The Right to a Decent Minimum of Health Care

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A consensus that there is (at least) a right to a decent minimum of health care pervades recent policy debates and much of the philosophical literature on health care. Disagreement centers on two issues. Is there a more extensive right than the right to a decent minimum of health care? What is included in the decent minimum to which there is a right?

Preliminary Clarification of the Concept

Different theories of distributive justice may yield different answers both to the question 'Is there a right to a decent minimum?' and to the question 'What comprises the decent minimum?' The justification a particular theory provides for the claim that there is a right to a decent minimum must at least cohere with the justifications it provides for other right-claims. Moreover, the character of this justification will determine, at least in part, the way in which the decent minimum is specified, since it will include an account of the nature and significance of health-care needs. To the extent that the concept of a decent minimum is theory-dependent, then, it would be naive to assume that a mere analysis of the concept of a decent minimum would tell us whether there is such a right and what its content is. Nonetheless, before we proceed to an examination of various theoretical attempts to ground and specify a right to a decent minimum, a preliminary analysis will be helpful.

Sometimes the notion of a decent minimum is applied not to health care but to health itself, the claim being that everyone is entitled to some minimal level, or welfare floor, of health. I shall not explore this variant of the decent minimum idea because I think its implausibility is obvious. The main difficulty is that assuring any significant level of health for all is simply not within the domain of social control. If the alleged right is
understood instead as the right to everything which can be done to achieve some significant level of health for all, then the claim that there is such a right becomes implausible simply because it ignores the fact that in circumstances of scarcity the total social expenditure on health must be constrained by the need to allocate resources for other goods.

Though the concept of a right is complex and controversial, for our purposes a partial sketch will do. To say that a person A has a right to something, X, is first of all to say that A is entitled to X, that X is due to him or her. This is not equivalent to saying that if A were granted X it would be a good thing, even a morally good thing, or that X is desired by or desirable for A. Second, it is usually held that valid right-claims, at least in the case of basic rights, may be backed by sanctions, including coercion if necessary (unless doing so would produce extremely great disutility or grave moral evil), and that (except in such highly exceptional circumstances) failure of an appropriate authority to apply the needed sanctions is itself an injustice. Recent rights-theorists have also emphasized a third feature of rights, or at least of basic rights or rights in the strict sense: valid right-claims 'trump' appeals to what would maximize utility, whether it be the utility of the right-holder, or social utility. In other words, if A has a right to X, then the mere fact that infringing A's right would maximize overall utility or even A's utility is not itself a sufficient reason for infringing it. Finally, a universal (or general) right is one which applies to all persons, not just to certain individuals or classes because of their involvement in special actions, relationships, or agreements.

The second feature—enforceability—is of crucial importance for those who assume or argue that there is a universal right to a decent minimum of health care. For, once it is granted that there is such a right and that such a right may be enforced (absent any extremely weighty reason against enforcement), the claim that there is a universal right provides the moral basis for using the coercive power of the state to assure a decent minimum for all. Indeed, the surprising absence of attempts to justify a coercively backed decent minimum policy by arguments that do not aim at establishing a universal right suggests the following hypothesis: advocates of a coercively backed decent minimum have operated on the assumption that such a policy must be based on a universal right to a

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decent minimum. The chief aim of this article is to show that this assumption is false.

I think it is fair to say that many who confidently assume there is a (universal) right to a decent minimum of health care have failed to appreciate the significance of the first feature of our sketch of the concept of a right. It is crucial to observe that the claim that there is a right to a decent minimum is much stronger than the claim that everyone ought to have access to such a minimum, or that if they did it would be a good thing, or that any society which is capable, without great sacrifice, of providing a decent minimum but fails to do so is deeply morally defective. None of the latter assertions implies the existence of a right, if this is understood as a moral entitlement which ought to be established by the coercive power of the state if necessary. This simple point finds expression in traditional ethical theories and in our ordinary moral discourse, for a distinction is made between both 'ought'-judgments that express claims of right and those that express imperatives founded on moral virtues other than justice. In particular, a distinction is drawn between imperatives of justice and imperatives of charity or beneficence or generosity, the assumption usually being that only the former may be enforced.

Further, the difference between 'we ought to provide X to A' and 'A has a right to X' is not a difference between different degrees of strength or constancy in our moral convictions. To the morally virtuous person the imperatives of charity may be as urgent as those of justice. This point has troubling implications for attempts to establish right-claims by the use of what Rawls calls the method of reflective equilibrium. According to this method, we are to appeal to our particular considered moral judgments as provisional data to be accounted for and organized by a smaller set of more general moral principles. The difficulty is that we may be much surer that someone ought not to lack a certain form of health care than we are about whether the ground of this judgment is a principle that structures our sense of justice or our sense of charity or beneficence or generosity. And even if we can show what makes health care, or certain kinds of health care, morally important, this in itself will not show that there is a right to health care, unless the appropriate connection with principles of justice can be made.

The Attractions of the Idea of a Decent Minimum

There are at least three features widely associated with the idea of a right to a decent minimum which, together with the facile consensus that
vagueness promotes, help explain its popularity over competing conceptions of the right to health care. First, it is usually, and quite reasonably, assumed that the idea of a decent minimum is to be understood in a society-relative sense. Surely it is plausible to assume that, as with other rights to goods or services, the content of the right must depend upon the resources available in a given society and perhaps also upon a certain consensus of expectations among its members. So the first advantage of the idea of a decent minimum, as it is usually understood, is that it allows us to adjust the level of services to be provided as a matter of right to relevant social conditions and also allows for the possibility that as a society becomes more affluent the floor provided by the decent minimum should be raised.

Second, the idea of a decent minimum avoids the excesses of what has been called the strong equal access principle, while still acknowledging a substantive universal right. According to the strong equal access principle, everyone has an equal right to the best health-care services available. Aside from the weakness of the justifications offered in support of it, the most implausible feature of the strong equal access principle is that it forces us to choose between two unpalatable alternatives. We can either set the publicly guaranteed level of health care lower than the level that is technically possible or we can set it as high as is technically possible. In the former case, we shall be committed to the uncomfortable conclusion that no matter how many resources have been expended to guarantee equal access to that level, individuals are forbidden to spend any of their resources for services not available to all. Granted that individuals are allowed to spend their after-tax incomes on more frivolous items, why shouldn't they be allowed to spend it on health? If the answer is that they should be so allowed, as long as this does not interfere with the provision of an adequate package of health-care services for everyone, then we have retreated from the strong equal access principle to something very like the principle of a decent minimum. If, on the other hand, we set the level of services guaranteed for all so high as to eliminate the problem of persons seeking extra care beyond this level, this would produce a huge drain on total resources, foreclosing opportunities for producing important goods other than health care.

So both the recognition that health care must compete with other goods and the conviction that beyond some less than maximal level of publicly guaranteed services individuals should be free to purchase additional services point toward a more limited right than the strong access principle
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asserts. Thus, the endorsement of a right to a decent minimum may be more of a recognition of the implausibility of the stronger right to equal access than a sign of any definite position on the content of the right to health care.\(^2\)

A third attraction of the idea of a decent minimum is that since the right to health care must be limited in scope (to avoid the consequences of a strong equal access right), it should be limited to the 'most basic' services, those normally 'adequate' for health, or for a 'decent' or 'tolerable' life. However, although this aspect of the idea of a decent minimum is useful because it calls attention to the fact that health-care needs are heterogeneous and must be assigned some order of priority, it does not itself provide any basis for determining which are most important.

The Need for a Supporting Theory

In spite of these attractions, the concept of a right to a decent minimum of health care is inadequate as a moral basis for a coercively backed decent minimum policy in the absence of a coherent and defensible theory of justice. Indeed, when taken together they do not even imply that there is a right to a decent minimum. Rather, they only support the weaker conditional claim that if there is a right to health care, then it is one that is more limited than a right of strong equal access, and is one whose content depends upon available resources and some scheme of priorities which shows certain health services to be more basic than others. It appears, then, that a theoretical grounding for the right to a decent minimum of health care is indispensable.

Arguments for a Universal Right to a Decent Minimum

Elsewhere I have explored what I believe to be the main approaches to justifying and specifying a (universal) right to a decent minimum of health care: utilitarian arguments (for a derivative right), Rawlsian ideal contract arguments, and an argument from equality of opportunity developed by Norman Daniels.\(^3\) Here I can only briefly summarize my reasons for concluding that none of these approaches is adequate.

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2. It is not my purpose in this article to articulate the main factors that should determine the content of the decent minimum. For an attempt to do so, see Securing Access to Health Care, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, D.C., U.S. Government Printing Office, 1983), esp. chap. 1.

**Utilitarian Arguments.** The chief difficulty with utilitarian arguments is that they are not capable of providing a secure foundation for a right to a decent minimum for everyone. Consider, for example, the class of Down’s syndrome newborns. These retarded individuals, who often suffer from various physical defects as well, require a large expenditure of social resources over a lifetime. And relative to these costs the contribution these individuals make to social utility is not large, at least as far as we must work with a conception of contribution that is in some way quantifiable. If this is so, then Utilitarianism will justify excluding these infants from even the most minimal health care provided to others as a matter of right.

It is important to see that individuals in this class are capable of various enjoyments and would greatly benefit from the services from which they are excluded. Thus Utilitarianism may require that, even for the most basic services, what is guaranteed for one individual may not be available to another, even though their needs are equal and both would benefit greatly from the service.

My purpose in developing this example is not to show conclusively that there are no circumstances or no likely circumstances in which Utilitarianism would support a (derivative) universal right to a decent minimum of health care. Instead I have only shown that, granted certain plausible factual assumptions which may in fact be satisfied in our society at this time, there is good reason to doubt that Utilitarianism provides a secure foundation for such a right.

**Rawls’s Ideal Contract Theory.** There are well-known objections to Rawls's ideal contract view as a general theory of rights. It has often been noted that the parties' choice of the difference principle depends upon the implausible assumption that they are extremely, indeed infinitely, averse to risk. Further, Nozick and others have challenged the intuitions about fairness on the basis of which Rawls constructs the original position and have also offered examples to show that the difference principle requires redistributions that are intuitively unfair to the better off. Instead of rehearsing these familiar issues, I will concentrate on a different question: Even if these general objections can be met, does Rawls’s theory provide the basis for a substantive right to a decent minimum of health care? If Rawls’s theory supports a right to health care, it must be derivative upon the basic rights laid down by the principle of greatest equal liberty,
the principle of equality of fair opportunity, or the difference principle. And if there is to be such a derivative right to health care, then health care must either be among the primary goods covered by the three principles or it must be importantly connected with some of those goods. Now at least some forms of health care (such as broad services for prevention and health maintenance, including mental health) seem to bear the earmarks of Rawlsian primary goods: they facilitate the effective pursuit of ends in general and may also enhance our ability to criticize and revise our conceptions of the good. Nonetheless, Rawls does not explicitly list health care among the social primary goods included under the three principles.

Let us suppose that health care is either itself a primary good covered by the difference principle or that health care may be purchased with income or some other form of wealth which is included under the difference principle. In the former case, depending upon various empirical conditions, it might turn out that the best way to satisfy the difference principle is to establish a state-enforced right to health care. But whether maximizing the prospects of the worst off will require such a right and what the content of the right will be depends upon what weight is to be assigned to health care relative to other primary goods included under the difference principle. Similarly, a weighting must also be assigned if we are to determine whether the share of wealth one receives under the difference principle would be sufficient both for health-care needs and for other ends. Until we have some solution to the weighting problem, Rawls’s theory can shed only limited light upon the question of priority-relations between health care and other goods and among various forms of health care.

It is important to see that the informational constraints imposed by Rawls’s “veil of ignorance” preclude a solution to the problem of weighting health care against other primary goods because the answer will depend upon facts about the particular conditions of the society in which the notions in question are to be applied. At best Rawls’s hypothetical contractors would choose a kind of placeholder for a principle establishing a right to a decent minimum of health care, on the assumption that the content of the right can only be filled out at later stages of agreement in the light of specific information about their particular society.

However, nothing in Rawls’s conception of rational decision suggests that once the relevant, concrete information is available, rational persons
will agree on a single assignment of weights to the primary goods. It follows that Rawls's theory does not itself supply content for the notion of a 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 processes specified by the list of equal basic liberties. Given this, Rawls’s theory advances us very little beyond the broad intuitive consensus that there is a universal right to a decent minimum of health care.

**Daniels’s Argument from Equality of Opportunity.** Partly in response to some of the difficulties noted in the previous section, Norman Daniels has developed an alternative Rawlsian approach to the right to health care. Instead of basing the right to health care on an intuitive but ill-defined notion of a decent minimum, Daniels founds a universal right to health care on a stronger, more inclusive version of Rawls’s principle of fair equality of opportunity.

Daniels approaches the right to health care by utilizing the idea of “the normal opportunity range” for a given society. This is “the array of life plans reasonable to pursue within given conditions obtaining in a society.” Daniels suggests that we can best understand the distinctive nature and importance of health care if we see that it promotes, restores, or provides surrogates for “normal species functioning,” and that normal species functioning is an important contributor to an individual’s attainment of the normal opportunity range for his society. The principle from which health-care rights are derived according to Daniels may be stated as follows:

D. Social resources are to be allocated so as to insure that everyone can attain the normal opportunity range for his or her society.

The success of Daniels’s approach depends both upon the plausibility of the overarching principle of equality of opportunity (D) and on the plausibility of the implications of this principle for health-care entitlements. Though he has not yet committed himself unequivocally on this issue, Daniels seems to believe that principle D implies that there is a right to health care that exceeds what is usually thought of as a right to a decent minimum. Daniels emphasizes that the connection between

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normal species functioning and opportunity and the idea that health care is to be understood as whatever promotes, restores, or replaces normal species functioning achieves two important goals of a theory of health care: it gives us a way of ranking various health-care services as to their relative importance for normal species functioning and provides a principled way of defining the class of health-care needs which does not limit them to medical needs as defined by the current health-care delivery system.

A natural objection to Daniels's view is that even if one reason why health care is important is that it contributes significantly to attainment of the normal opportunity range, this is surely not the only reason, or in many cases not the most basic one. After all, health care often relieves suffering, prevents unwanted death, or enhances one's capacity for enjoying what everyone is able to do, even when it does not extend one's range of opportunities. Though I think this criticism has considerable force, I believe there are other, more telling objections.

The first difficulty is the definition of "normal opportunity range." The phrase "the array of life-plans reasonable to pursue" is ambiguous. For whom must a life-plan be reasonable to pursue if it is to be included in the normal opportunity range? If to be included a plan must be reasonable for everyone to pursue, regardless of his or her physical abilities, skills, and talents, then the list will be so modest that it is doubtful that it could provide content for a substantive universal right to health care of the sort Daniels wants. If, on the other hand, inclusion in the normal opportunity range requires only that the plan be such that it is reasonable for someone or other to pursue it, then D becomes astonishingly strong, since it will include life-plans requiring exceptional talents and rare characteristics.

On this strong interpretation, Daniels's principle of equality of opportunity is vulnerable to the same objection that leads to the rejection of the strong equal access principle. Granted the gap between most individuals' actual opportunity ranges and the array of plans it is reasonable for some individuals to pursue, and granted the almost limitless possibility for technology and other services which can help narrow the gap, a conscientious commitment to D would create an enormous drain on resources. To say that everyone has a right to whatever arrangements are necessary to insure that it is reasonable for him to aspire to become a neurosurgeon, a first-class logician, an accomplished pianist, or the spouse of a movie star seems excessive to say the least.
It is important to see that this objection cannot be met by replying that the right to health care is only a right to the resources required to achieve normal species functioning for all. For even if it could be shown that this goal is much more modest than that of achieving the normal opportunity range (on the strong interpretation) for all, this would be beside the point. In Daniels’s view the basic consideration is the attainment of equality with respect to the normal opportunity range—normal species functioning is only important as one factor among others that contribute to it. So my objection is to the basic principle of justice Daniels proposes.

Finally, if neither the strong nor the weak interpretation is acceptable, Daniels might suggest that the normal opportunity range is that of life-plans which constitute a normal or tolerable or adequate or decent life in the society in question. This strategy, however, is one which Daniels should be reluctant to embrace, since he introduced the notion of a normal opportunity range in the first place to avoid the unilluminating move of ‘specifying’ the notion of a decent minimum by reference to equally uninformative notions such as that of an adequate or tolerable life.

A second difficulty is that if we eschew the strong interpretation, the attempt to derive a right to health care from the right to enjoy the normal opportunity range for one’s own society may involve a sort of circularity which has unfortunately conservative implications for health-care policy. The array of life-plans which all (or most or many) people in a given society can reasonably pursue or that constitute a tolerable or normal or adequate life in that society will be determined in part by the availability and quality of health care in that society. In other words, the normal opportunity range is itself in part a social artifact. Thus in a society with very poor health-care services the normal opportunity range is correspondingly narrow, even if the society were in fact affluent enough to afford a wider range of services which would allow a wider normal opportunity range. Consequently, a principle which requires only that resources be allocated so as to assure that everyone attains the normal opportunity range would be inadequate in situations in which the normal opportunity range was unacceptably narrow due to a failure to allocate sufficient resources for health care. This suggests that Daniels’s principle requiring equal opportunity must be supplemented with a principle requiring maximization of the opportunity range, or at least that the opportunity range is to be maximized up to some limit. After all, the im-
portance of health care on Daniels's account is that it facilitates opportunity, and anyone who is concerned with opportunity rather than with equality for its own sake will desire arrangements which require more than mere equality of opportunity if opportunities are few but can be expanded.

Now a principle requiring equality of opportunity relative to a given opportunity range and a principle requiring maximization of the opportunity range (or maximization up to some limit) may conflict with one another. But if this is so, then some way of balancing the demands of these two principles must be found. In a society in which there were no legal barriers to opportunity and none based on racial or sexual discrimination, it is not obvious that either justice or rational self-interest would require, as Daniels seems to assume, the choice of a system that guarantees equality with respect to the opportunity range rather than a system that allows some inequalities but a wider opportunity range. If the latter alternative is appropriate, then we are again pushed in the direction of the vague but intuitively plausible notion of a decent minimum: this time the notion of a decent minimum opportunity range to which the requirement of equality applies.

A third and somewhat surprising feature of Daniels's position, and one which many will view as objectionable, is that it appears that principle D does not guarantee a universal right to a decent minimum of health care. For D is silent on how we are to make difficult and basic allocation decisions: it does not tell us whether we are to devote all resources to narrowing the distance between the opportunity ranges of the worst off and the normal opportunity range or to divide resources among all who fall short of the normal opportunity range. Indeed nothing in D even acknowledges that there is a problem of scarcity.

Whether or not D will require some minimal set of health-care services for all will depend upon which additional principles we adopt to cope with priority problems in the face of scarcity. If our first priority is to narrow the gap between the worst off and the normal opportunity range, then, depending on how badly off the worst off are and depending upon the total amount of resources available, there may be nothing left for even minimal services for those who do not fall within the worst off class. As in the case of Utilitarianism, whether there is a universal right to a decent minimum will depend upon the facts about the society in question. But in Daniels's scheme it will also depend upon what additional prin-
ciples of distributive justice are used to supplement the principle of equality of opportunity when the commitment to such a strong principle collides with the realities of scarcity.

If, on the other hand, the commitment to raising the opportunity range of the worst off is to be limited by a principle stating that everyone has a right to some set of services even if there are others who are farther from the normal opportunity range, then, unless this universal right-claim can be nonarbitrarily specified and supported, it appears that we have again ushered in the idea of a decent minimum. And contrary to what Daniels says, his principle of equality of opportunity is a supplement, rather than a replacement for it.

A Change of Strategy

So far I have considered several proposed principles or theories of justice and seen, rather surprisingly, that they do not provide a firm basis for the claim that there is a universal right to a decent minimum of health care or else that they encounter serious difficulties in supplying a practical specification of the content of that right. These deflationary results would be welcomed by a libertarian, who would explain them by the hypothesis that there is no right to a decent minimum. Further, a sophisticated libertarian would explain the pervasiveness of the (false) belief that there is a right to a decent minimum by the hypothesis that those who hold this belief have mistaken the moral imperatives of beneficence or charity for those of justice.

I shall argue, however, that even if the libertarian were right thus far there is still a sound justification for an enforced principle guaranteeing a decent minimum of health care to everyone. The alternative strategy I wish to explore is pluralistic. My suggestion is that the combined weight of arguments from special (as opposed to universal) rights to health care, harm-prevention, prudential arguments of the sort used to justify public health measures, and two arguments that show that effective charity shares features of public goods (in the technical sense) is sufficient to do the work of an alleged universal right to a decent minimum of health care.

Arguments from Special Rights. The right-claim we have been examining (and find unsupported) has been a universal right-claim: one
that attributes the same right to all persons. Special right-claims, in contrast, restrict the right in question to certain individuals or groups.

There are at least three types of arguments that can be given for special rights to health care. First, there are arguments from the requirements of rectifying past or present institutional injustices. It can be argued, for example, that American blacks and native Americans are entitled to a certain core set of health-care services owing to their history of unjust treatment by government or other social institutions, on the grounds that these injustices have directly or indirectly had detrimental effects on the health of the groups in question. Second, there are arguments from the requirements of compensation to those who have suffered unjust harm or who have been unjustly exposed to health risks by the assignable actions of private individuals or corporations—for instance, those who have suffered neurological damage from the effects of chemical pollutants.

Third, a strong moral case can be made for special rights to health care for those who have undergone exceptional sacrifices for the good of society as a whole—in particular those whose health has been adversely affected through military service. The most obvious candidates for such compensatory special rights are soldiers wounded in combat.

Arguments from the Prevention of Harm. The content of the right to a decent minimum is typically understood as being more extensive than those traditional public health services that are usually justified on the grounds that they are required to protect the citizenry from certain harms arising from the interactions of persons living together in large numbers. Yet such services have been a major factor—if not the major factor—in reducing morbidity and mortality rates. Examples include sanitation and immunization. The moral justification of such measures, which constitute an important element in a decent minimum of health care, rests upon the widely accepted Harm (Prevention) Principle, not upon a right to health care.

The Harm Prevention argument for traditional public health services, however, may be elaborated in a way that brings them closer to arguments for a universal right to health care. With some plausibility one might contend that once the case has been made for expending public resources on public health measures, there is a moral (and perhaps Constitutional)
obligation to achieve some standard of *equal protection* from the harms these measures are designed to prevent. Such an argument, if it could be made out, would imply that the availability of basic public health services should not vary greatly across different racial, ethnic, or geographic groups within the country.

**Prudential Arguments.** Prudent arguments for health-care services typically emphasize benefits rather than the prevention of harm. It has often been argued, in particular, that the availability of certain basic forms of health care make for a more productive labor force or improve the fitness of the citizenry for national defense. This type of argument, too, does not assume that individuals have moral rights (whether special or universal) to the services in question.

It seems very likely that the combined scope of the various special health-care rights discussed above, when taken together with harm prevention and prudential arguments for basic health services and an argument from equal protection through public health measures, would do a great deal toward satisfying the health-care needs which those who advocate a universal right to a decent minimum are most concerned about. In other words, once the strength of a more pluralistic approach is appreciated, we may come to question the popular dogma that policy initiatives designed to achieve a decent minimum of health care for all must be grounded in a universal moral right to a decent minimum. This suggestion is worth considering because it again brings home the importance of the methodological difficulty encountered earlier. Even if, for instance, there is wide consensus on the considered judgment that the lower health prospects of inner city blacks are not only morally unacceptable but an injustice, it does not follow that this injustice consists of the infringement of a universal right to a decent minimum of health care. Instead, the injustice might lie in the failure to rectify past injustices or in the failure to achieve public health arrangements that meet a reasonable standard of equal protection for all.

**Two Arguments for Enforced Beneficence.** The pluralistic moral case for a legal entitlement to a decent minimum of health care (in the absence of a universal moral right) may be strengthened further by non-rights-based arguments from the principle of beneficence.\(^5\) The possibility of

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\(^5\) For an exploration of various arguments for a duty of beneficence and an examination of the relationship between justice and beneficence, in general and in health care, see
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making out such arguments depends upon the assumption that some principles may be justifiably enforced even if they are not principles specifying valid right-claims. There is at least one widely recognized class of such principles requiring contribution to the production of ‘public goods’ in the technical sense (for example, tax laws requiring contribution to national defense). It is characteristic of public goods that each individual has an incentive to withhold his contribution to the collective goal even though the net result is that the goal will not be achieved. Enforcement of a principle requiring all individuals to contribute to the goal is necessary to overcome the individual’s incentive to withhold contribution by imposing penalties for his own failure to contribute and by assuring him that others will contribute. There is a special subclass of principles whose enforcement is justified not only by the need to overcome the individual’s incentive to withhold compliance with the principle but also to ensure that individuals’ efforts are appropriately coordinated. For example, enforcing the rule of the road to drive only on the right not only ensures a joint effort toward the goal of safe driving but also coordinates individuals’ efforts so as to make the attainment of that goal possible. Indeed, in the case of the ‘rule of the road’ a certain kind of coordinated joint effort is the public good whose attainment justifies enforcement. But regardless of whether the production of a public good requires the solution of a coordination problem or not, there may be no right that is the correlative of the coercively backed obligation specified by the principle. There are two arguments for enforced beneficence, and they each depend upon both the idea of coordination and on certain aspects of the concept of a public good.

Both arguments begin with an assumption reasonable libertarians accept: there is a basic moral obligation of charity or beneficence to those in need. In a society that has the resources and technical knowledge to improve health or at least to ameliorate important health defects, the application of this requirement of beneficence includes the provision of resources for at least certain forms of health care. If we are sincere, we will be concerned with the efficacy of our charitable or beneficent impulses. It is all well and good for the libertarian to say that voluntary giving can replace the existing array of government entitlement pro-

grams, but this possibility will be cold comfort to the needy if, for any of several reasons, voluntary giving falters.

Social critics on the left often argue that in a highly competitive acquisitive society such as ours it is naive to think that the sense of beneficence will win out over the urgent promptings of self-interest. One need not argue, however, that voluntary giving fails from weakness of the will. Instead one can argue that even if each individual recognizes a moral duty to contribute to the aid of others and is motivationally capable of acting on that duty, some important forms of beneficence will not be forthcoming because each individual will rationally conclude that he should not contribute.

Many important forms of health care, especially those involving large-scale capital investment for technology, cannot be provided except through the contributions of large numbers of persons. This is also true of the most important forms of medical research. But if so, then the beneficent individual will not be able to act effectively, in isolation. What is needed is a coordinated joint effort.

First argument. There are many ways in which I might help others in need. Granted the importance of health, providing a decent minimum of health care for all, through large-scale collective efforts, will be a more important form of beneficence than the various charitable acts A, B, and C, which I might perform independently, that is, whose success does not depend upon the contributions of others. Nonetheless, if I am rationally beneficent I will reason as follows: either enough others will contribute to the decent minimum project to achieve this goal, even if I do not contribute to it; or not enough others will contribute to achieve a decent minimum, even if I do contribute. In either case, my contribution will be wasted. In other words, granted the scale of the investment required and the virtually negligible size of my own contribution, I can disregard the minute possibility that my contribution might make the difference between success and failure. But if so, then the rationally beneficent thing for me to do is not to waste my contribution on the project of ensuring a decent minimum but instead to undertake an independent act of beneficence; A, B, or C—where I know my efforts will be needed and efficacious. But if everyone, or even many people, reason in this way, then what we each recognize as the most effective form of beneficence will not come about. Enforcement of a principle requiring contributions to ensuring a decent minimum is needed.
The first argument is of the same form as standard public goods arguments for enforced contributions to national defense, energy conservation, and many other goods, with this exception. In standard public goods arguments, it is usually assumed that the individual's incentive for not contributing is self-interest and that it is in his interest not to contribute because he will be able to partake of the good, if it is produced, even if he does not contribute. In the case at hand, however, the individual's incentive for not contributing to the joint effort is not self-interest, but rather his desire to maximize the good he can do for others with a given amount of his resources. Thus if he contributes but the goal of achieving a decent minimum for all would have been achieved without his contribution, then he has still failed to use his resources in a maximally beneficent way relative to the options of either contributing or not to the joint project, even though the goal of achieving a decent minimum is attained. The rationally beneficent thing to do, then, is not to contribute, even though the result of everyone's acting in a rationally beneficent way will be a relatively ineffective patchwork of small-scale individual acts of beneficence rather than a large-scale, coordinated effort.

Second argument. I believe that ensuring a decent minimum of health care for all is more important than projects A, B, or C, and I am willing to contribute to the decent minimum project, but only if I have assurance that enough others will contribute to achieve the threshold of investment necessary for success. Unless I have this assurance, I will conclude that it is less than rational—and perhaps even morally irresponsible—to contribute my resources to the decent minimum project. For my contribution will be wasted if not enough others contribute. If I lack assurance of sufficient contributions by others, the rationally beneficent thing for me to do is to expend my 'beneficence budget' on some less-than-optimal project A, B, or C, whose success does not depend on the contribution of others. But without enforcement, I cannot be assured that enough others will contribute, and if others reason as I do, then what we all believe to be the most effective form of beneficence will not be forthcoming. Others may fail to contribute either because the promptings of self-interest overpower their sense of beneficence, or because they reason as I did in the First Argument, or for some other reason.

Both arguments conclude that an enforced decent minimum principle is needed to achieve coordinated joint effort. However, there is this difference. The Second Argument focuses on the assurance problem, while
the first does not. In the Second Argument all that is needed is the assumption that rational beneficence requires assurance that enough others will contribute. In the First Argument the individual's reason for not contributing is not that he lacks assurance that enough others will contribute, but rather that it is better for him not to contribute regardless of whether others do or not.

Neither argument depends on an assumption of conflict between the individual's moral motivation of beneficence and his inclination of self-interest. Instead the difficulty is that in the absence of enforcement, individuals who strive to make their beneficence most effective will thereby fail to benefit the needy as much as they might.

A standard response to those paradoxes of rationality known as public goods problems is to introduce a coercive mechanism which attaches penalties to noncontribution and thereby provides each individual with the assurance that enough others will reciprocate so that his contribution will not be wasted and an effective incentive for him to contribute even if he has reason to believe that enough others will contribute to achieve the goal without his contribution. My suggestion is that the same type of argument that is widely accepted as a justification for enforced principles requiring contributions toward familiar public goods provides support for a coercively backed principle specifying a certain list of health programs for the needy and requiring those who possess the needed resources to contribute to the establishment of such programs, even if the needy have no right to the services those programs provide. Such an arrangement would serve a dual function: it would coordinate charitable efforts by focusing them on one set of services among the indefinitely large constellation of possible expressions of beneficence, and it would ensure that the decision to allocate resources to these services will become effective.

Objections and Replies

It might be objected that these two arguments rest upon either of two unacceptable premises: (1) that if something is a moral principle (or at least a basic moral principle) then it may be given the status of a law and enforced by the state, or (2) that it is the role of the state to insure that its citizens are morally virtuous. If the enforced beneficence arguments rested on either of these very general premises they would be implausible, because both (1) and (2) have unacceptable implications for
individual liberty. But the enforced beneficence arguments do not assume that any moral principle, or any basic moral principle, may be enforced; nor do they assume that the state is in general the guardian of our morals. Instead, they only contend that one important moral principle may be enforced if, in the absence of enforcement, familiar problems of coordinated joint action would arise. Further, it seems most plausible to regard the conclusion of the enforced beneficence arguments as defeasible: if political conditions were such that the establishment of the required enforcement mechanism would contribute to a dangerous concentration of government power, then the lesser of evils might be to forgo a solution to the coordination and assurance problems.

However, it is unpersuasive to argue that—at least in the United States at this time—a compulsory contribution scheme constitutes an unacceptable threat to liberty by endowing the government with uncontrollable powers. Moreover, some of the most significant dangers which make a general policy of the 'enforcement of morals' unacceptable simply do not apply with any force to the case at hand. In particular, opponents of the enforcement of morals usually rightly point out that such policy would destroy the conditions required for individual autonomy, privacy, and for the flourishing of intimate personal relationships. This is certainly true for the enforcement of many moral principles, especially principles of sexual or religious morality, but it is not at all convincing in the case of arrangements to enforce the moral duty of charity or beneficence. Nor is it obvious that enforced beneficence should be rejected because it will inevitably lead to the enforcement of those moral principles which are more closely connected with autonomy, privacy, and intimate personal relationships.

A more interesting objection is that the enforced beneficence arguments rests on a misunderstanding of the nature of the duty of beneficence: beneficence is traditionally understood as an imperfect duty not just in the sense that the amount of aid one renders is a matter of choice but also in the sense that the choice of recipients is also discretionary. In other words, beneficence only requires that one render aid to some who are needy, not to all. But if so, then the enforced beneficence argument is vulnerable to the same objection I leveled earlier at Utilitarianism: it does not provide a firm moral foundation for a guaranteed minimum for all.

At this point, it is important to approach the traditional concept of
beneficence more critically than is usually done. Three points must be emphasized. First, some support must be given for the view that beneficence is discretionary with respect to the choice of recipients of aid. It is not enough to offer this assumption as an analytic truth which follows from the concept of the duty of beneficence. Even if the boundaries of the traditional concept could be so clearly delineated, the question of whether it is permissible to choose to aid A and not to aid B (when A’s and B’s needs are identical) is a moral question. And depending on the answer we arrive at, we may find it appropriate to revise the traditional concept. Second, the more plausible accounts of why the benefactor may be selective seem to be pragmatic rather than conceptual or moral. Third, these pragmatic considerations seem to have less weight when beneficence is viewed—as it is in the enforced beneficence arguments—as a collective, rather than an individual, enterprise.

Even if we could say with confidence that the traditional concept of beneficence includes the idea that the benefactor may be selective, we should ask why this is so. If one examines the grounds for the duty of beneficence, either in common-sense morality or in ethical theory, it seems that these are so general that the conclusion they support is that there is a duty to aid the needy—anyone in need, not just some, if one is able to do so.

For example, in the Second Part of The Foundations of the Metaphysics of Morals, Kant offers an argument for the conclusion that one ought to help those in need, at least if one can do so without excessive costs to oneself. Kant’s claim is that one cannot consistently will the universalization of a maxim of not aiding others in need because to do so would be to deprive oneself of aid from others: a world in which everyone acted on this maxim of nonbeneficence would be one in which one could not count on being helped by others. Now it appears that the same argument would rule out a maxim of helping another in need only if one chooses to: in a world of discretionary benefactors one could not count on aid. Thus one would expect Kant to reject a formulation of the duty of beneficence that allows the benefactor to choose which of the needy he will help (independently of any consideration of the degree or importance of their need). However, Kant does not draw this conclusion. Though he provides an argument that supports the conclusion that we ought to help whoever is in need, Kant does not challenge the traditional view that the
duty of beneficence allows the benefactor to exercise discretion in deciding whom to aid.

Similarly, at the level of common-sense morality, the considerations that underlie the duty of beneficence seem very general. One ought to help those in need because they are our fellow human beings in need—not because of any further special characteristics they happen to possess or because of any special preferences we have. Yet here, too, as in Kant's theory, it is usually said that there is much latitude in discharging the duty of beneficence. One may choose to help some and not help others.

How can the very general character of the ground of the duty of beneficence be reconciled with the assumption that the benefactor may exercise discretion? The explanation, I suggest, lies not in moral theory or in an analysis of the concept of beneficence, but in an appreciation of two facts about the circumstances in which individual—opposed to collective—beneficence often occurs. The first is that an individual's resources are so limited that either he will not be able to render significant aid to anyone unless he is selective or he will be able to do so only at excessive cost. The second is that in many cases the individual has more control over his beneficent efforts, and hence more assurance of their success, if he renders aid directly to those close at hand. (One may refrain from contributing to the aid of those far away simply because one is aware that there are numerous opportunities for diverting and diluting one's contribution before it reaches the intended recipient.) It may also be that some of those who accept uncritically the traditional view that beneficence is wholly discretionary as to the choice of beneficiaries do so because of a rather simplistic and overly optimistic assumption: namely, that if each of us freely chooses some beneficiary or other, everyone, or virtually everyone in need, will receive some aid. This assumption ignores the problem of coordinating individual acts of beneficence emphasized in the two arguments above.

Each of these reasons can, in particular circumstances, justify a policy of selective beneficence. However, in conditions in which a collective effort can provide a minimum of care for all who can need it, without excessive costs to the benefactors, the same very general considerations that ground the duty of beneficence support a nonselective policy.

It is true that two perplexing questions remain unanswered. What counts as excessive costs? And should a guaranteed decent minimum
policy aim only at the needy who dwell within the borders of a particular nation-state? Neither of these problems, however, is peculiar to the enforced beneficence arguments; they afflict rights-based approaches as well. Further, while the various moral justifications offered to support the alleged right to a decent minimum are also general in that they apply to human beings as such, the reasons for restricting the enforcement of rights to the national level, when they are good reasons, are as pragmatic as those that explain the assumption that benefactors may be selective. Even if these pragmatic considerations support a restriction of the class of those who are to be aided (or those whose rights are to be protected by our government), they do not justify the much stronger claim that beneficence (or the protection of rights) is essentially discretionary. I conclude, then, that the idea that beneficence allows discretion in the selection of recipients does not itself constitute a telling objection to the enforced beneficence argument for a decent minimum of health care. Instead, it seems more accurate to conclude that the enforced beneficence arguments force us to get clearer about what is central to the concept of beneficence and what is a practical concession to the difficulties of being beneficent in an imperfect world.

A libertarian might raise the potentially more serious objection that the enforced beneficence argument fails to recognize a fundamental qualification. While acknowledging that there may be some rules of social coordination or some principles specifying moral obligations or obligations to contribute to public goods that may be enforced, even in the absence of corresponding rights, the libertarian will point out that enforcing them is permissible only if doing so does not violate important moral rights. I agree wholeheartedly with this qualification. However, if the qualification is to become a sound criticism of the enforced beneficence arguments, the libertarian must discharge two difficult tasks, the second of which no one has yet successfully executed. First, he must clearly specify which basic moral rights would be violated by any attempt to enforce the principle of beneficence as it is applied to health care. Second, he must provide a coherent and plausible justification for the claim that these basic moral rights do exist. To rule out in principle an enforceable duty of beneficence the libertarian would have to specify and justify either a virtually unlimited general right against interference or coercion or a virtually unlimited right to private property. The great obstacle to doing either is that he must avoid begging the question by appealing to intui-
tions that his nonlibertarian opponent does not share. In the absence of
a sound theoretical justification for such rights, the burden of proof is
on the libertarian to substantiate the claim that the enforcement in ques-
tion violates important moral rights.

We have now come full circle. At the outset, I noted that the burden
of proof is on those who claim that there is universal right to a decent
minimum of health care. I then argued that various attempts to provide
theoretical support for the claim that there is such a right are inadequate.
If we abandon the quest for a justification for the claim that there is a
universal right, however, we should not conclude that the libertarian
view triumphs by default. The non-rights-based enforced beneficence
arguments shift a similar burden of proof onto the libertarian.

If the approach I have outlined succeeds, it provides a way of avoiding
both the burden of justifying the claim that there is a universal right to
health care and the equally onerous burden of justifying a virtually un-
limited right to private property or against coercion. Surprising as it may
seem, an answer to the question of whether society ought to guarantee
certain health-care services for all does not depend upon our ability to
adjudicate decisively between libertarian and welfarist theories of basic
rights.

I would like to conclude by observing that the non-rights-based, en-
forced beneficence approach has interesting implications for the issue of
how we are to specify the content of the decent minimum. We have seen
that while the type of rights-based argument determines the sorts of
considerations which are to guide the specification of content, little can
be said about the specification prior to the outcome of political processes
or extensive empirical research. This conclusion will be disturbing if one
assumes that the guaranteed minimum is a matter of right, since we
often tend to think of rights as rather sharply defined. However, the
traditional notion of duties of charity or beneficence is that they are
'imperfect duties': by their very nature they are not precisely delineated.

Now those who favor the non-rights-based approach can argue that
the difficulty encountered by rights-based approaches in specifying the
content of an alleged right to a decent minimum provides indirect support
for the position that there is no right to a decent minimum but only an
enforceable duty of beneficence or charity to contribute to the attainment
of a decent minimum. In other words, the advocate of the enforced be-
neficence approach can warmly welcome the lack of a principled speci-
fication as a vindication of his view rather than accept it begrudgingly as an embarrassing theoretical lacuna. The idea would be that we must frankly acknowledge that the character and scope of the list of services included in the decent minimum is a matter of collective choice. All that is necessary is that there be some fair procedure for reaching a social decision on which set of services to provide.

I would like to thank Mary Anne Bailey, Jules Coleman, Thomas Hill, Jr., Daniel Wikler, and the Editors of Philosophy & Public Affairs for their perceptive comments on an earlier draft of this essay. I am especially indebted to Deborah Buchanan for her careful and detailed criticisms.