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"Is there a »Right to health« A Comment on Dr. Nagel's paper"

Introduction

Nagel's paper [2000] is mainly concerned with the question of whether standardization of medical treatment is both an economically useful and a medically responsible way of cutting down the costs in the public healthcare system. Though Nagel is willing to admit that therapeutic guidelines may be helpful in *some* areas of diseases, e.g., in endocrinological diagnosis, he strongly doubts whether adequate guidelines can be developed also for other areas of medicine, especially when "complex clinical pictures" are involved. He illustrates this point by means of a case study of a "32-year-old woman with a large retroperitoneal tumor of unclear genesis" (p. 3)[1] where experts from different disciplines have serious problems in agreeing upon the proper therapy. Somewhat surprisingly, however, Nagel does not take the difficulties of the case at hand to show the uselessness or even *impossibility* of standardized guidelines for clinically complex diseases; rather he recognizes that if such guidelines could be developed, they would offer a "*necessary* aid to orientation" (p. 4). Dr. Nagel concludes the section entitled "Assessment of the Debate" by acknowledging, on the one hand, the importance of orientating "oneself towards transparent, in general binding characteristics in the formulation of a positive or negative recommendation for treatment". On the other hand, he stresses the importance of strictly distinguishing between criteria which "can be assigned to the medical standards or standards of treatment" and criteria "which can be assigned to the standards of provision based on insurance law and the law of liability" (p. 5). The next two sections of the paper are devoted to a closer discussion of standards of treatment vs. standards of provision. The most important points can be summarized as follows. Medical standards:

- "indicate which diagnostic and therapeutic measures are medically »appropriate and necessary«";
- "must continually be adapted to scientific and technical progress"; and
- enable the doctor to explain the patient "the reasons for his treatment methods" while yet leaving room for his "essential therapeutic freedom" in the individual case (pp. 4 – 6).

However, in some (or even in many) cases the medical standards will "not offer an adequate basis for decisions concerning allocations" because there may be "a lack of resources" so that the necessary therapy can*not*[2] be provided for all patients. Here standards of health provision must be formulated which define

- "what the individual insured person can expect from the community with regard to »appropriate and necessary« provision", i.e.
- "which items of health provision are regarded as being so important and necessary […] that their costs will be taken over by the caring society" (p. 6).

Nagel then points out that not only the medical standards (which, unfortunately, "have not [yet] been defined in broad fields of medicine") should be backed up by "scientifically sound evaluation studies" (p. 7), but also "the determination of standards of provision [requires] scientific validation" (p. 8). Furthermore, "standards of provision include additional ethical and socio-political judgments" (ibid.) which are accordingly discussed in the concluding part (pp. 10 – 12)of Nagel [2000]. Since I am a philosopher with particular interests in applied ethics, my subsequent commentary will mainly be concerned with these ethical issues. Otherwise let me just mention that I basically agree to the following conclusions about medical standards and standards of provision:

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[1] Page references without indication of an author's name always refer to Nagel [2000].

[2] In the corresponding passage on p.6 of Nagel [2000] the word ‚not' is missing!

- Standards *can* be useful guidelines which "fill the empty formula of »medically appropriate and necessary«" [measures] with a firm content";
- "Standards can bring about greater uniformity of provision";
- "[..] standards can contribute towards greater transparency of the doctor's behavior"; and
- "[…] standards permit the opening up of potentials for rationalization" (pp. 8-9).

Some ethical issues in public health-care

In the following passage, Nagel [2000: 10-11] outlines his own *ideal* of a public healthcare system:

> "[In] Spain […] health provision is a right of the individual laid down by the constitution. Financial aspects, even those of the community as a whole, are of only secondary importance. The worth of maintaining a concrete, individual human life is a value guideline that cannot be measured against the costs incurred in doing so. The fundamental right to life, as well as the protection of the individual regarding his personality [and] individuality as laid down in the constitution forbids that a human being should be degraded to an item on a bill of an economic calculation. The fundamental right to health bears an egalitarian character to a special degree."

On the basis of these ideas (or ideals), Nagel comes to conclude that:

(1) "Unequal treatment of patients under the law of liability on the basis of cost-effectiveness calculations must be excluded."

(2) "A system whose goal is to make available good provision for the sick and health care for all, the security of provision, equal access and the greatest possible balancing out of given and social differences, must not have its real purpose taken away from it on the level of finance."

(3) "Practised and practicable solidarity must not be sacrificed to the phantom of a supposedly uncontrollable cost explosion."

It is these normative and evaluative statements plus the attempted foundation by means of the aforementioned "fundamental right to health" that I want to discuss in what follows.

First of all, speaking quite generally, I do not find it very useful to discuss ethical issues in terms of *rights*. Such a discussion typically tries to prove a certain action *A* to be morally wrong by showing that *A* stands in conflict with a certain right *R*. This strategy, however, faces a serious problem, viz., to explain how (or why) a certain individual *X* attains right *R*. Consider, e.g., the most important and most fundamental of all rights, the so-called "right to life". It appears far from clear *who exactly owns it*. Do only humans own this right, or must a "right to life" also be granted to flowers, trees, bacteria, viruses, mosquitoes, worms, frogs, horses, and cats? Furthermore, even if we restrict our considerations to human beings, we cannot determine for sure at which stage of the development, or by virtue of which process or property, a human being begins to own a "right to life". Does an unfertilized egg already have such a right, or only the early embryo; a fetus up to the 12th week, or only the newborn baby?

As has been argued in Lenzen [1999], esp. section 2.3, it seems more promising to solve the ethical problems behind these questions in a more direct way which doesn't resort to the notion of a "right to life". This approach attempts, first, to develop general criteria for the moral acceptability, or unacceptability, of arbitrary actions *A* and, second, to apply these criteria to the particular problem or situation at hand. The general criteria will plausibly derived from (suitably refined versions of) traditional maxims such as the "Golden Rule", the principle of "Neminem laedere" ("Do no harm"), or perhaps also the principle of Utilitarianism. One particularly uncontroversial corollary of such a moral theory could be formulated as follows:

(NL) Action *A* (of an agent *X*) is morally acceptable if *A* does no harm to, i.e. doesn't violate the interests of, any other individual *Y* (≠*X*).[3]

This very weak principle can yet be used to explain, e.g., the moral difference between contraception and abortion by noting that depriving a fetus *F* of its life (which *F* would have lived if it hadn't been aborted) does constitute *a harm done to F*, while the "act" of contraception, i.e. of *not* fertilizing an ovum *E*, cannot be classified as a *harm* because *E* is not (yet) a living being and therefore *E* simply *doesn't have any interests* which might possibly be violated by any action *A*.[4]

Returning now to our main issue of the ethics of public healthcare, I similarly want to suggest that one better totally dispenses with Nagel's notion of a "right to health". Even if in some countries such as Spain there exists a *legal* (or constitutional) right to health-provision, it is not at all clear what a *moral* "right to health" might reasonably consist in. In particular, it is hard to see in which sense the "fundamental right to health bears an egalitarian character to a special degree". Perhaps this sentence was meant to emphasize that healthcare should, *ideally*, be provided in an egalitarian, i.e. universal, way to everybody (within a given society, or even all over the world?).[5] Otherwise I do agree with Nagel in considering health as a very important prerequisite for leading a life which is worth while living. Thus I also agree that "health is a *primary* value" (p. 11) while "financial aspects, even those of the community as a whole, are of only *secondary* importance". Yet I am not willing to admit that the "worth of maintaining a concrete, individual human life is a value guideline *that cannot be measured against the costs* incurred in doing so", provided this statement is to taken to mean that medical treatments, i.e. life-saving or life prolonging measures must be carried out *no matter the costs*![6]

Irrespective of the high value that we all attribute to health, health should not be regarded as something which any individual has a *right* to. In my opinion health is better considered from a totally different point of view, namely as a *gift*, as something for which we should be grateful as long as we enjoy it. Correspondingly, losing one's health, falling seriously sick, or catching a grave disease is a *bad luck*, sometimes even an outright catastrophe. But none of us has a right to remain saved from such mishaps. If we happen to become the victim of a crime and lose our property, our health, or even our life, then we do normally have both the legal and the moral right (entailed, e.g., by the above principle NL) that this harm be redeemed. However, falling sick does not constitute a *harm* done to us by others. Therefore we cannot claim a *right* to be automatically restored to health, although, in a humanistic society, we are morally entitled *to expect help* from the others.

To provide help for sick people on a basis more reliable than mere charity, the social institution of *health insurance* has been developed in most civilized countries. *Ideally*, this insurance should cover the whole risk and make good for all possible harms. However, it *may* turn out that such a universal and all-comprehensive health insurance becomes financially unaffordable in the sense that we (i.e., the whole society) are no longer be willing to pay the full prize for it. I do not mean to suggest that the present situation in Germany already justifies such a decision. I am not an expert in medical economics and I have no idea whether the "uncontrollable cost explosion" mentioned in Nagel's thesis (3) is a "phantom" or not. I only want to point out that his appeal to a "Practised and practicable solidarity" implicitly

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[3] In some cases it may be necessary to include also utilitarian considerations as, e.g., in the following principle:

(NL_{Ut}) Action *A* (of an agent *X*) is morally acceptable if the harm done by *A* to some individual (or group of individuals) *Y* is smaller than the good done by *A* to another individual (or group of individuals) *Z*.

For a more detailed discussion cf. section 0.5 of Lenzen [1999].

[4] For a more detailed discussion the reader is referred to section 3.3 of Lenzen [1999].

[5] Unfortunately, for reasons of space, I cannot discuss this important issue here. Some brief remarks on the problem of a "two-classes-medicine" may be found in section 2.6 of Lenzen [1999].

[6] The view of health as "a value […] that cannot be measured against the costs" strongly reminds of the doctrine of the sanctity of life which has been aptly criticized cf., e.g., in Kuhse [1987].

acknowledges that healthcare must remain also *financially practicable*. Similarly, Nagel's thesis (2) quoted above doesn't necessarily postulate that "good provision [be provided] for the sick and health care for all" *no matter the costs*, but only within the limits of "the greatest possible balancing out of given and social differences".

It is, of course, a wide field for further discussion how such a balance between what is »medically appropriate and necessary« on the one hand and what is financially affordable on the other might be achieved in detail. My critical remarks do not pretend to be more than the very first "prolegomena" to the ethical basis of solidarity. A philosophical guideline for further discussion of the ethics and economics of public healthcare should perhaps be orientated towards another traditional principle, the so-called *Golden Rule*, (GR). In its original form, GR says that "we should never do to others what we do not want to be done to ourselves". Hare [1975: 208] put forward the following variant according to which "we should do to others as we wish them to do to us". When applied to illness and sickness (and other mishaps and catastrophes) this position appears to entail the following twofold principle:

(GR_{BL}) (1) In a situation of bad luck, help should be granted to the other to the same extent that we wish help to be granted to us.
(2) In a situation of bad luck, we are morally entitled to expect help from others only to the extent that we are willing to grant to others.

Literature

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