

Is health care a human right?

Daniel Brudney¹

Published online: 13 August 2016
© Springer Science+Business Media Dordrecht 2016

Few things in human life seem as important as health. Without it, one's projects are likely to flag and falter, one's experiences may darken, one's life be less than it could be. In an era that invokes human rights for many phenomena that are less crucial than health, it seems natural to assert a human right to health. In the last few decades this assertion has been made by activists, by politicians, by the United Nations. The rhetoric of a human right to health has become a rallying cry. And because the talk of such a human right is so widespread, it is important that philosophers now do what they are good at doing: analyzing and assessing this sort of claim.

It is easy to see what might concern a philosopher. Take Article 12 of the International Covenant on Economic, Social and Cultural Rights. It proclaims a “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” [1]. Can this be correct? Can there be a right to health? Rights usually correspond to duties, and duties obtain only if some duty-bearer has the power to do some particular thing. But can there be a duty-bearer who has the power to make everyone *healthy*? It seems possible at most to provide *health care*, with the hope that this will lead to health. And even if the right is not to health but to health care, can *everyone* be given “the highest attainable standard” of health care? Should we neglect all other good things in order to procure the maximum health for the maximum number of people? Surely, health care is only one important good among others (e.g., education, safety from violence), and in a world of scarce resources, everyone cannot have all good things. Should we then construe a human right to

✉ Daniel Brudney
dbrudney@uchicago.edu

¹ Department of Philosophy, The University of Chicago, 1115 East 58th Street, Chicago, IL 60637, USA

health as a right to health care and attempt to specify it in some reasonably clear way?

Doing so will generate plenty of questions. What are the grounds for thinking that there is in fact such a human right? If the right exists, what is its content and what are its limits? Can the right be justified by linking it to other things that are already widely accepted as human rights? Who are the duty-bearers of the right? Does the right depend on accepting some picture of human flourishing, even if only a broad and general one? How does the right fit with the common belief that governments have an obligation to provide many of the material conditions for a healthy life, many of the so-called social determinants of health, such as clean air and water?

The contributors to this special issue develop these topics from a variety of perspectives. There is, I think, no basic agreement among the contributors. That is all to the good. What emerges are reasons to support the claim that there is a human right to health care, but also reasons to be mindful of that right's limits, and even reasons to be skeptical about the claim that there is such a right. As I say, such differences are welcome. They are what one gets when one applies seven first-class philosophical minds to a deep and difficult topic.

Matthew Liao argues for a human right to health care on the ground that health care is a fundamental condition for the pursuit of a good life. Here is his argument for the *fundamental conditions approach*:

- (1) Human beings have human rights to the fundamental conditions for pursuing a good life.
- (2) Basic health is a fundamental condition for pursuing a good life.
- (3) Therefore, human beings have a human right to basic health.
- (4) A human right to basic health implies a human right to those essential resources for maintaining and promoting basic health.
- (5) Basic health care is an essential resource for maintaining and promoting basic health.
- (6) Therefore, there is a human right to basic health care.[2]

Liao's central thought is that there are some activities such "that if a human life did not involve the pursuit of any of them, then that life could not be a good life." A condition of the good life involves being able to pursue an adequate range of these activities (e.g., deep personal relationships; active pleasures such as creative work and play). What Liao calls "the fundamental capacities" are those capacities required to pursue the basic activities. These include, e.g., "the capacity to think, to be motivated by facts, to know, to choose an act freely ... to develop interpersonal relationships, and to have control of the direction of one's life." The ground for a human right to health care is its relation to the fundamental capacities, and this relation goes through the fact that, in general, health care is crucial to sustaining these capacities.

Now, Liao accepts (1) that there can be no right to health but at most a right to some of the social determinants of health, among them being health care, and (2) that health care is unlikely to be the most important social determinant of health.

Nevertheless, he argues, “if we have a right to X, and Y is an essential means to X, it seems that we should have a right to Y”; we do have a right to health; health care is an essential means to health (even if other things are as well); therefore, we have a right to health care.

Many issues remain. For instance, who has the duty to make good on that right? Here, Liao distinguishes between primary and associate duty-bearers of rights. Primary duty-bearers are those who are at the levers of power. With health care, primary duty-bearers have the duty to set up institutions such that basic health care is available to all. Secondary duty-bearers must merely do what is needed to enable the primary duty-bearers to do their job. Secondary duty-bearers might be merely obliged to pay the taxes that support the institutions that make health care available.

Liao finishes by asking whether, in practice, the duty to make health care available to all could be so demanding as to call the human right into question. This goes to the more general question of the limits to the demandingness of morality. In a world of scarce resources and vast human needs, we are likely to have to adjust what can be demanded of us in one sphere to what can be demanded in another. Liao’s thought is that any such adjustment ought to be framed in terms of the thesis that there is a human right to the fundamental conditions for pursuing a good life. Health care is not the only such condition; however, it is an important condition and any balancing of duties will have to find an important place for it.

Jennifer Prah Ruger [3] begins by noting four features of current American health care. First, in terms of the United States constitution, health care rights are purely negative rights, e.g., the state may not prevent a woman from having an early-term abortion. Second, a patchwork of statutes (among them EMTALA, Medicare, Medicaid, SCHIP, ACA) has created a patchwork of positive legal rights to health care. Third, this patchwork of legal rights is fundamentally inadequate and needs to be replaced. Finally, fourth, as part of replacing it, a morally proper standard for health care provision is needed.

The standard that Ruger proposes is the health capability paradigm (HCP). Based on the capabilities approach pioneered by Amartya Sen and Martha Nussbaum, the “HCP provides a standard for health and health care toward which we can strive in our social and political organization, and a yardstick against which to measure our progress.... [It] is rooted in the Aristotelian view of the good life as human flourishing.” (One can see an overlap with Matthew Liao’s view.)

A couple of things should be noted about the HCP. First, it is different from an equality of opportunity approach to access to health care.¹ The latter has no independent standard for health care’s contribution to a good human life; rather, it stresses that access to health care is a condition for having an equal opportunity to attain the things that a modern society makes available. Such equal opportunity is assumed to be a requirement of fairness, independent of any substantive view of human flourishing. By contrast, the HCP builds in an outline of human flourishing through its specification of what it takes to be the key human capacities. Second, for policy purposes that outline needs to be made more precise, but in a diverse society it is important that no *detailed* account of human flourishing be built into health care

¹ An equal opportunity approach is associated especially with the work of Norman Daniels; see [4].

legislation. Here, as a way to find useable content for such legislation, Ruger appeals to the idea of an incompletely theorized agreement. The hope is that, although we might have reasonable disagreements about many details, we can accept some basic goals for health care legislation, for instance, “preventing premature death and preventable morbidity.... These central elements represent universally valued elements of health capability.”

This might seem anodyne. In fact, in Ruger’s hands it becomes radical because it is coupled with a commitment to equality. “The HCP employs ‘shortfall equality,’ used in welfare economics, to assess health policies and health inequalities.... Inequalities in health capabilities are unjust if they represent a shortfall from the optimal standard and can be prevented, avoided, or ameliorated.” It is easy to move from the standard of shortfall equality to the conclusion that, at least in terms of the distribution of health capabilities, many existing societies, almost certainly including the United States, are unjust.

Ultimately, Ruger argues, a just and stable distribution of health capabilities will depend upon the widespread internalization of an appropriate social norm with regard to such things. Citizens must come to regard health care as a positive right and so come to see inequality in health care as a basic injustice that must be remedied. In this regard, achieving just health care in the United States will require much transformation of our public norms.

In his contribution, James Nickel [5] takes on the topic of linkage arguments. Such arguments are popular in the human rights literature. They move from a right of some kind that is widely accepted—widely accepted *as* a right—to another right that is claimed to be, in some sense, a condition of realizing the widely accepted right. However, as Nickel shows, the structure of this sort of argument is not simple. Nickel’s claim, made in careful and subtle detail, is that there are many ways in which one right Alpha might have another right Beta as its condition, that most of these ways come in degrees, and that, in the end, whether a given Beta is a sufficiently crucial condition of a given Alpha so as itself to count as a right will depend on a variety of empirical facts.

Here are a few of the many complexities that Nickel details. Beta might reduce the cost of realizing Alpha, thus making Alpha’s realization more likely; Beta might promote “acceptance, knowledge, and use” of Alpha (suppose there is a right to political participation; a population of adequately educated citizens might avail themselves more often and easily of that right); or Beta might promote “the willingness and ability of dutybearers to meet their responsibilities” (suppose there is a right to political participation; adequately educated officials might be more adept at making sure that citizens can avail themselves of this right).

The complexities also include ways in which it might be a mistake to think that Beta is a needed support of Alpha. For instance, a given Beta might be needed for a *complete* realization of right Alpha but not for its *sufficient* realization, in which case there may not be a compelling defense of Beta as a right.

Focused more particularly on a right to health care (RHC), Nickel asks “whether or not the full realization of RHC is indispensable or very useful to the realization of other [important] rights.” Nickel’s conclusion is complex, specific, and remarkable for its carefulness. He argues that there are ways in which RHC contributes to other

rights. For example, it is less costly to educate healthy children; moreover, good health care reduces the likelihood of epidemics with their associated threat to such rights as freedom of movement and association. There are other ways in which Nickel believes RHC supports other rights (although he also notes that there might be ways in which RHC undermines other rights). However, he finds, and perhaps this is not surprising, the strongest linkage argument to be between RHC and a right to life. “The availability to all of an adequate basket of health care services and products will save lives from injuries and diseases that are amenable to medical treatment. Full realization of RHC is arguably indispensable to blocking some important threats to the right to life of many residents of [a] country.” Thus, Nickel concludes, a linkage argument does in fact ground RHC in its support of other rights, and it strongly grounds RHC in support of a right to life. Such conclusions, Nickel notes, “are not spectacular, but neither are they insignificant.”

Sarah Conly [6] accepts the existence of a right to health care but stresses that, like any right, its scope is limited by facts about scarce resources and human psychological tendencies. Rights are constrained by context, and, Conly argues, context involves considering costs and benefits. “How important is the exercise of a particular practice or the provision of a particular good? And, how costly is it to others? ... [W]hat one can claim as a right will be sensitive to social costs, individual benefits, and the ratio of the two.”

There are real world limits to the supply of health care. Without beggaring other needs—in effect, other human rights, e.g., the right to education or to be safe from crime—we cannot supply health care to the max. But if health care is a great benefit, and yet, sadly, we cannot supply it to the max, then we ought to reduce the demand for it. This consideration naturally leads Conly to preventive health care. An obvious tack is health education, and Conly supports it. However, health education alone is insufficient. Incentives are needed. “We need to make it much more difficult to engage in behaviors that are bad for us.” There are many possibilities: taxing fast food or soda, prohibiting ads for such things, imposing portion limits in restaurants. Conly calls for creative ways to get us to adhere to a healthier form of living. At the limit, harmful foods and other things could be banned.

Conly knows that talk of taxes and prohibitions will raise hackles. “The right to health care is typically taken to expand our options, not to reduce them.” But if rights are sensitive to costs, then we must think about reducing the cost of a right to health care. Moreover, rights come with obligations: “the recipients of health care, in claiming their right, also place themselves under some obligations.”

An opponent might urge that lifestyle changes, although desirable, ought to be voluntary. And those who fail to adopt healthy lifestyles have only themselves to blame, and so ought to have no claim to health care resources. Conly thinks this “ignores too many realities of human psychology.” People are weak of will. They will predictably often take the course of least resistance, i.e., poor self-care. Conly thinks that such realities are sufficiently pervasive that institutions must play a role in guiding our choices. Nevertheless, Conly acknowledges that there is a difference between a person who engages in an unhealthy lifestyle because of limited alternatives (e.g., living in a food desert), difficult-to-avoid flaws in rationality, or other excusing conditions and a person who does so with full knowledge and

unimpaired rationality. She thinks that the first retains a right to health care while the second does not. However, she goes on to note both that few people will fit into the second category and that society might still have a duty not to let such people suffer. That someone has no rights claim to health care does not entail that society has no duty to provide it. (Of course, the duty must then be justified in a different way.)

Overall, Conly's essay is a plea to approach the issue of a right to health care with realism as well as with a willingness to make hard choices. Health care is resource intensive. We cannot all have all of it that we want; perhaps all of us cannot even have all of it that we need. Therefore, we must recognize our duty to conserve the resource and to find rules (legal and otherwise) to ensure that we do so.

In his essay, David Reidy [7] argues for a "cautious and circumspect use of human rights language within deliberation over and advocacy for improved health and health care policies around the world." Reidy reaches this conclusion in an unusual way: by focusing on the moral status of the international treaties that guarantee a right to health care (e.g., the International Covenant on Economic, Social and Cultural Rights (ICESCR)). These are often regarded as signal international achievements. They seem to be proper responses to the fact, as Reidy emphasizes, that our moral rights often need institutional embodiment for their effective exercise. To "provide persons ... with specific, targeted high-priority normative direction," he notes, "rights typically require some measure of conventional or institutional embodiment or social recognition."

It is precisely for this reason that one might applaud treaties such as the ICESCR. Here at last, one might think, is the needed institutional embodiment. Yet Reidy points out that there is a normative gap between the existence of such treaties and their moral force to bind individuals. The problem is not that the treaty signatories might have signed unwillingly. Even if they were willing signers, the internal structure of a signing state might not provide it with the moral power to bind individuals in its territory. Reidy asks the reader to consider a treaty between Syria and North Korea. Even if the various leaders signed it with enthusiasm, its content would hardly be morally binding on individual Syrians and North Koreans. Reidy's point is that the content of a treaty is not morally binding unless the entity that signs the treaty is morally entitled to impose obligations upon those under its jurisdiction—and in many actual cases, including with some states that signed the ICESCR, the signatory does not hold legitimate power and so does not have such an entitlement. A treaty could thus be legally binding under international law but fail morally to bind individuals to act in accordance with it.

Reidy argues that valid legal obligations are also valid moral obligations only if they "arise out of a law-making process that satisfies certain substantive conditions of legitimacy." He presses that it is "the nature of domestic law-making processes [that] determines whether states have the standing or status necessary for the international legal obligations and legal reasons created by their voluntary or consensual undertakings to have *prima facie* moral force." Reidy develops this point by urging that only a "constitutional, rule of law, republic," one that already protects "the most basic of human rights," can generate moral obligations that bind its citizens.

The implication of Reidy's argument is startling. Rights need duty-bearers to make them effective. But who counts as a moral—not merely a legal—duty-bearer for a human right to health care turns out to be far from straightforward. The mere fact that, say, the ICESCR is valid international law is not enough. According to Reidy, there can be no proper international moral structure for the human right to health care until the states that are signatories to the relevant treaties are internally structured in a morally adequate way. Perhaps all individuals do have a human right to health care, and perhaps such rights require institutional embodiment to be effective. Still, for such international arrangements to be morally binding on the individuals subject to them, the states involved must have met an appropriate standard of political legitimacy.

Gopal Sreenivasan [8] notes the following common claims:

- (1) There can be no human right to health because achieving health is beyond what social institutions can accomplish.
- (2) If there is a human right in this neighborhood, it is a two-pronged right: a right to an adequate provision of the social determinants of health (e.g., clean water) and a right to health care, for such things are within the purview of social institutions.

Sreenivasan challenges both of these claims. Against the claim that there is a human right to the social determinants of health, he presses that a human right is an individual right, something due the individual, but that the social determinants of health often require large-scale state action that affects and might even place duties upon many people. He concludes that such state action cannot be due an individual as her human right. His example is herd immunity from a disease. Jack cannot have a human right to such immunity because achieving it would require vaccinating millions of people. This might be good to do, but Jack, merely as one human being among others, cannot have a human right that millions of people be vaccinated. The burden is too great. It is one thing to claim that one has a right that the state do X with respect to oneself; it is quite another to claim that one has a right that the state do X (or Y or Z) to millions of others.

This tosses the ball back to whether there is a human right to health care. That looks as if its focus is properly individual. Here, Sreenivasan makes a different point. The appeal to health care rather than to the general provision of what makes for health (health care *plus* the social determinants of health) seems arbitrary because, in the end, what we care about is that social institutions facilitate citizens' health to the extent that existing technology and resources permit. But if what makes for health are two instruments for achieving what we care about, namely, health, and if there is no human right (no individual right) to one of them (the social determinants), then it is unclear that what we care about, namely, health, can ground a human right to the other instrument. Consider that both instruments are focused on attaining the same goal. Now, given that health resources are finite, any sensible health bureaucrat must trade off resources allotted to one instrument against those allotted to the other. If one instrument is a human right while the other is not, it would seem that individual health care (the alleged human right) ought generally to

win out over the social determinants of health (a goal, not a right). But the social determinants of health are far and away the more important instrument for attaining citizens' health—the thing we care about. It would be a pyrrhic victory to gain a human right at the cost of losing the point of the right. It seems conceptually more sensible, Sreenivasan argues, to concede that there is no human right to health care.

Sreenivasan has further ingenious arguments against the claim that there is a human right to health care. As with the argument above, they target the common thought that one can get a human right to health care by subtracting from the claim of a human right to health. One concedes the absence of a right to the latter but asserts the seemingly more straightforward right to the former. Sreenivasan shows that this move requires far more defense than it has been given.

John Tasioulas and Effy Vayena [9] stress the need to distinguish between a claim of individual right to health care and the general social duty (incumbent upon governments, multi-national companies, perhaps even individuals) to remedy health shortfalls. Even were all human rights met, there could still be such shortfalls. This could be due to many things, e.g., unhealthy choices by individuals, problematic social determinants of health. Unlike other contributors to this issue, Tasioulas and Vayena accept that there is a right to health but they insist that it has two components: “health policy ... has to be responsive both to human rights, including prominently the right to health, and to global common goods that bear on health.”

Many issues now need resolution. For instance, there is the problem of distinguishing what falls under the right to health from what falls under other rights (or is not a right at all). Health is clearly connected to many things but Tasioulas and Vayena argue that mere connection does not entail inclusion in a human right to health. It is both misleading and a hindrance to useful policy to put “entitlements to food, housing, life, education, privacy” and many other things under a right to health. (Here, Tasioulas and Vayena seem to agree with James Nickel that we should be *very* careful about linkage arguments.) Tasioulas and Vayena urge that the right to health includes only such other rights as serve “one’s interest in health as [their] primary and direct objective, as in the case of clean air and water.”

A second issue concerns the determination of when a health interest becomes a health right. Tasioulas and Vayena press that duty-bearers who are supposed to act in such a way as to realize the purported right must actually be able to do so (e.g., at present it is not a practical possibility for all human beings to have “the highest attainable standard of physical and mental health”). Moreover, even if it is possible to realize an alleged health right, there is a threshold of burdensomeness on the duty-bearer that would remove the duty and thus forestall the claim of right. In practice, applying the standards of possibility and burden to determine what is and is not a health right will surely be difficult; still, these are the key standards to apply.

Finally, Tasioulas and Vayena address the issue of global common goods. These differ from rights but can be of profound importance. An individual might not have a right to a new kidney but it would be a great common good for there to be “a social ethos that ... helps maintain an adequate supply of organs for transplant.” Both the state and individuals might have a duty to promote such an ethos.

Although they press the distinction between individual rights and common goods, Tasioulas and Vayena also stress that the distinction can be complicated. In some

cases, they argue, individual rights do entail a common good. “[T]he relationship between human rights and common goods is not mutually exclusive.” Here, they disagree with Gopal Sreenivasan. In particular, they argue that herd immunity is a human right although each individual’s rights claim is not to make millions of others be vaccinated but to “a proportionate share” of what is involved “in a vaccination programme aimed at securing” herd immunity. Tasioulas and Vayena draw the inference that “some aspects of the common good are rights-based, in the sense that they include elements to which we have a right; and what these rights confer is a right to benefit from the common good in question.” This disputed issue—whether or how far a health care common good can be rooted in a claim of individual human right—is clearly among the most important to resolve.

In a vague and general way all the writers in this special issue and, indeed, most people believe that it would be a good thing if everyone were able to avail herself of adequate health care. Yet public policy requires that choices be made, and making policy choices usually involves setting up a moral hierarchy. The frequent claim that health care is a human right is a way to assert that it belongs near the top of any moral hierarchy. But of course not every claim is justified, so we need to know whether health care truly is a human right. It will be clear from reading the contributions to this special issue that there is ongoing disagreement about whether there is indeed a human right to health care; and if there is, what grounds such a right as well as how, in a morally defensible way, limits can be set to it. There is, then, plenty of work still to be done.

Acknowledgments These papers were initially given at a symposium, “Is Health Care a Human Right?” presented by the Neubauer Collegium for Culture and Society and the Pozen Family Center for Human Rights at the University of Chicago on October 10–11, 2014. I am very grateful to both the Neubauer Collegium and the Pozen Center for their help. I want also to thank the Franke Institute for the Humanities for its support of the symposium.

References

1. United Nations. General Assembly. 1966. *International covenant on economic, social and cultural rights*. Resolution 2200A (XXI) of December 16, 1966. Entered into force January 3, 1976. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>. Accessed July 14, 2016.
2. Liao, Matthew. 2016. Health (care) and human rights: A fundamental conditions approach. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9373-9.
3. Ruger, Jennifer P. 2016. The health capability paradigm and the right to health care in the United States. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9371-y.
4. Daniels, Norman. 1985. *Just health care*. Cambridge: Cambridge University Press.
5. Nickel, James W. 2016. Can a right to health care be justified by linkage arguments? *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9369-5.
6. Conly, Sarah. 2016. The right to preventive health care. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9374-8.
7. Reidy, David. 2016. A right to health care? Participatory politics, progressive policy, and the price of loose language. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9370-z.
8. Sreenivasan, Gopal. 2016. Health care and human rights: Against the split duty gambit. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9375-7.
9. Tasioulas, John, and Effy Vayena. 2016. The place of human rights and the common good in global health policy. *Theoretical Medicine and Bioethics*. doi:10.1007/s11017-016-9372-x.