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# The Various Human Rights in Healthcare

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# The Various Human Rights in Healthcare

By Alison Barnes and Michael McChrystal

In John Grisham's best-selling novel *The Rainmaker*, a young man dies of leukemia because his health insurance company wrongly refuses to pay for the bone marrow transplants that probably would have saved his life. An outraged jury awards punitive damages of $50 million. The evil insurer in this story is no more. But what about real-life insurers with equally insidious tactics? Is government, by its failure to prevent such abuses, acting as the insurer's evil twin? Should we in fact blame government for its failure to ensure timely care?

The underlying question here is whether healthcare is a human right, such that government is ethically required to act for the benefit of the individual in need of healthcare services. A human right, the existence of which derives from principles of natural law, is based in the dignity and worth of the human being. Thus, the right exists regardless of whether positive law has given it expression; a human right not recognized by positive law is a failure in the law, not an absence of the right. A just government is compelled to recognize the rights of its citizens. Is healthcare such a right, such that a just government is compelled to provide for it by positive law? The complexity of the problem in the United States—where needed healthcare is often denied within the structure of a healthcare system designed for extraordinary feats of technical virtuosity and dramatic pharmaceutical achievements—emphasizes the complexity of the human rights query. The solution cannot be a visceral appeal to faith. Rather, it must be considered in its component parts.

Any general right to healthcare is comprised of at least three different types of rights, each of which must be considered for its weight or credibility in the history and diversity of societies. First, a right exists to be free from government interference in securing healthcare, e.g., the right to choose abortion over childbirth (or vice versa), or to choose treatment over nontreatment (or vice versa). Second is a right to be free from wrongful discrimination in securing healthcare, a right paralleling generally recognized rights to freely seek housing, education, employment, and public accommodation. Third, a right exists to receive healthcare services provided or assured by government to those who need them, for the well-being of all or specifically for the well-being of the individual. This might be termed "a right to services."

The third statement of right seems to capture the heart of the American debate over a "human right to healthcare." It is easy to forget the affluence and infrastructure underlying such an assertion of health services rights for each and all. The United Nations Universal Declaration of Human Rights (UDHR), celebrated for its fiftieth anniversary this year, states in Article 25 no more than the principle that all are guaranteed the right to a standard of living adequate for health and well-being, including medical care. The rights to dignity and equality of Articles 1 and 2 have been interpreted, with regard to healthcare, to be incompatible with healthcare systems that respond to political and war prisoners with faulty or absent medical care, or compel women to suffer great risks and frequent disease and early death by their reproductive policies. Fifty years ago, when the UDHA was written, torture was even more common than today and provided the context to the rights articulated there.

These statements of international policy, however bold, fall far short of an assertion of the right to government-assured healthcare. On the other hand, they do endorse the existence of human rights to healthcare in the sense that there is some true minimum of healthcare below which intolerable circumstances occur, i.e., circumstances in which the society must be considered significantly broken if it does not respond. But these truly minimal standards are not the aspirations of human rights advocates, who do and should seek to discover what a healthier society

must do to fulfill its obligations for the health of its citizens. Rather, those aspirations, and the rest of this article, place the debate squarely in the context of the government and society called upon to recognize the extent of some broader human right, and to try to define that right in terms of other rights already secured. The inquiry requires an initial consideration of the scope and complexity of the rights in the first and second statements: government should not interfere; government should prohibit wrongful discrimination in healthcare.

The right to be free from government interference in securing healthcare follows the classic formulation of a legally recognized right. Both the Magna Carta and the American Bill of Rights focus on protection of the individual against the wrongful use of governmental power. The right to be free of oppressive and arbitrary government interference generally enjoys widespread popular and critical support from the political right and left. When the government interferes, the question is whether it is doing so rationally and in the public interest.

Government interferes in many ways with our efforts to secure healthcare. Licensing requirements for healthcare workers and healthcare facilities reduce consumer choice and increase cost, both significant forms of interference in the consumer's selection of care. Approval requirements for new drugs limit personal choices, and perhaps even fatally so, to the extent that the patient is dead before the treatment is available, as asserted in the era of Laetrile for cancer and, more recently, new drugs for AIDS. Some healthcare transactions are absolutely prohibited, such as the purchase of human organs from willing sellers, while most children in need of transplants die on government-mandated waiting lists.

The principal means of assuring healthcare in the United States is employer-based insurance, but the economy calls for frequent job changes for many, not for lifelong employment. Approximately 13 percent of the population has been uninsured at some time in the past five years, possibly for extended periods. Up to 30 percent are considered to be underinsured (i.e., exposed to great financial hardship in the event of a serious illness). These market failures are partly the fault of government interference. Government increases the cost of care by endorsing (and subsidizing) extended, high-cost training for physicians before they can seek state licensing. States require that basic healthcare coverage include specific benefits regardless of whether the policy purchaser wants that coverage, increasing the cost to each policyholder in the risk pool. The federal government in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) reduced insurers' freedom to exclude new enrollees in employment plans, and shortened the period for which coverage can be denied if the enrollee has preexisting conditions. While this decreases the number of uninsured and underinsured among those with job changes and preexisting conditions, it increases the overall cost of coverage for those in the risk pool. Government raises the rates for institutional care by limiting the high-tech infrastructure in a region. With only one costly MRI facility, there can be no MRI price war. Government has also established detailed institutional quality assurance standards, leading to accreditation, for all hospitals receiving Medi-care payments. Though voluntary, the need for accreditation is so powerful that no hospital with more than twenty-five beds forgoes it.

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All these forms of government interference might be justified, and in law are justified, by the state's responsibility for health and welfare. Provided the mandates reasonably address a legitimate public concern, the individual right must yield to the well-being of the society.

In healthcare regulation, the government interferes with individual efforts to secure healthcare by raising standards to protect the public from bad care. Surely, the consumer, whether well or already ill, has difficulty discerning quality in healthcare, or even avoiding deadly or useless treatments. Substandard care may indeed be more to be feared than excessive government regulation. Government is often regarded as a do-gooder in its healthcare role, and many of us hope that it does what it must to keep away the incompetents and quacks. Recognizing the cost of these interferences, however, we also hope that the regulation is not simply protectionist or a giveaway to some powerful element in the healthcare industry. Thus, freedom from government interference is limited by the structures of quality assurance, and few would eliminate all government interference with private healthcare choices.

Freedom from wrongful discrimination in healthcare is an inescapable corollary to a general right to equality of treatment. Government carries out the principle in programs that provide vaccinations to all at a given public location, or health screenings for children at the start of the public school year regardless of whether the child attends public schools.

Yet, equal treatment is a standard complicated by the varying needs of individuals and groups, according to age and sex, as well as to factors tied to race, religion, and ethnicity. Government has sought to deliver some "equal" care that acknowledges differences in needs by means of Medicare for the aged, who statistically have reduced incomes and higher healthcare costs. Medicaid, the federal program for low-income persons, provides a far broader package of benefits than Medicare, including eyeglasses and dentures, because the poor cannot afford copayments.

Freedom from discrimination has been embraced as a right that we can expect government to enforce not only when the government itself acts but also against private actors. Even so, there are many unresolved healthcare issues relating to discrimination on the basis of gender, race, religion, national origin, age, sexual orientation, and disability. For example, may private insurers exclude from coverage certain healthcare options more likely to be needed by a particular segment of the population, such as expensive infertility treatments for women? Should gay and lesbian households be excluded from eligibility for family plan health insurance?

Finally, there is the third (and most

ballyhooed) question surrounding the right to healthcare—what kind of healthcare services might we have a right to? Surely, the strongest moral claim on government-provided healthcare involves the public health, i.e., care provided the individual that benefits both the individual and society in general. Government does in fact do a great deal to ensure the public health by regulation for safety in the air and water supply, transportation, foods, medicines, workplaces, and sanitation. More directly, government provides intervention to limit the spread of infectious disease. (The treatment of AIDS, unlike other infectious diseases that are subject to routine reporting in public records, is a remarkable example of collision between individual and public interests in the public health sphere.) Tobacco restrictions, gun control, building codes, and motorcycle helmets are examples of the scope of government's activities that make life in the United States less hazardous to health than in nearly any other country in the world. Whatever one's opinion of a particular restriction—e.g., only seeing eye dogs in restaurants—the positive purposes and high level of protection are undeniable.

After public health, the next most compelling claim is to healthcare for imminently life-threatening conditions. Economic constraints on healthcare occasionally produce a publicized case, generally an uninsured patient denied surgery and hospital services. The community might rally with private funds, or the hospital may eat the cost of care as an investment in its good name. Yet, aside for the stabilization of emergency patients mandated by the Emergency Medical Treatment and Active Labor Act, there is no general mandate that healthcare providers must serve the needy patient.

Protective services, the system of emergency intervention in domestic abuse for children and disabled adults, is chronically short of funds for effective services in virtually every state. Indeed, the law supports the principle that the state is not responsible for the healthcare of an individual who has not been taken into the state's custody.

If society need not intervene to prevent death, as this reasoning suggests, it might seem difficult to argue that healthcare should be provided to restore and maintain health. Yet, it might be more important to the individual and society to minimize disability among the living. By this reasoning, the higher claim to government health benefits may be for care designed to prevent or treat illness that may not raise the prospect of imminent death, but threatens well-being and function.

If we speak of a right to healthcare, we need to ask: What kind of healthcare? Perfectly healthy people seek healthcare simply to confirm that they are healthy. Some people seek treatments—vaccines, nutritional and hormonal supplements, surgery

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to eliminate genetic cancer risks—as preventive measures in order to preserve their health. Some people seek healthcare for conditions that others would not, such as minor colds, common balding, or sports performance enhancement. Few of us would be willing to recognize, or finance, a "right" to whatever kind of healthcare a person might think desirable.

Healthcare is a social and technical response to a condition of illness, which has been defined as a condition that interferes, or predictably will interfere, with natural function. Yet, clearly, not all lack of natural function is illness. The controversy over funding and insurance coverage for Viagra suggests that some fundamental human activities outside of work may not be within the scope of a universal healthcare benefit. The cue to provide the social response of healthcare, i.e., to excuse the individual from responsibility or activity, or the technical response of treatment, is for most people the inability to act in ways that benefit society. The function of adults is, unfortunately, generally considered to be performance of work. The desirable function of children is generally considered to be learning. An appropriate scope of healthcare, greatly improving the quality of life, could be delivered using a measure that means health generates good function in and for the society.

Not all individuals are considered to contribute to society primarily by work or learning, however. A different standard for scope of care must be considered for the old and persons with disabilities. When work is not desirable or possible because of infirmities or chronic impairments, the scope of healthcare might be defined as services that promote self-maintenance. We as a society have endorsed the intention to maintain chronically disabled persons; this possible definition expands the "healthcare" response to potentially include a range of long-term care services as well. The thorny problem of allocation of scarce and costly interventions is deferred to another article.

The difficult task of defining what forms of healthcare must be offered in the insurance marketplace, as required in health insurance coverage, is at the leading edge in defining the human right to services. Government creates the economic and social circumstances in which the need for and delivery of healthcare services arise. The current political and economic climate in the United States presents a rare opportunity for meaningful progress in understanding and defining the nature of the human right to healthcare and the government's moral obligation. There is no assurance that a political process, balancing the interests of industrial resources against the wishes of sometime or prospective patients, will result in a sound decision about the healthcare essential for all. Our new surgeon general calls for equal access, citing lack of basic care for the poor and unempowered, while the larger question of health and healthcare remains to be defined for the society as a whole.

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