# Donnelly's Constructivism: a New Foundation for the Right to Health Care

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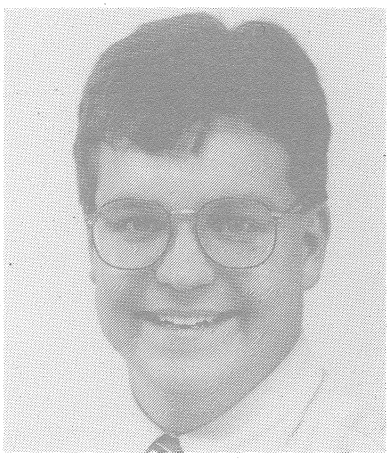

How can one establish a right to health care and maintain reasonable limits on it? We require a philosophical foundation that contains the subtlety to distinguish between health care needs that entail a right and those which do not. Furthermore, this foundation should allow us to capture the big picture and make comparisons between health care and other positive moral rights (eg., education, police protection, food, shelter, etc.). Obviously, this is a tall order.

Since health care resources are scarce, priorities must be set, and different right-claims for health care merit different priorities. For example, the man with dyspepsia has less of a claim on our resources than his neighbour who suffered an open fracture after falling from a ladder. This is not to trivialise dyspepsia; it may be the early symptoms of a stomach ulcer which may later pose him with a life-threatening problem. However, priorities must be set, and the foundation of a right to health care should assist us in this task.

This article will apply the constructivism human rights theory to health care and examine two main rival accounts of justice in health care: Robert Evatt's egalitarianism and Norman Daniels' *Just Health Care*.

Veatch argues 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."[1] Norman Daniels applies Rawlsian justice to health care, and argues that health care is necessary to guarantee fair equality of opportunity. Each theory must operate under the same budgetary constraints and assist us in setting priorities. The priority-setting mechanisms of the two main rival theories will be outlined, and then the superior human rights approach will be sketched.

Egalitarian Robert Veatch is clear about how to set priorities: the worst-off patients get first priority. He writes,

> Those whose health is worst are entitled to enough health care to get them as healthy as others. We should target our efforts on the sickest ... The medically worst off have a complete claim of justice on health care resources in order to bring them, as far as possible, up to the level of health of others ... the egalitarian claim is that, difficult though it may be, we must include those conditions which constitute the greatest assault on one's health.[2]

> Do we favour completely effective treatments for mild disorders over significantly (but not completely) effective treatments for serious disorders? Is preventing a disorder preferred to curing it?

While this is lucid, it is not very helpful. We already expend a tremendous amount of resources on the worst off. It is estimated that the healthiest 50% of patients only account for 3% of expenditures while the sickest 10% account for the majority of health expenditures. If we shift priorities to further favour the worst-off, there would be nothing left for anyone else. This is not to advocate abandoning the worst off, but giving them a *complete* claim on health resources does not seem rational. Where do pregnant women fit into this kind of priority list? Surely they cannot be considered among the worst off, but do we want to give maternity care a low priority? How about people with chronic diseases? And because healthy individuals are clearly not the worst-off, prevention does not enjoy its proper place in this prioritization, either.

It is tempting to think this is a misreading of Veatch. The above quotes are nearly twenty years old, and the conclusions flowing from this argument seem too unreasonable. However, Veatch has remained steadfast in his views. Consider his more recent discussion of the infinite demand problem and its effects on preventative medicine:

> Surely the blind are not as healthy as others and egalitarian justice would require diverting some resources to try to help them, but if enough resources were diverted so that it cut into the healthy persons' supply of polio vaccine, the healthy would be medically worse off. In fact, if enough doses were diverted, polio could become rampant and all would be at serious risk. At some point the previously healthy would be at a high risk and might actually be worse off than the group of blind persons. Justice would then require diverting resources from the better off blind persons in order to benefit the now least well off persons at high risk for polio. Justice itself sets its own limits to the infinite demand problem.[3]

If prevention can only merit a high priority as the risk of acquiring a completely avoidable disease increases, there is something faulty with the theory of justice. It would seem Veatch has taken a good idea, giving some priority to the worst off, and allowed it to destroy the workability of his theory.

Now we turn to the stronger of the rival theories, Norman Daniels' application of Rawlsian justice. In *Just Health Care* Daniels argues that the "moral function of the health care system must be to help guarantee equality of opportunity."[4] For Rawls, equality of opportunity is connected with individuals' ability to secure jobs and positions of power. As this does not assist us in ascribing value to health care for non-workers (children, retired people, etc.), Daniels broadens equality of opportunity to include all the things individuals want to do, and he adds the idea of an age-relative opportunity range.

Daniels proposes a sensible criterion for setting priorities. He recognises that some kinds of health care are more important than others, and suggests health care interventions should be prioritised by their relative ability to correct impairments of the normal opportunity range. This, of course, does not answer all questions. Do we favour completely effective treatments for mild disorders over significantly (but not completely) effective treatments for serious disorders? Is preventing a disorder preferred to curing it?

Some of these questions are answered when Daniels lists the following "layers" of health care services:[5]

a) preventative services
b) curative services
c) chronic care
d) terminal care and care for the seriously mentally and physically disabled.

This ranking is quite problematic. Prevention may be overvalued here. Many of the greatest successes of medicine have been in the area of prevention: immunisations, for the best example, have had a profound impact. However, most prevention is not as effective as immunisations, and some things billed as prevention are simply wasteful. Furthermore, the category of chronic care suggests similarities where none exist. Much chronic care merits ranking behind (some) preventative services and curative services, but some chronic care deserves a high ranking. Consider insulin treatment for type I diabetes mellitus. It is a daily, lifelong treatment, certainly chronic, but it is highly effective and life-saving. Without insulin, type I diabetics would die, and with it they can lead a reasonably long, relatively normal life. Surely, insulin treatment should be ranked highly.

While it would seem Daniels' theory could be adjusted to suitably accommodate the previous concerns, it contains a fatal weakness exposed by a final criticism: a theory of justice in health care that rests on equality of opportunity cannot give appropriate consideration to the terminally ill and seriously disabled. Returning these people to "the normal opportunity range" is nonsensical, yet caring for similarly-placed individuals has always been one of the most important things the health system does. Caring for these individuals is an important mission of the health service, and it deserves a much higher relative priority. Daniels is aware of this problem; he writes that treatment of the terminally ill and seriously mentally and physically disabled raises "serious issues which may not just be issues of justice. Indeed, by the time we get to the fourth layer virtues other than justice become prominent."[6] A better theory of justice would give caring for these patients its proper priority without appealing to "other considerations."

The ability to enhance the dignity of individual lives gives health care moral importance. The other theories have only gained a glimpse of the real purpose of the health system.

That brings us to Jack Donnelly's constructivist theory of human rights which provides an appropriate foundation for the right to health care. He argues

> the source of human rights is man's *moral* nature ... Human rights are "needed" for human *dignity*, rather than health, and violations of human rights are denials of one's *humanity* rather than deprivations of needs. We have human rights ... to those things "needed" for a truly human life."[7]

The items on a constructivist list of human rights will be those things necessary to lead a life of human dignity. Clearly, health care meets this standard; without health care sick individuals are reduced to a pathetic and sometimes hopeless state.

Allowing individuals to live a life of human dignity is the unifying feature of many health care interventions that we hold to be important which seem to have little else in common: the hospitalisation of an acutely psychotic young man, reconstructive surgery following mastectomy for a fifty year old woman, hospice care for a woman with inoperable lung cancer, habilitative services for the congenitally handicapped, nursing home care for the elderly, rehabilitative services for a young man following a serious auto accident. Health care's ability to enhance the dignity of people's lives is more than a least common denominator, it gets at the essence of the health care system. The ability to enhance the dignity of individual lives gives health care moral importance. The other theories have only gained a glimpse of the real purpose of the health system. Sometimes maintaining dignity involves saving life; sometimes it is returning individuals to the normal opportunity range; sometimes it is caring for the terminally ill; sometimes it involves providing basic care; and sometimes it can also mean not saving life. The unifying concept is dignity.

The constructivist theory suggests that health care interventions should be prioritized by their relative ability to allow individuals to live a life of dignity. This approach does not leave the obvious gaps like preventative medicine (for Veatch) and care for the terminally ill (for Daniels). Admittedly, though, the increased usefulness of this approach is purchased at the expense of specificity. Arguing over what dignity entails could be lengthy. Consequently, we require a community definition of dignity in order to set priorities. Those priorities call for explicit and public rationing: by now a familiar cry in the medical literature.

Dignity requires a communal definition: it is not an "objective" criterion such that we can assign values to various health care interventions and rank them. Discussing openly where community health care priorities lie is valuable both for the community and the health service. The community can become more familiar with the difficulties of rationing, and the health service can be told explicitly which types of services the community wants to be

targeted. It is not enough to rank condition/treatment pairs and effortlessly fund the list as far as the budget will allow. Simply because society places a high priority on certain services, it does not follow that those services are exempt from any rationing. It should be kept in mind that low priority services make some contribution to dignity also, and we should labour to fund as much of the list as possible by controlling costs high on the list.

Dignity is such a lofty standard that it could be asserted that it is not compatible with any forms of rationing. This, of course, would be a perversion of the argument. Although health care rationing is both difficult and painful, it is necessary. Indeed, implicit rationing has been with us for a long time through capped budgets in some countries and prohibitive pricing in others. The constructivist account of the right to health care holds that the moral importance of health care lies in its ability to assist individuals to live a life of dignity. Explicit rationing with this principle in mind should yield far superior results to implicit, random rationing. Thus, to argue that rationing infringes upon dignity entirely misses the thrust of the constructivist argument.

To conclude, the constructivist theory can be seen to be applicable across the spectrum of resource allocation. At the extreme macro end of the spectrum, the constructivist theory of human rights asks the question "What are the entitlements necessary to live a life of human dignity?" This is a strong starting point as it captures the big picture: it is not just freedoms, shelter, food, education, or health care that enables each of us to have a truly human life. We should apportion our resources to positive material entitlements so as to reflect the vital importance of each of these areas. Focusing on health care, the constructivist theory asserts that we should prioritise health services with specific reference to the ability of health care to maintain dignity. Finally, at the extreme micro end of the spectrum, the constructivist theory asserts that the doctor-patient relationship should have the dignity of the patient as its focus.


1 Veatch, Robert (1976) "What is a 'Just' Health Care Delivery?" in *Ethics and Health Policy*. Veatch and Branson (eds) Cambridge, MA: Ballinger, p134.

2 Ibid., pp. 133-141.

3 Veatch, Robert (1991) "Justice and the Right to Health Care: An Egalitarian Account". In Rights to Health Care. Thomas Bole and William Bondeson, (eds) Dordrecht, The Netherlands: Kluwer Academic. p98-99.

4 Ibid., p 41.

5 Ibid., p 48.

6 Daniels, Norman (1985) *Just Health Care*. Cambridge: Cambridge University Press, p 48. 7Donnelly, Jack (1985) *The Concept of Human Rights*. Sydney: Croom Helm Ltd, p31.


*The Editor invites readers' comments on this suggested approach to health care rights.*

Address letters to: The Editor, Otago Bioethics Report, Bioethics Research Centre, PO Box 913, Dunedin, New Zealand.

## *Visitors to the Centre*

Roger Higgs visited the Centre from to 7 April to 26 April. Roger was a William Evans Fellow at the University. He works at Kings College London where he is professor in General Practice. During his time here Roger was involved in all the Centre's regular teaching commitments and workshops. Roger gave a well attended public lecture titled "Is there a case for Physician assisted death?"

William Evans Fellow Ian Freckleton made himself very available to Bioethics Research Centre. Ian participated in both BITC 401 and BITC 403. Ian's practical experience as a barrister as well as his extended knowledge of the law meant he was a valuable resource for students in these classes. Ian also presented in the Centre's Journal Club. He spoke on health professionals code of ethics, paying attention to the relative effectiveness of punishment for white collar criminals.

We are expecting Professor Ruth Chadwick from July 27 to August 1. Ruth is in New Zealand to contribute to the HRC consensus conference "Whose genes are they anyway". She will be taking a seminar within the department, and giving a public lecture on Monday July 31.


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