount of health care a patient requires to return to an objective level of health fits well into this social goods index.

Kenneth Arrow<sup>199</sup> points out that Rawls' second principle succeeds in utilising the unaltered original list of primary social goods because society can always take positive steps towards compensating the worst-off for their inadequate holdings. Health, however, is altogether different: the medically worst-off in society are often beyond improvement. Once again bottomless medical black holes open up, because maximin conflicts with the QALYs approach in demanding the limitless financing of terminally ill patients with minimal improvement in their condition. Arrow finds it unacceptable that maximin, when applied to medical matters, "implies that any benefit, no matter how small, to the worst-off member of society, will outweigh any loss to a better-off individual, provided it does not reduce the second below the level of the first."<sup>200</sup> A maximin medical plan of this sort transforms the institution of

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<sup>199</sup> K. Arrow, (1973), p. 251

<sup>200</sup> K. Arrow, (1973), p. 251

health care into a fiscal black hole, reducing the rest of society to a level of poverty. This is not a course of action that would be accepted by the hypothetical contractors; therefore, this proposal, as it stands, does not succeed. Before investigating the possibility of modifying maximin to exclude the medically irreconcilable, I wish to consider one final frequently cited proposal for incorporating health care.

#### **4b. (iii): Health Care as an Imperative Primary Social Good**

Ronald Green slightly modifies Daniels' above approach by placing health care as a primary social good of insurmountable importance. Because any loss in health care access would mean that the contractors risk not satisfying a basic human need, Green believes that the hypothetical contractors will reject laissez-faire and utilitarian macro-allocation in favour of ranking health care as a primary social good that it is *on a par* with the equal basic liberties. Green assumed this overriding importance to be true without argument when he said, "there seems to be little question that in the priorities of rational agents health care stands near to the basic liberties themselves."<sup>201</sup> Equating health care with liberties and the social bases of self-respect is not a unique position. I have already discussed Gene Outka's support for the overriding importance of health care; while elsewhere, Cecile Fabre<sup>202</sup> likens health care to the various liberties, supporting the existence of second generation social rights by noting their similarities to first generation rights.<sup>203</sup> David Lyons and

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<sup>201</sup> R. Green, (1976), p. 117

<sup>202</sup> Cecile Fabre, *Social Rights Under the Constitution*, (Oxford: Oxford University Press, 2000)

<sup>203</sup> You will recall Chapter One where this generational distinction was made. First generation rights constitute Articles 2-21 of the UDHR and contain negative "freedoms from X" rather than positive "rights to X". The second generation of rights are generally described as "rights to a substantive good X" rather than "freedoms from X", and are embodied in Articles 22 – 27 of the UDHR. It is worth noting, however, that this classification is only a general rule of thumb.

Michael Teitelman<sup>204</sup> further echoed Green's comparison of health care to liberty when they questioned Rawls' list of equal basic liberties, arguing physical well-being and security to be rationally preferable for the contractors. Green believes that impartial reasoning by the contractors will favour a structure that guarantees the highest possible level of health care for themselves and, owing to the liberty-like importance of health care, a *third* principle of justice will be dedicated to an equal allocation of this high ranked primary social good:

Principle of Equal Access to Health Care: Each member of society, whatever his position or background, would be guaranteed an equal right to the most extensive health services the society allows.<sup>205</sup>

This principle is different from Veatch's concept of equal access, which forbid inequality in health levels, and is far removed from an equality of resource distribution. Green is advocating a taxpayer-funded single tier system that forbids inequalities in a person's ability to access any health care service provided by society. Given that there is a limited amount of resources, there shall be a reduced level of service quality and specialisation, in order to fund health care for the masses. For example, it may be necessary to exclude expensive atypical treatments and esoteric medical research in order to afford universal access to influenza vaccines and free visits to General Practitioners.<sup>206</sup>

Aware of the importance of not turning the health care institution into a vacuous black hole, Green is quick to emphasise that this third principle applies only to *accessing* the health care system; stating that medical distribution within the

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<sup>204</sup> David Lyons and Michael Teitelman, Symposium: A Theory of Justice by John Rawls, *Journal of Philosophy*, 69:18:1972:535-557

<sup>205</sup> R. Green, (1976), p. 117

<sup>206</sup> R. Green, (1976), p. 120



institution should be in accordance with “whatever other principles impartial rational agents consider appropriate.”<sup>207</sup> These “other principles”, not elucidated by Green, are obviously on the micro-allocative level and will define an adequate upper and lower limit on expenditure that forbids a situation of black hole absorption. Given that impartial rational agents will agree with the practice, I find QALYs ideally suited for such a task.

Green also provides two weaker arguments as to why the original contractors will not allow the health care institution to drain funding away from other social institutions, in the manner of Outka. First, Green points out that advances in the normal sectors of society can often be applied to medical care, for example, the way in which a telecommunications initiative (the laser) is used to treat glaucoma. Therefore, according to Green, it benefits those medically worst-off if society adequately funds projects that, on face value, hold no relation to health needs.<sup>208</sup> Second, the World Health Organisation incorporates conceptions of well-being into its definition of health; defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>209</sup> Green expands on this line of thought, claiming that these mental and social factors are largely influenced by a person’s ability to pursue a range of opportunities over a lifetime. A health care system that drains large amounts of resources from the rest of society will diminish individuals’ range of social opportunities, negatively affecting their mental and social health.<sup>210</sup> Green finds it a benefit of his equal access principle that “in contract terms, we can say that the members of the original position have very good

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<sup>207</sup> R. Green, (1976), p. 118

<sup>208</sup> R. Green, (1976), p. 121

<sup>209</sup> World Health Organisation Regional Office for South-East Asia, *Constitution of the World Health Organisation*, <<http://www.searo.who.int/EN/Section898/Section1441.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 3

<sup>210</sup> R. Green, (1976), p. 121

reasons for not settling for a society where its members are free from physical disability, but who otherwise live at a level of economic austerity.”<sup>211</sup>

Green’s principle is parallel to the principle of equal basic liberties, in that it does not allow any one person to have more or less health care access than other people. Consequently, Green cannot allow people to purchase more medical access than others with their share of income and wealth, so the principle seems to rule out the existence of a medical marketplace. It appears that Green faces those serious problems found in Veatch’s equal access theory, where a prohibition on the free market results in a reduction of provider and consumer autonomy and it creates undesirable medical black markets.

In reply, Green states that as long as the medical market follows what Rawls called “pure procedural justice”,<sup>212</sup> there is no reason why his distributive principle would rule out the possibility of a medical marketplace. “The major objection to reliance on the free market”, Green claims, “is that it seems to re-introduce the income based distribution already repudiated by the contract parties. But this objection need not be decisive.”<sup>213</sup> Under pure procedural justice, there is no criterion for what constitutes a just outcome other than the procedure itself. Therefore, as long as the procedure for market distribution is fair – as long as the medical market is in keeping with Green’s equal access principle – the resulting distribution must also be considered fair. Green suggests that a medical marketplace could be set up to follow the principle of equal access if it had progressive payment rates for care, when the poor would receive taxpayer subsidised health care and the rich would pay proportionately more according to a means tested sliding scale. This dual tier system

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<sup>211</sup> R. Green, (1976), p. 121

<sup>212</sup> J. Rawls, (1971), pp. 85-87

<sup>213</sup> R. Green, (1976), p. 122

would secure universal access to the most extensive health services society can afford through a government provided first tier, with a second market tier providing services that are competitively priced for the rich and subsidised for the poor. Consumer and provider choice would be maintained and the freedom that would be created within the marketplace would discourage renegade medical markets. Equal access would be maintained as long as practitioners in the market do not provide a level of service for the rich that is unattainable by those who rely on government funding, and as long as the procedure is properly followed and no one cheats the system. Green insists that “at least theoretically... the free market in health care would function as an instance of ‘pure procedural justice’ on a parallel with Rawls’ hope for the economic system as a whole.”<sup>214</sup>

#### **4b. (iv): Objections to Health Care as a Distinct Primary Social Good**

Allan Buchanan criticises the abstract nature of Green’s theory, and Rawlsian contract theory generally, as being too uninformative for practical use. The upper and lower limits of health care expenditure are left undefined by the original contractors because the veil of ignorance obstructs any information of this type; they only know that they prefer more health care rather than less. Moreover, contractors need to make the health care principles as non-specific as possible so that they function successfully in a variety of societies at varying levels of medical development. Green’s health care principle simply guarantees access to whatever the system can support for all, no more, no less, with the definition of what constitutes such basic care being flexible and relative to the society’s capability. For Buchanan, this abstract theorising does not

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<sup>214</sup> R. Green, (1976), p. 123

go far enough because hypothetical reasoning can only generate a “placeholder”<sup>215</sup> for health care within the basic structure, providing no guidance as to the content of a right to health care and providing no way to define a fair level of health care funding or service provision. Buchanan writes:

Rawls’ theory does not itself supply content for the notion of the right to a decent minimum of health care: instead, at best, it lays down a very abstract structure within which this content will be worked out through the democratic political process specified by the list of equal basic liberties. Given this, Rawls’ theory advances us very little beyond the broad intuitive consensus that there is a universal right to a decent minimum of health care.<sup>216</sup>

I believe that Buchanan is confused about what can be achieved by a distributional theory, such as that described in *A Theory of Justice*. Buchanan essentially states that he is seeking a concrete foundation for the intuitive consensus that there is a universal right to a decent minimum of health care. From this foundation he intends to derive specific health information, such as an intercultural and trans-historical definition of those services to be included in the decent minimum of health care. However, it must be clear that he will not find such foundations in the original position section of Rawls’ theory (which is the section that Green’s argument concerns), because at this level of development the theory is too abstract to concern human rights content. Moreover, in the above quotation Buchanan precisely articulates the proper role of Rawls’ theory at the original position stage of development; it is actually designed to establish a placeholder for those societal goods or ideals held to be morally desirable, and then will create a political process that ensures their realisation in due course. If Buchanan is concerned that Green’s theory does not define content for the human right to health care, I must say that his

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<sup>215</sup> A. Buchanan, (1984), p. 61

<sup>216</sup> A. Buchanan (1984), p. 62

objection seems out of place, because defining content for a right to health care is an issue that is best taken up prior to deciding just methods for distributing such content. This is why I presented foundational arguments above in Chapter Two, prior to distributional arguments in Chapters Three and Four.

Norman Daniels<sup>217</sup> objects that the somewhat assumptive argument that Green uses to promote health care can also be used to promote the other social goods of food, clothing and shelter. This is because the rational contractors would obviously want to secure more rather than less of these goods, with guaranteed access predominantly for the worst-off. In exactly the same way that Green proposed health care to be a primary social good of supreme importance, every other social good could be argued to be on par with the basic liberties. As a result, a principle of equal access would be formulated for each good by the hypothetical contractors, changing Rawls' uncluttered view of social justice into a reasonably complicated indicator of need satisfaction. Daniels claims that Green, by introducing health care to the list, has corrupted the nature of the primary goods list. He has turned it from a list of general all-purpose goods that any rational person needs regardless of knowing specific needs, into a list of specific needs that must be satisfied because of their importance to the individual. This major change to Rawls' theory is performed without adequate discussion when Green assumes health care to be the most important primary social good.

To a degree, Green's high prioritisation of health care goes against much of what I have been saying about the social good of health care. The moral obligation imposed by a second generation right is in direct proportion to the moral urgency of other social projects and a prioritisation of social expenditure. When the education

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<sup>217</sup> N. Daniels, (1985), p. 45

system, national defence, infrastructural maintenance, police and fire services are competing against one another for resources, there must be a certain degree of trade-offs between goods. For example, in situations of natural disaster where many are sick and injured, the obligation for a state to secure health care may be at its strongest, but can be equally as strong as the obligation to provide clean drinking water, open lines of communication and transport, or provide a fire service and police presence to secure the area. Another example is the situation of imminent invasion and civil unrest, where health care obligations are weakened and must come after the stronger obligation of providing a well-staffed and well-armed defence force. It would not be right to say that a country has an atrocious human rights record if it slashes the health budget, then reallocates funds to quash violent civil unrest and aid fire fighters battle out of control infernos consuming major cities. The basic point here, implied by Daniels when he said “man does not live by good health care alone”,<sup>218</sup> is that trade-offs must occur between the social goods. This is true on the level of the representative individual trading between fair shares of primary social goods, and true on a macro-allocative level, trading between the services of social institutions. A problem arises because in the priorities of rational agents, health care is a social good that stands near to the basic liberties; a weighting that is so restrictively high that it does not permit ready trade-offs between the primary social goods. Daniels objects that “[f]rom the point of view of the original position, once we rank health care as the centrally important primary good Green takes it to be, it is hard to see how we can allow trade-offs of it with other social goods.”<sup>219</sup>

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<sup>218</sup> N. Daniels, (1979), p. 186

<sup>219</sup> N. Daniels, (1979), p. 186

While health care will be undoubtedly important to the hypothetical contractors, as are all primary social goods, I am not yet convinced that it is a rational thing for the contractors to rank health care as an eminently important social good. Certainly, if the contractors are born into contemporary Western society, with all the conveniences of modern medicine, it is true that they may want more rather than less health care and might rank it on the same level of importance as the equal basic liberties. However, the opposite could be said if the contractors were born into a society of Dark Age medical practice, when painful bloodletting, leaches, exorcism and unhygienic open surgery could kill people faster and in a more gruesome manner than their ailment.<sup>220</sup> Being adverse to risk, rational contractors simply will not rank health care as highly as Green does – having such importance that any loss of the good constitutes a severe loss to the individual – because in many societies throughout history a loss in health care access may potentially be of benefit to the individual. The epistemological constraints of the original position forbid the contractors from knowing how important health care will be during their life; therefore, being risk adverse, it is rational for the contractors to rank health care equal amongst the social goods, permitting trade-offs once beyond the veil of ignorance if they turn out to be in a society of undesirable medicine. This, of course, collapses Green’s approach into the problematic approach examined earlier (where health care was one primary good amongst others) and undermines the foundations of Green’s principle of equal access to health care.

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<sup>220</sup> I concede that by modern standards it is a stretch of the imagination to call these practices “health care”; nonetheless, those physicians who performed such procedures certainly considered them to be the greatest and latest in medical achievement. Perhaps physicians a thousand years from now will look back at 21<sup>st</sup> century medical practice with similar contempt, being reluctant to label our medicine as health care.

#### **4c: A Proposal for Fair Health Care Distribution**

I now wish to reconsider Norman Daniels' argument from Section 4b. (i), which attempted to include health care in the list of primary social goods. Daniels mentions the possibility of adding "the share of health services needed to satisfy some objective measure of health"<sup>221</sup> as a sixth primary social good on Rawls' list, so that maximin will demand the financing of health care for society's medically worst-off. You may recall that Kenneth Arrow made the definitive objection that it is unacceptable to place health care as one primary good amongst others, since maximin will demand that limitless amounts of resources be poured into medical procedures for the sick, on the sole condition that those treatments bring about at least an infinitesimal improvement in health. While a principle of social justice that ensures treatment for the medically worst-off is morally desirable, it is problematic that maximin has no concern for essential cost-benefit restrictions. Many radical and expensive medical procedures such as nuclear powered hearts and cryogenics will become a regular demand of justice, transforming the institution of health care into a financial black hole that reduces the rest of society to a level of poverty. This is not a course of action that would be accepted by the hypothetical contractors because, as Green has already pointed out in section 4b.(iii), "members of the original position have very good reasons for not settling for a society where its members are free from physical disability, but who otherwise live at a level of economic austerity."<sup>222</sup> Therefore, Daniels' proposition of placing health care as one primary good amongst others is not successful.

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<sup>221</sup> N. Daniels, (1979), pp.181

<sup>222</sup> R. Green, (1976), p. 121



If health care is to be kept as a primary social good, qualifications must be made to Rawls' second principle so to restrain maximin allocation. I suggest the following parenthesised additions to Rawls' work:

*Second Principle [Amended]*

Social and economic inequalities are to be arranged so that they are...:

- (a) to the greatest benefit of the [generally] least advantaged, consistent with the just savings principle, and
- (b) [to the greatest benefit of the medically least advantaged, consistent with a fair principle of rationing, and
- (c)] attached to offices and positions open to all under conditions of fair equality of opportunity.<sup>223</sup>

I define the *generally* least advantaged as those who would be deficient in Rawls' original list of five primary social goods: basic rights and liberties, freedom of movement and free choice of occupation, powers and prerogatives of offices and positions of authority and responsibility, income and wealth, and the social bases of self-respect. Therefore, in spite of the introduction of the word "generally", clause (a) of the second principle continues to operate in keeping with Rawls' original intent. The word "generally" is introduced for the sole purpose of distinguishing those individuals with medical needs, who are the legitimate subjects of rationing, from those individuals who are deficient in the other primary social goods, in whose case rationing is unnecessary or even an injustice. A separate clause (b) is created to regulate the additional primary social good of health care. The promotion of the health care institution above society's other institutions is a matter on which many notable philosophers – Singer, Outka, Veatch, Daniels, and Green – have all agreed. For that reason, the creation of this extra health care clause and the manner in which it

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<sup>223</sup> J. Rawls, (1971), p. 302. Note: My additions to Rawls' original principle have been placed within square brackets.

operates independently from the regulation of the five other social goods implicitly distinguishes health care as a primary social good of special importance.<sup>224</sup> My clause (b) concerns the *medically* least advantaged; defined as those who require a share of health services to fulfil an objectively ascribable medical need. I expect that it is rational for the hypothetical contractors to formulate this separate health care clause because of the supreme importance they place on having good health, and also because they would realise that health care is clearly discontinuous from the other social goods. In short, the hypothetical contractors will appreciate that health care is vastly different from the other primary social goods, so its distribution must be governed by a separate rule.

When the unqualified maximin worked upon the health care institution it required that resources be dedicated to the unhealthiest member of society regardless of ailment, then to the second unhealthiest, then the third, and so on, with the goal of improving their medical situation. If left unqualified, this approach would be open to Arrow's objection that maximin demands costly treatments for only minute returns. To avoid this, clause (b) now reads that maximin allocation for the medically least advantaged must be consistent with a fair rationing principle. The details of this rationing principle, however, cannot be determined from the original position under a veil of ignorance. This is because a major determinant of any rationing mechanism's efficiency is the cost-benefit calculation, which depends heavily on precluded specifics such as the level of financial and technological availability. Clause (b) serves merely as a placeholder for a future rationing mechanism, stipulating that a

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<sup>224</sup> It has been mentioned above that Green attempted to account for the importance of health care by placing it as the most important good in the index, creating weighting problems amongst the goods and ruling out trade-offs with income and wealth. On my account this problem is avoided, since the importance of health care is implied by the formulation of clause (b); all goods remain roughly equal for the purpose of trade-offs and weighting, while discontinuity is accounted for without upsetting the balance of goods within the index.

maximin delivery of health care must be cost-effective. In this way, the health care institution functions in accordance with maximin – by arranging any inequalities in medical allocation to work towards the greatest benefit of the medically least advantaged – on the condition that the allocation is consistent with those fair rationing techniques best employed by the society in question. In other words, maximin will guarantee that the medically least well-off can access the medical system, while QALYs or some similar mechanism will ascertain the most cost-effective treatment plan, financing treatment options in a fair and just manner.<sup>225</sup>

#### **4c. (i): Practical Implementation: Government Tier**

As a way of guaranteeing that the position of the medically least advantaged is maximised, the envisaged health care system must ensure that all people with a medical need have access to medical services. Having already ascertained that distribution according to holdings of income and wealth does not adequately satisfy medical needs, and hence does not adequately satisfy justice as fairness, it seems that maximin will require a taxpayer-funded nationalised health system. Bernard Williams articulated an appropriate policy for accessing this governmental first tier, when he said: “Leaving aside preventative medicine, the proper ground of distribution of medical care is ill-health: this is a necessary truth.”<sup>226</sup>

Universal access is an expensive goal for the government to achieve. To keep the costs of the health care system down and bring additional funds into the system, I

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<sup>225</sup> It is likely that QALYs may even decide that the treatment of some medically least well-off is never cost-effective, on the grounds that only miniscule benefits will be produced. This decision would contradict the *unaltered* difference principle by excluding some of the least well-off from redistribution. Any such decision to withdraw medical care does *not* contradict my *amended* difference principle, since the amended difference principle permits fair rationing procedures and therefore permits the exclusion of some of the least well-off from treatment.

<sup>226</sup> Bernard Williams, *The Idea of Equality*, In: Hugo Bedau (ed), *Justice and Equality*, (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1971), p. 127

believe it is best for the first tier to operate in a manner similar to Green's scheme of progressive payment rates.<sup>227</sup> It is important to note that progressive payments are not a direct implication of the amended second principle; the system is merely a practical mechanism to share the financial burden of carrying society's sick and provide equal access. Those financially worst-off individuals will receive heavily subsidised medical care while society's richest individuals will pay near full-price, with a sliding-scale of income-tested subsidies available to all between these two poles. The idea is that everyone in society will pay for medical care in proportion to their income; and likewise, everyone in society will be eligible for government subsidies. For example, the poorest representative individual may only pay one dollar, while the richest representative individual may only receive a one dollar subsidy on the same service.

This progressive payment system has multiple advantages. Unpaid medical bills from society's least well-off mean the costs of treatment is passed onto the rest of society in the form of higher costs for treatment, higher insurance premiums and co-payments, and higher deductibles. A recent paper released by the New America Foundation estimates the Californian average family pays \$1,186 a year in "hidden taxes", such as increased insurance premiums to cover unpaid bills left behind by society's uninsured.<sup>228</sup> In response to the outstanding debt, insurance companies stop offering coverage to certain groups in society, which leads to more people without insurance creating unpaid bills, and the whole cycle keeps repeating. By creating universal access to a decent minimum of health services, no more unaffordable debt will be created, breaking the cycle. Moreover, dependence on charity would

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<sup>227</sup> R. Green, (1976), p. 123

<sup>228</sup> New America Foundation, *A Premium Price*,  
<[http://www.newamerica.net/publications/policy/a\\_premium\\_price](http://www.newamerica.net/publications/policy/a_premium_price)> (15<sup>th</sup> of January, 2007)

ultimately reduce, as only the most destitute and socially isolated disabled would not be able to find funds for care. Perhaps a more extensive welfare system could even rule out the need for medical charity entirely, by securing a decent minimum of income through sickness or unemployment benefits; although it is beyond the scope of this essay to argue for such non-medical welfare systems.

Making people pay for health care prevents reckless overuse of medical services, while the progressive subsidies will make it affordable for all people to attend regular preventative check-ups. Making people pay for health care will also increase public awareness of price, improving the individual's ability to make informed medical choices. This increased public awareness of costs will allow the nationalised system to function like a quasi-marketplace; discerning consumers can choose to purchase care from those providers who keep their prices low, eliminating the practise of defensive medicine and an artificial inflation of price. This will therefore reduce the taxpayers' national bill for subsidising health care. Furthermore, it is often said that equal access is an expensive goal that can only be achieved by reducing the service quality and level of specialisation to a decent minimum; for example, much medical research and complicated surgery must be sacrificed for universal influenza shots and general practitioner visits. My proposed structure avoids this criticism, since progressive payment rates combined with revenue raised by taxes will undoubtedly bring millions of dollars of increased funding into the health care system. Increased funding will allow the government to provide a full-spectrum of needed medical services, providing what Norman Daniels calls a "high-option plan".<sup>229</sup> If these extra funds are spent on creating increased service options and quality, health care provision may be improved to the point where even Veatch's

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<sup>229</sup> N. Daniels, (1985), p. 75

optimistic vision<sup>230</sup> could be realised; we shall truly have the funds available to work our way up the list of the worst ailments before the question of financial limits is raised.

#### **4c. (ii): A Decent Minimum**

Because government tiers of universal access are expensive to provide and there is a very real danger of creating an open-ended obligation to satisfy medical need, there should only be a decent minimum of service necessary in the first tier. Having said this, owing to the increase in funding that progressive payments provide, the first tier should be a *high-option decent minimum*. The decent minimum ought to work in conjunction with rationing techniques; a decent minimum of medical services admits ailments X, Y, and Z, while QALYs decides whether a sufferer of X ailment is justified in receiving treatment option A or B. Attempts have been made to flesh out this idea of a high-option decent minimum, with each proposal being markedly different from the next. The World Health Organisation unrealistically suggests a broad array of provision, including comprehensive psychological and social services.<sup>231</sup> On the other hand, Norman Daniels allegedly maintains that many psychological services are used disproportionately by the wealthy to increase their well-being, not necessarily to treat illness, and therefore these services must not be included in a taxpayer-funded decent minimum.<sup>232</sup> The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research

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<sup>230</sup> Veatch maintained that resource rationing is largely unnecessary as society currently has adequate means for improving the health of the medically least well-off. He goes on to claim that even the worst ailments can be treated without the need for disease prioritization and waiting lists. See: R. Veatch, (1976), p. 141

<sup>231</sup> World Health Organisation Regional Office for South-East Asia, *Constitution of the World Health Organisation*, <<http://www.searo.who.int/EN/Section898/Section1441.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 3

<sup>232</sup> R. Bayer *et al*, (1988), p. 585

formulated a comprehensive report, *Securing Access to Health Care*, in which it was suggested that the government provide a decent minimum of “adequate care without being subject to excessive burdens”.<sup>233</sup> The President’s Commission stopped short of clarifying this proposal in any great detail, admitting that the terms “adequacy” and “excessive burden” are “amorphous” and “relative” notions best defined by a professional consensus within the medical institution.<sup>234</sup> Ronald Bayer, Daniel Callahan, Arthur Caplan and Bruce Jennings propose a similarly ambiguous notion; that all must have access to services of “medical necessity”.<sup>235</sup> Bayer *et al* leave the notion of necessity largely unexplained, concluding along similar lines to the President’s Commission, that “necessity in medicine is an extraordinarily complex notion” which will change over time and between cultures, given the availability of resources.<sup>236</sup>

While the conclusions of Bayer *et al* and The President’s Commission seem generally correct in the characterization of the terms “adequacy” and “necessity” as best defined by current medical practices, both terms require further explanation before their practical application can be taken seriously. The most likely way that professionals within the health care system will determine which services are adequate or necessary for a decent minimum is by looking at the *average* utilization of various medical procedures within society. For example, a prioritized list of necessary services can be created according to statistical frequency of use; perhaps qualified by factors such as the financial costs of treatment, prospects of treatment

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<sup>233</sup> The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Securing Access to Health Care Volume One: The Ethical Implications of Differences in the Availability of Health Services*, (Washington, DC: US Government Printing Office, 1983), p. 22

<sup>234</sup> The President’s Commission, (1983), p. 20

<sup>235</sup> R. Bayer *et al*, (1988), p. 585

<sup>236</sup> R. Bayer *et al*, (1988), p. 586

success, and the importance the individual and society place on curing the ailment. In the USA, the Oregon State Health Board was the first to formulate such a prioritized list of necessary services as part of an attempt to expand Medicaid to 100 per cent of people below the state poverty line. The Oregon Basic Health Services Act of 1989 made use of the QALYs approach, along with population census and common-sense adjustments, to classify 1600 medical services according to their degree of necessity.<sup>237</sup> Oregon's list is reviewed annually, with the prioritization technique still in use today to fund procedures relative to their line on the list. The 2006 catalogue begins with treatments for severe/moderate head injury and ends with disorders of the eye.<sup>238</sup>

At first glance, defining necessary or adequate medical services by average statistical use and then creating a decent minimum list of necessary services works to the advantage of society's least-advantaged. It frees up resources by sacrificing obscure or infrequently used services, in order to improve access to reasonably common services for society's least well-off. Before 1989, the uninsured least well-off would not have been able to access those sacrificed services in the first place, so the uninsured are benefited at the expense of the insured. In this way, list prioritization reduces overall inequality between the poor and the rest of society. While this process cannot be faulted as violating Rawls' distributive maxim, list prioritization is morally problematic in the way it uses current statistical averages as a

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<sup>237</sup> David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, *Hastings Center Report*, 21:3:1991 (This list has decreased over time to 710 services in 2006)

<sup>238</sup> Oregon Health Services Commission, *Prioritized List of Health Services: October 1<sup>st</sup>, 2006*, <<http://egov.oregon.gov/DAS/OHPPR/HSC/docs/Oct06Plist.pdf>> (15<sup>th</sup> of January, 2007)  
The bottom end cut-off point of the list is necessarily arbitrary. While we all will agree that treatments for severe head injury (line 1) or insulin for diabetics (line 2) must be included in a decent minimum, further down the list the choice to end the 2006 decent minimum at line 710 (near and far-sightedness) and not 709 (difficulty controlling the volume/pitch of speech) or even line 711 (ailment unspecified) seems entirely without reason.



means of defining a just allocation of funds.<sup>239</sup> The Oregon Health Services Commission was naïve to think that it could determine a fair decent minimum of necessary services by looking at current consumption trends of society. In a way, the Commission takes an annual snapshot of the medical system, riddled with injustice and inequality, and defines medically necessary services based on this distorted picture. Because insured people use more health care than uninsured people, and because the rich use more health care than the poor, current averages in medical consumption are going to be stacked in favour of these particular groups. Daniels correctly objects that average trends of medical consumption will formulate a highly inaccurate list, which in reality reflects “*average use by people in the upper-middle income levels*”.<sup>240</sup> When the list of so-called “necessary” services is used to determine a decent minimum, the resulting decent minimum will reflect the many injustices that are present in the current health care system and work to benefit those of upper-middle income.

Both Bayer *et al* and the President’s Commission remain vague at crucial points, particularly concerning definition of their propositions and suggestions for effective practical implementation. Determining a list of necessary or adequate services for society is an extremely complicated matter that requires extensive empirical knowledge about the health care institution, such as demographic-relative consumption, the importance of treatments to the individual and society, and general considerations of resource availability. What is more, the task of generating accurate lists is never-ending since the decisive variables and statistics are in continuous flux, as are medical technologies and treatment trends. Rather than creating a list based on

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<sup>239</sup> N. Daniels, (1985), p. 77. Daniels’ italics.

<sup>240</sup> N. Daniels, (1985), p. 77

societal averages, a preferable alternative to prioritization lists is to determine a specific *criterion*, where all services within the decent minimum will have in common a morally relevant characteristic, while those legitimately excludable from funding will lack that feature.

Charles Fried proposed that decent minimum services are distinctive in ensuring “tolerable life prospects in general.”<sup>241</sup> He goes on to state the decent minimum “should speak quite strongly towards things like maternal and child health, which set the terms under which individuals will complete and develop.”<sup>242</sup> Fried’s criterion is perhaps even more obscure than the terms “necessity” and “adequacy”; his idea of “tolerable life prospects” is flawed by interpersonal subjectivity. As John Arras succinctly asked, “tolerable to whom?”<sup>243</sup>

Norman Daniels has produced one of the more readily acceptable criteria for decent minimum services, stating that a decent minimum of health services will bring individuals back into the range of “species-typical normal functioning”.<sup>244</sup> Normal functioning is important to Daniels, because departures from this norm reduce individuals’ opportunities to construct and fulfill their life plan or conception of the good. By ensuring an individual is kept within the range of species-typical normal function, the health care institution secures or restores an individual’s range of equal opportunities. The decent minimum generated by this criterion is a plan of services prioritized and funded in accordance with the negative impact a disease has on an individual’s possible opportunities. Those that impair opportunity the most would receive priority and proportionately more funding, given other important

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<sup>241</sup> Charles Fried, Equality and Rights in Medical Care, *Hastings Center Report*, 6:1976:29-34, p. 32

<sup>242</sup> C. Fried, (1976), p. 32

<sup>243</sup> John Arras, Health Care Vouchers for the Poor and the Rhetoric of Equity, *Hastings Center Report*, 11:4:1981, p. 32

<sup>244</sup> N. Daniels, (1985), p. 26

considerations such as the costs of treatment. Without having to refer to current health trends or make value laden assumptions about which life prospects are tolerable, this principled account appears to be successful to some degree. Species-typical normal function also has the benefit of excluding many historically and culturally relative “diseases”, such as drapetomania. Nevertheless, a clear empirical notion of health and disease is still required to rank deviations from species-typical function. Lacking adequate empirical knowledge of the human condition, Daniels is reluctant to speculate on which disorders place a person beyond normal function. He also fails to provide a procedure for evaluating which ailments restrict opportunity more than others. In one telling example, he does state that a blocked nose constitutes deviation from normal function, while unwanted pregnancy does not.<sup>245</sup> Daniels also claims, “adding mental disease and health into the picture complicates the issue further, most particularly because we have a less well-developed theory of species-typical mental functions and functional organization.”<sup>246</sup> Having given a criterion for defining the decent minimum of service, Daniels simply turns the task of further defining species-typical normal function and disease over to those involved in the bio-medical sciences.

#### **4c. (iii): Practical Implementation: Market Tier**

Finally, there is no reason why this philosophical system would not allow a free market of health care providers to operate alongside the government-provided tier. This second tier will obviously be unsubsidised, will therefore be more expensive than most people could or would be willing to afford, and will arguably be of a higher

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<sup>245</sup> N. Daniels, (1981), p. 157

<sup>246</sup> N. Daniels, (1981), p. 155

quality of service than the first. It is even possible that having two tiers will undermine the quality of the government's first, as asserted by McCreadie,<sup>247</sup> producing unequal health levels that are directly influenced by income and wealth. While these were all problematic for Veatch's strict egalitarianism, the amended difference principle does not require equal levels of health. It does not even require that the medically worst-off have access to the best medical services available in society. It only requires that any medical inequalities that are present in society work to the advantage of the medically least-advantaged. So long as the first tier is accessible to all who have a medical need, then a free market allocation in accordance with income and wealth is allowed to offer higher quality goods and services. Moreover, since the free market promotes provider and consumer autonomy and eliminates the threat of medical black markets it is morally and factually desirable for a market system to work alongside the governmental tier. When both tiers operate side by side, the total system satisfies almost all imaginable medical needs and preferences. If there is enough demand for obscure medical procedure it will be satisfied by the market tier, while all other medical needs will be met by the high-option nationalised tier.

#### **4d: A Summary and Conclusions of Distributive Sections**

It is desirable for a health care system to satisfy the objectively ascribable medical needs of the medically least well-off, by providing a decent quantity and quality of medical options under conditions that maximise consumer and provider autonomy. Utilitarian macro-allocation was refuted on the grounds that it advocates a semi-genocidal health policy that will exclude a medical underclass in order to improve

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<sup>247</sup> C. McCreadie, (1976), p. 128

care for the majority. I then acknowledged the cost-benefit approach of QALYs as an ideal mechanism for rationing at the level of micro-allocation. Health care distribution regulated entirely by the laissez-faire distributional principle – to each according to their personal share of income and wealth – was shown to be far from efficient, falling short of medical justice. As seen in my case study of the United States, market transactions are often guided by a self-interested policy of maximising financial returns, rather than creating an equitable distribution of goods and services. The competitive nature of laissez-faire distribution forces medical providers to introduce cost-cutting measures that are ill-suited for health care, creating excessive financial burdens on the medical consumer and reducing access to care for the medically and financially least advantaged. Privatisation also promotes the attitude that doctors are just another market commodity that can be bought, sold, and sued if they fail to live up to consumer expectations. This generates a fear of malpractice litigation, which destroys the sacred patient-doctor relationship and encourages the wasteful practice of defensive medicine. What is perhaps most worrying to the moral philosopher is the way in which the insurance industries actively obstruct the flow of health-related information to the consumer. Reducing the consumers' access to health related information is an immoral cost-saving technique that is designed to under-insure the medically least well-off and hence reduce the company's cost of caring for the sick. This policy primarily disadvantages the medically and financially least well-off groups in society. I find that these major problems, along with many more issues outlined in Section 3b, make the medical market an inadequate mechanism for satisfying medical needs.

This is not to say, however, that the medical marketplace must be shunned entirely for just health care to prevail. It is beneficial for society to allow free-market

transactions in medicine, because the medical market place improves consumer choice and autonomy if it operates alongside a nationalised health system. This nationalised system must work to satisfy the medical needs of those who cannot, for whatever reason, access the private market. As discussed in Section 3b (iii), having these two tiers working alongside one another will eliminate the most serious problems with medical markets and provide universal access for those in medical need.

In choosing an adequate distributional principle for the nationalised tier I rejected a principle of strong equal access on the grounds that the position is theoretically and practically flawed. In theory, this strict egalitarianism is based on a discontinuity of the health care system, which relies on the false proposition that *all* health care needs are undeserved, unpredictable, and of overriding importance whenever they occur. Discontinuity also places health care on such a high moral pedestal that it cannot account for health care's diminished importance in outstanding circumstances, such as imminent military invasion. In practical application, the strict equal access principle fails for two reasons. First, the principle is incompatible with a medical marketplace and therefore restricts patient and provider autonomy, encouraging medical black-markets. Second, because strict equality necessarily collapses the services of the second tier into the nationalised first tier, this requires a levelling down of service quality and quantity. Moreover, the demands placed on the nationalised tier to raise quality and quantity will be too great to succeed within a society of limited resources, ultimately disadvantaging society's worst-off.

It is proposed that Justice as Fairness best captures the concept of medical distributive justice. By placing the share of medical services required to satisfy medical needs as a primary social good, it becomes a demand of social justice that

society provide enough resources to satisfy the health needs of the medically least-advantaged. In order to fairly restrict treatment options for the medically irreconcilable, a modified maximin is suggested to permit the use of rationing techniques, such as the QALYs approach. A government provided decent minimum of services, defined and prioritised by referencing the procedure's effect on species-typical normal function, will arrange inequalities in the health care system to work to benefit the medically least well-off. This proposed system will not hinder private medical research and will permit government medical research, so long as the research fits into the criterion of a service required within the decent minimum. It is proposed that all people must pay to access the first tier, with universal taxpayer-funded subsidies provided on an income-tested sliding scale. Making the medical consumer pay for services has the primary practical benefit of bringing extra funds into medical system, which shall be used to expand the quality and quantity of the decent minimum. Moreover, making people pay will allow the governmental tier to be influenced by beneficial market forces; competition between providers will prevent an artificial inflation of the health care bill, and the price of services shall be dictated by the consumption demands of the people. A primary moral benefit of making people pay for services is that it enables the consumer to make cost-conscious medical decisions, transforming the role of the patient from a passive observer into a fully autonomous and active participant in medical decision making. If consumers are allowed to make fully informed choices within a medical system, then prudent purchasing by the people will work as cost-control for the macro-allocation of health care.

## **Chapter Five: Conclusion**

The universal human right to health care is a cliché that is frequently invoked by politicians and various activist groups to express the idea that inequalities in the distribution of medical resources are unjust. These disgruntled social reformers are largely uninformed as to the nature of human rights, claiming that any society in which citizens go without comprehensive medical services is in violation of Article 25 of the United Nations' Universal Declaration of Human Rights. Politicians and rights activists often make exaggerated and expectant claims about the progress of medical technology and the accomplishments of the health care system, which only serve to distort the public conception of human rights and social justice in general.

Furthermore, the United Nations itself is also the source of much misrepresentation of the nature of human rights, by making the strong universal claim that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including... medical care and necessary social services... and the right to security in the event of... sickness, disability,... old age or other lack of livelihood in circumstances beyond his control.”<sup>248</sup> In this paper, I have attempted to elucidate the human right to health care, explaining what it actually means for a person to hold such a right. As well as outlining the implications this right has for the individual, this paper has explained the obligation that the right imposes on society. An appropriate distributive mechanism has also been proposed, based in Rawlsian justice as fairness, which will fulfill society's duty to the medically needy in the fairest manner possible, assuming a situation of scarce medical resources.

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<sup>248</sup> The Office of the High Commissioner for Human Rights, *Universal Declaration of Human Rights*, <<http://www.unhcr.ch/udhr/lang/eng.htm>> (15<sup>th</sup> of January, 2007), See: Appendix 1.



The human right to health care is a second generation welfare right, which finds its origin in the socialist tradition of socio-economic arrangements designed to secure access to important institutions such as education, housing, employment and health care. Welfare rights are embodied in Articles 22 – 27 of the UDHR, so the right to health care, being Article 25, finds itself squarely in the centre of this second generation. I have argued, contrary to popular philosophical opinion, that not all socio-economic rights are to positive assistance. Within the medical institution, preventive care or quarantine can often be the best medicinal course available; a largely inexpensive act of omission is enacted by the medical institution in order to satisfy medical needs. It has therefore been concluded that the right to health care is a second generation right that contains elements of negative duties of omission *and* positive duties of assistance. Furthermore, in a system of limited resources, expensive second generation rights frequently come into conflict and must be traded-off against one another. It is legitimate for a government to override some human rights in order to secure other “more important” rights, or to obtain a substantial public benefit. For this reason, I have defined the right to health care as a *prima facie* right. This means that the right to health care is not alienated if conflicting rights or considerations of the greater public good receive priority of implementation. As Beauchamp and Faden poetically point out, there cannot be multiple absolutes without contradiction: “virtually all agree that no right always has the right of way when rights themselves come into conflicting traffic.”<sup>249</sup>

I have argued that a theory of human rights is only a part of a more general account that stakes out a valid claim to socio-economic goods. In order to uncover the true nature of rights, an ethical theory of respondent obligation must be devised that

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<sup>249</sup> T. Beauchamp and R. Faden, (1979), p. 122

explains the varying strength of obligation that human rights impose on respondents. I have argued that respondent obligation can vary in weight; from strong obligations where a particular right and duty are necessarily co-existent, to weak obligations where, as a matter of normative modality, fulfilment of obligation is not required. The right to health care seems to be the prime example of an “open textured”<sup>250</sup> or ambiguous right, with the strength of obligation imposed on respondent institutions depending very much on varying situational contexts. Owing to this “firm but untidy correlation between rights and obligation”,<sup>251</sup> and because the UDHR is ill-defined in its formulation, I have concluded that exercising a right to health care will not always necessitate a response from health care providers. When combined with the prima facie nature of rights, the effective exercise of the right to health care is severely weakened by variable factors, such as the availability of financial resources, society’s level of technological development, the considered prioritisation of competing social projects, and the demands of the greater good.

The above description of the right to health care portrays the right as fickle. Under certain circumstances that are very real and imminent in many societies, Article 25 may be weakened to the point that it is frequently overruled by competing moral considerations. The lightweight nature of the right could be viewed by some critics as bringing its very existence into question, particularly in light of criticism from cultural relativist and anti-foundationalist philosophers. For this reason, I dedicated considerable space in this paper to securing the relatively universal and inalienable existence of the right to health care. It is proposed that the right has ethical foundations in the moral requirement to respond to basic and instinctive human needs.

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<sup>250</sup> David Braybrooke, *The Firm but Untidy Correlativity of Rights and Obligations*, *Canadian Journal of Philosophy* 1:3:1972:351-363, p. 360

<sup>251</sup> D. Braybrooke, (1972), p. 351

In order to determine those needs that are relevant to justice, it was suggested that the medical institution concerns itself with survival and development needs. This approach grounds the existence of rights that fulfil scientifically ascertainable survival needs, such as a minimum quantity of essential nutrients, and also expands this scientific conception to include developmental needs, such as freedoms of expression, association, religious practise, and non-interference. The health care system can easily be understood as an institution concerned with helping people survive. What is more, modern health care institutions are also intimately concerned with the development of patients, and even the development of members of the wider healthy community. Medical practitioners not only help people to survive physiologically by treating debilitating diseases, but also provide rehabilitative, educational and social working services that aid people in their psychological, social and even spiritual development. It was proposed that all relevant survival and development needs must fit into a truncated scale, with the most urgent and objectively ascribable medical needs being fulfilled first.

This survival and development approach has the supreme benefit of providing a way to indirectly ground normative claims in empirically determinable factors, without violating the logical rule that you cannot deduce an “ought” (human rights) from an “is” (human survival and development needs). The two considerations – human rights and empirically determinable needs – are logically independent from one another, yet the latter provides an excellent reason why the former is worthy of respect. Some critics of human rights will find it problematic that, despite numerous attempts, no foundation has been proven absolutely, objectively, or logically true. This is not only a problem concerning rights theory, but ethical theory in general.

In the course of arguing the above foundational approach, I encountered a substantial relativist objection to universal human rights, which stated that strict universality denies the ethical autonomy of some non-western cultures. This objection served as the first premise of Jack Donnelly's theory for relatively weak universalism, which proposes that many traditional cultures do not and cannot understand fundamental concepts necessary for human rights claims, such as "equality" and "individual". In societies where a level of respect for human beings is maintained through alternative means such as religion or tribal hierarchy, it must be accepted that these rules can perform identical functions and achieve the same beneficial ends as human rights. I find that the strict universality of human rights, as portrayed by the UDHR, must be weakened, out of a need to respect the ideologies of those "lower" moral communities who do not share the same moral aspirations or needs of the Western Liberal Democratic tradition.

I find that the main problem with human rights charters is that they read like a child's Christmas wish list; the representative level of resources chosen by the authors of the United Nations declarations was too high to successfully protect all the interests it addresses. Throughout this thesis I have portrayed the successful exercise of the right to health care as being dependent on situational contexts, such as the availability of financial resources, society's level of technological development, the considered prioritisation of competing social projects, and the demands of the greater good. As a result, it seems that people are justified in claiming a right to health care only if it can be harvested from an acceptable theory of distributive justice, because if there are no mechanisms for health care allocation, then the right to receive medical care is reduced to impractical rhetoric. Some philosophers have even gone so far as to argue that a right to health care is unintelligible, even as abstract theory, without a particular

distributive framework in which to view it. I have attempted to address the contextual restrictions on practical implementation by articulating a theory of distributive justice for health care; given that not all people can be equally treated, an adequate theory of distributive justice shall decide which representative individuals must miss out.

Distribution by Quality Adjusted Life Years was proposed and accepted as an ideal mechanism for deciding between treatment options. It was argued that the cost-benefit calculation plays an important role in the distribution of medical resources, whenever a choice must be made between competing treatment options. I have concluded that the QALYs approach is philosophically defensible and a practically useful tool for conducting cost-benefit assessments on a micro-allocative level.

Three distributive principles for macro-allocation were criticised and ultimately rejected: a utilitarian maximisation of the greatest good, distribution in accordance with income and wealth, and distribution in order to produce a strict equality of health levels. Rawlsian justice as fairness was accepted as being the most equitable way for society to satisfy medical needs; however, it was not accepted without qualification. The share of health services needed to satisfy some objective measure of health was added to Rawls' primary social goods list. To avoid situations of medical black holes reducing society to a level of poverty in the name of maximin, Rawls' second principle was adjusted to permit the utilisation of rationing techniques, such as QALYs, when distributing to the medically least well-off. I then proceeded to argue that practical implementation of the second principle will be eased by instituting a taxpayer-funded national health system, with universal access provided according to income tested progressive payments. The idea is that all must make out-of-pocket payments to access the health care institution and all shall receive state funded subsidies to ease the burden of these payments, relative to the individual's level of

income. Owing to limited funds within the health care system, it has been proposed that government is only obliged to supply a so-called decent minimum of health care services. A decent minimum of health care services will be designed to bring the medically least well-off back within the range of species-typical normal function, and will be prioritised with regard to the impact an ailment has on the patient's range of opportunities. For example, those ailments that impair opportunity most severely would be included in the decent minimum, will receive treatment priority, and will receive proportionately more funding relative to other important considerations such as the costs of treatment. Finally, there is no reason why this philosophical system would not allow a free market of health care providers to operate alongside the government-provided tier. Since the free market promotes provider and consumer autonomy and eliminates the threat of medical black markets, it is morally and factually desirable for a market system to work alongside the governmental tier. When both tiers operate side by side, the total system satisfies almost all imaginable medical needs and preferences. If there is enough demand for an obscure medical procedure it will be satisfied by the market tier, while most other medical needs will be met by the high-option nationalised tier.

As a final note to my conclusion, it is worth mentioning that one week before this thesis is going to print, the Governor of California, Arnold Schwarzenegger, announced controversial health care reforms that fundamentally resemble my proposed system. The plan consists of three basic premises; cost containment, universal coverage for the medically least well-off, and an emphasis on public education for health related issues.<sup>252</sup> If the plan is ratified by General Council, 100

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<sup>252</sup> Office of the Governor, *Press Release*, <<http://gov.ca.gov/index.php?/press-release/5057/>> (20<sup>th</sup> of January, 2007)

per cent of Californians will be required by law to purchase “a minimum level”<sup>253</sup> of health insurance, with substantial state subsidies for those who cannot afford private insurance. While the state subsidies are not as extensive as I have proposed, all citizens below 250 per cent of the federal poverty line shall receive some form of subsidy.<sup>254</sup> The most controversial aspect of the proposal has been universal access, as many private citizens have objected to having their tax dollars spent on subsidising insurance for vagrants or illegal immigrants, who do not pay state tax. The state reform also proposes that government will have increased powers of regulation over private insurance companies, demanding that no providers shall continue the current practice of denying coverage or increasing the price of coverage based on age and health status. To lower the administrative costs of the health system, the state will also mandate in law that 85 per cent of every dollar spent by medical and insurance providers must be dedicated specifically to the health care of patients. Moreover, to increase consumer autonomy and improve the patient’s ability to make informed health decisions, Gov. Schwarzenegger proposes to establish “a one-stop resource for information on health plan performance... to increase the transparency of quality of care and [to provide] access to other information to help inform consumers.”<sup>255</sup>

California’s proposed health care plan is certainly interesting and, had it been announced earlier, I would have enjoyed examining it in greater detail with reference to my thesis topic of human rights and just health care distribution. On first look, the

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<sup>253</sup> Office of the Governor, *Governor’s Health Care Proposal*, <[http://gov.ca.gov/pdf/press/Governors\\_HC\\_Proposal.pdf](http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf)> (20<sup>th</sup> of January, 2007)

<sup>254</sup> For example, if the federal poverty line for a family of four is defined as an income below US\$20,000 per year. Those earning under US\$50,000 will receive subsidy from Gov. Schwarzenegger’s scheme.

Office of the Governor, *Governor’s Health Care Proposal*, <[http://gov.ca.gov/pdf/press/Governors\\_HC\\_Proposal.pdf](http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf)> (20<sup>th</sup> of January, 2007)

<sup>255</sup> Office of the Governor, *Governor’s Health Care Proposal*, <[http://gov.ca.gov/pdf/press/Governors\\_HC\\_Proposal.pdf](http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf)> (20<sup>th</sup> of January, 2007)

plan appears to address the majority of issues raised in this paper; it is particularly responsive to almost all of the injustices mentioned in Chapter Three, concerning inequities in the US health care system. Arnold Schwarzenegger (or at least the team of advisers he formed to tackle the health care issue) appears to be one of the few politicians who takes the right to health care as more than just a vote-winning cliché. He seems to understand the moral importance of equitable health care distribution in society and has the political nerve to provide state funded universal access, grounded in the moral premise of satisfying the needs of the medically least well-off. It is true that justice in health care costs a huge amount of money; however, as I have demonstrated in this paper, it is possible to make fiscal responsibility and ethical responsibility concurrent.



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## **Appendices**

### **Appendix 1: The 1948 Universal Declaration of Human Rights**

#### **Preamble**

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

**Article 1**

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

**Article 2**

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

**Article 3**

Everyone has the right to life, liberty and security of person.

**Article 4**

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

**Article 5**

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

**Article 6**

Everyone has the right to recognition everywhere as a person before the law.

**Article 7**

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

**Article 8**

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

**Article 9**

No one shall be subjected to arbitrary arrest, detention or exile.

**Article 10**

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

**Article 11**

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

**Article 12**

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

**Article 13**

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

**Article 14**

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

**Article 15**

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

**Article 16**

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

**Article 17**

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

**Article 18**

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

**Article 19**

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

**Article 20**

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

**Article 21**

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.
3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

**Article 22**

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

**Article 23**

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

**Article 24**

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

**Article 25**

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

**Article 26**

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

**Article 27**

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

### **Article 28**

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

### **Article 29**

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

### **Article 30**

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.”

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Retrieved from the World Wide Web on the 15<sup>th</sup> of January, 2007.

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## **Appendix 2: Declaration on the Right to Development**

**Adopted by General Assembly resolution 41/128 on the 4<sup>th</sup> of December, 1986.**

### **The General Assembly,**

*Bearing in mind* the purposes and principles of the Charter of the United Nations relating to the achievement of international co-operation in solving international problems of an economic, social, cultural or humanitarian nature, and in promoting and encouraging respect for human rights and fundamental freedoms for all without distinction as to race, sex, language or religion,

*Recognizing* that development is a comprehensive economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom,

*Considering* that under the provisions of the Universal Declaration of Human Rights everyone is entitled to a social and international order in which the rights and freedoms set forth in that Declaration can be fully realized,

*Recalling* the provisions of the International Covenant on Economic, Social and Cultural Rights and of the International Covenant on Civil and Political Rights,

*Recalling further* the relevant agreements, conventions, resolutions, recommendations and other instruments of the United Nations and its specialized agencies concerning the integral development of the human being, economic and social progress and development of all peoples, including those instruments concerning decolonization, the prevention of discrimination, respect for and observance of, human rights and fundamental freedoms, the maintenance of international peace and security and the further promotion of friendly relations and co-operation among States in accordance with the Charter,

*Recalling* the right of peoples to self-determination, by virtue of which they have the right freely to determine their political status and to pursue their economic, social and cultural development,

*Recalling also* the right of peoples to exercise, subject to the relevant provisions of both International Covenants on Human Rights, full and complete sovereignty over all their natural wealth and resources,

*Mindful* of the obligation of States under the Charter to promote universal respect for and observance of human rights and fundamental freedoms for all without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

*Considering* that the elimination of the massive and flagrant violations of the human rights of the peoples and individuals affected by situations such as those resulting from colonialism, neo-colonialism, apartheid, all forms of racism and racial discrimination, foreign domination and occupation, aggression and threats against national sovereignty, national unity and territorial integrity and threats of war would contribute to the establishment of circumstances propitious to the development of a great part of mankind,

*Concerned* at the existence of serious obstacles to development, as well as to the complete fulfilment of human beings and of peoples, constituted, inter alia, by the denial of civil, political, economic, social and cultural rights, and considering that all human rights and fundamental freedoms are indivisible and interdependent and that, in order to promote development, equal attention and urgent consideration should be given to the implementation, promotion and protection of civil, political, economic, social and cultural rights and that, accordingly, the promotion of, respect for and enjoyment of certain human rights and fundamental freedoms cannot justify the denial of other human rights and fundamental freedoms,

*Considering* that international peace and security are essential elements for the realization of the right to development,

*Reaffirming* that there is a close relationship between disarmament and development and that progress in the field of disarmament would considerably promote progress in the field of development and that resources released through disarmament measures should be devoted to the economic and social development and well-being of all peoples and, in particular, those of the developing countries,

*Recognizing* that the human person is the central subject of the development process and that development policy should therefore make the human being the main participant and beneficiary of development,

*Recognizing* that the creation of conditions favourable to the development of peoples and individuals is the primary responsibility of their States,

*Aware* that efforts at the international level to promote and protect human rights should be accompanied by efforts to establish a new international economic order,

*Confirming* that the right to development is an inalienable human right and that equality of opportunity for development is a prerogative both of nations and of individuals who make up nations,

*Proclaims* the following Declaration on the Right to Development:

**Article 1**

1. The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.
2. The human right to development also implies the full realization of the right of peoples to self-determination, which includes, subject to the relevant provisions of both International Covenants on Human Rights, the exercise of their inalienable right to full sovereignty over all their natural wealth and resources.

**Article 2**

1. The human person is the central subject of development and should be the active participant and beneficiary of the right to development.
2. All human beings have a responsibility for development, individually and collectively, taking into account the need for full respect for their human rights and fundamental freedoms as well as their duties to the community, which alone can ensure the free and complete fulfilment of the human being, and they should therefore promote and protect an appropriate political, social and economic order for development.
3. States have the right and the duty to formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals, on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting therefrom.

**Article 3**

1. States have the primary responsibility for the creation of national and international conditions favourable to the realization of the right to development.
2. The realization of the right to development requires full respect for the principles of international law concerning friendly relations and co-operation among States in accordance with the Charter of the United Nations.
3. States have the duty to co-operate with each other in ensuring development and eliminating obstacles to development. States should realize their rights and fulfil their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, mutual interest and co-operation among all States, as well as to encourage the observance and realization of human rights.

**Article 4**

1. States have the duty to take steps, individually and collectively, to formulate international development policies with a view to facilitating the full realization of the right to development.
2. Sustained action is required to promote more rapid development of developing countries. As a complement to the efforts of developing countries, effective international co-operation is essential in providing these countries with appropriate means and facilities to foster their comprehensive development.

**Article 5**

States shall take resolute steps to eliminate the massive and flagrant violations of the human rights of peoples and human beings affected by situations such as those resulting from apartheid, all forms of racism and racial discrimination, colonialism, foreign domination and occupation, aggression, foreign interference and threats against national sovereignty, national unity and territorial integrity, threats of war and refusal to recognize the fundamental right of peoples to self-determination.

**Article 6**

1. All States should co-operate with a view to promoting, encouraging and strengthening universal respect for and observance of all human rights and fundamental freedoms for all without any distinction as to race, sex, language or religion.
2. All human rights and fundamental freedoms are indivisible and interdependent; equal attention and urgent consideration should be given to the implementation, promotion and protection of civil, political, economic, social and cultural rights.
3. States should take steps to eliminate obstacles to development resulting from failure to observe civil and political rights, as well as economic social and cultural rights.

**Article 7**

All States should promote the establishment, maintenance and strengthening of international peace and security and, to that end, should do their utmost to achieve general and complete disarmament under effective international control, as well as to ensure that the resources released by effective disarmament measures are used for comprehensive development, in particular that of the developing countries.

**Article 8**

1. States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income. Effective measures should

be undertaken to ensure that women have an active role in the development process. Appropriate economic and social reforms should be carried out with a view to eradicating all social injustices.

2. States should encourage popular participation in all spheres as an important factor in development and in the full realization of all human rights.

#### **Article 9**

1. All the aspects of the right to development set forth in the present Declaration are indivisible and interdependent and each of them should be considered in the context of the whole.

2. Nothing in the present Declaration shall be construed as being contrary to the purposes and principles of the United Nations, or as implying that any State, group or person has a right to engage in any activity or to perform any act aimed at the violation of the rights set forth in the Universal Declaration of Human Rights and in the International Covenants on Human Rights.

#### **Article 10**

Steps should be taken to ensure the full exercise and progressive enhancement of the right to development, including the formulation, adoption and implementation of policy, legislative and other measures at the national and international levels.

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Retrieved from the World Wide Web on the 15<sup>th</sup> of January, 2007. The Office of the High Commissioner for Human Rights, *Declaration on the Right to Development*, <<http://www.unhchr.ch/html/menu3/b/74.htm>>

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### **Appendix 3: Constitution of the World Health Organization**

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

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Retrieved from the World Wide Web on the 15<sup>th</sup> of January, 2007. World Health Organization Regional Office for South-East Asia, *Constitution of the World Health Organization*, <<http://www.searo.who.int/EN/Section898/Section1441.htm>>

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**Appendix 4: International Covenant on Economic, Social and Cultural Rights**

**Adopted and opened for signature, ratification and accession by General  
Assembly  
resolution 2200A (XXI) of 16 December 1966.**

**entry into force 3 January 1976, in accordance with article 27.**

**Preamble**

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

**PART I**

**Article 1**

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.
3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the

realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

## **PART II**

### **Article 2**

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

### **Article 3**

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

### **Article 4**

The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

### **Article 5**

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights or freedoms recognized herein, or at their limitation to a greater extent than is provided for in the present Covenant.
2. No restriction upon or derogation from any of the fundamental human rights recognized or existing in any country in virtue of law, conventions, regulations or custom shall be admitted on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.



### PART III

#### Article 6

1. The States Parties to the present Covenant recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
2. The steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.

#### Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

- (a) Remuneration which provides all workers, as a minimum, with:
  - (i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
  - (ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;
- (b) Safe and healthy working conditions;
- (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;
- (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays

#### Article 8

1. The States Parties to the present Covenant undertake to ensure:
  - (a) The right of everyone to form trade unions and join the trade union of his choice, subject only to the rules of the organization concerned, for the promotion and protection of his economic and social interests. No restrictions may be placed on the exercise of this right other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;
  - (b) The right of trade unions to establish national federations or confederations and the right of the latter to form or join international trade-union organizations;
  - (c) The right of trade unions to function freely subject to no limitations other than those prescribed by law and which are necessary in a democratic society in the

interests of national security or public order or for the protection of the rights and freedoms of others;

(d) The right to strike, provided that it is exercised in conformity with the laws of the particular country.

2. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces or of the police or of the administration of the State.

3. Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in that Convention.

#### **Article 9**

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

#### **Article 10**

The States Parties to the present Covenant recognize that:

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.

2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

#### **Article 11**

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.

2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:

(a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;

(b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.

#### **Article 12**

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

#### **Article 13**

1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.

2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:

(a) Primary education shall be compulsory and available free to all;

(b) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;

(c) Higher education shall be made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular by the progressive introduction of free education;

(d) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;

(e) The development of a system of schools at all levels shall be actively pursued, an adequate fellowship system shall be established, and the material conditions of teaching staff shall be continuously improved.

3. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions.

4. No part of this article shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph I of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

#### **Article 14**

Each State Party to the present Covenant which, at the time of becoming a Party, has not been able to secure in its metropolitan territory or other territories under its jurisdiction compulsory primary education, free of charge, undertakes, within two years, to work out and adopt a detailed plan of action for the progressive implementation, within a reasonable number of years, to be fixed in the plan, of the principle of compulsory education free of charge for all.

#### **Article 15**

1. The States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications;

(c) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture.

3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

4. The States Parties to the present Covenant recognize the benefits to be derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields.

## **PART IV**

### **Article 16**

1. The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein.

2. (a) All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit copies to the Economic and Social Council consideration in accordance with the provisions of the present Covenant;

(b) The Secretary-General of the United Nations shall also transmit to the specialized agencies copies of the reports, or any relevant parts therefrom, from States Parties to the present Covenant which are also members of these specialized agencies in so far as these reports, or parts therefrom, relate to any matters which fall within the responsibilities of the said agencies in accordance with their constitutional instruments.

### **Article 17**

1. The States Parties to the present Covenant shall furnish their reports in stages, in accordance with a programme to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the States Parties and the specialized agencies concerned.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Covenant.

3. Where relevant information has previously been furnished to the United Nations or to any specialized agency by any State Party to the present Covenant, it will not be necessary to reproduce that information, but a precise reference to the information so furnished will suffice.

### **Article 18**

Pursuant to its responsibilities under the Charter of the United Nations in the field of human rights and fundamental freedoms, the Economic and Social Council may make arrangements with the specialized agencies in respect of their reporting to it on the progress made in achieving the observance of the provisions of the present Covenant falling within the scope of their activities. These reports may include particulars of decisions and recommendations on such implementation adopted by their competent organs.

**Article 19**

The Economic and Social Council may transmit to the Commission on Human Rights for study and general recommendation or, as appropriate, for information the reports concerning human rights submitted by States in accordance with articles 16 and 17, and those concerning human rights submitted by the specialized agencies in accordance with article 18.

**Article 20**

The States Parties to the present Covenant and the specialized agencies concerned may submit comments to the Economic and Social Council on any general recommendation under article 19 or reference to such general recommendation in any report of the Commission on Human Rights or any documentation referred to therein.

**Article 21**

The Economic and Social Council may submit from time to time to the General Assembly reports with recommendations of a general nature and a summary of the information received from the States Parties to the present Covenant and the specialized agencies on the measures taken and the progress made in achieving general observance of the rights recognized in the present Covenant.

**Article 22**

The Economic and Social Council may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.

**Article 23**

The States Parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned.

**Article 24**

Nothing in the present Covenant shall be interpreted as impairing the provisions of the Charter of the United Nations and of the constitutions of the specialized agencies which define the respective responsibilities of the various organs of the United Nations and of the specialized agencies in regard to the matters dealt with in the present Covenant.

**Article 25**

Nothing in the present Covenant shall be interpreted as impairing the inherent right of all peoples to enjoy and utilize fully and freely their natural wealth and resources.

## PART V

### Article 26

1. The present Covenant is open for signature by any State Member of the United Nations or member of any of its specialized agencies, by any State Party to the Statute of the International Court of Justice, and by any other State which has been invited by the General Assembly of the United Nations to become a party to the present Covenant.
2. The present Covenant is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
3. The present Covenant shall be open to accession by any State referred to in paragraph 1 of this article.
4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.
5. The Secretary-General of the United Nations shall inform all States which have signed the present Covenant or acceded to it of the deposit of each instrument of ratification or accession.

### Article 27

1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession.
2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession.

### Article 28

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

### Article 29

1. Any State Party to the present Covenant may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate any proposed amendments to the States Parties to the present Covenant with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that at least one third of the States Parties favours such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted to the General Assembly of the United Nations for approval.

2. Amendments shall come into force when they have been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of the States Parties to the present Covenant in accordance with their respective constitutional processes.

3. When amendments come into force they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of the present Covenant and any earlier amendment which they have accepted.

#### **Article 30**

Irrespective of the notifications made under article 26, paragraph 5, the Secretary-General of the United Nations shall inform all States referred to in paragraph I of the same article of the following particulars:

(a) Signatures, ratifications and accessions under article 26;

(b) The date of the entry into force of the present Covenant under article 27 and the date of the entry into force of any amendments under article 29.

#### **Article 31**

1. The present Covenant, of which the Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited in the archives of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of the present Covenant to all States referred to in article 26.

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Retrieved from the World Wide Web on the 15<sup>th</sup> of January, 2007.

The Office of the High Commissioner for Human Rights, *International Covenant on Economic, Social and Cultural Rights*,

<[http://www.unhchr.ch/html/menu3/b/a\\_cescr.htm](http://www.unhchr.ch/html/menu3/b/a_cescr.htm)>

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