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Health Care As A Human Right

by Roger A. Ritvo*
Edward A. McKinney**
Pranab Chatterjee***

Espousing the position that health care in the United States is a human right, the trio of authors in the following article develop their thesis through an analysis of several disciplines. History, philosophy, and sociology serve as the primary focal points for the discussion, and attention is also drawn to existing technology which is the resource to be supplied on an equal basis to the general public. Just as political and civil liberties have become guaranteed rights subject to judicial enforcement, so too, it is argued, the time has come to vest all American citizens with the right to timely and adequate health care.

INTRODUCTION

THIS PAPER OUTLINES the contexts in which health care can be viewed as a human right by members of any society as well as the structural prerequisites of such an evolution. Toward that end, discussion will include the concept of human rights, the different categories of rights, and the various social structures which foster the development of these rights. Drawing from several philosophical perspectives, the argument illustrates that health care is a human right. Through an analysis of the current health system and its programs in the United States, the conclusion is reached that health care is a right, but that there are a number of problems regarding its full implementation at the present time.

The major theme of the paper is that the necessary technology exists to make health care a human right but that the required social management of this technology is not fully present. There are issues concerning the role of the hospital, and the costs, accessibility, and

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impartiality of the current medical care delivery system. As is clearly documented, the social management process requires strong leadership from the Federal Government, both in tangible and symbolic ways. This must be augmented by programs that can deliver the services to those most in need. The policy pronouncements have all been made; absent is the effective implementation of those health services throughout the population. These are concerns that cross geographic and political boundaries. They are global in the truest meaning of the word.

I. THE DILEMMA

Health care as a human right is a contemporary view that has its roots in several different spheres of activity. As a social policy, it has been mandated, legalized and implemented. As an outgrowth of scientific knowledge, it has the potential for widespread application. As a logical development of expanding technology, health care as a human right could be achieved. As a part of a social class struggle, the “have-nots” are demanding their equitable share of the health services, resources and facilities available to others. These trends raise a number of important issues that cannot be avoided in the late 20th century. Is health care a human right? If so, how can it be achieved? What are the consequences of establishing social, national and international policies to implement this focus?

As an introduction to the pitfalls, dilemmas and contradictions of the problem, the following quote is most applicable:

"The National Institute of Health has contracted with the Rand Corporation to conduct a major study of the social impact of biomedical research. Recently a panel of experts concluded that the development of a nuclear-powered artificial heart would be dangerous and that funding should not be continued. The cost of adding nine years to the life of kidney patients through dialysis is estimated at $71,000. On the other hand, using the same amount of money to facilitate the early detection of cervical cancer could save as many as 9,000 lives a year. Who should live and who should die?"

In this short paragraph, several key points emerge. First, technological improvements, i.e., nuclear-powered artificial hearts, will consistently challenge us in the future. While for some this equipment is a vital necessity, there are nevertheless dangerous consequences. Sometimes

these dangers can be anticipated and in other instances they may not be so clear. Second, the need to complement rigorous research with resource funding is an interrelated objective. Without the appropriate monies and other supports, these achievements would not be forthcoming. Third, the need to choose between competing population groups each in need of additional support is unavoidable. Given the realities of limited funds, choices will and must be made. Such decisions will be formulated only after consideration of numerous tangential concerns. These concerns include who decides what the proper body should be for ultimate decision-making and, once it is established, by what criteria should it operate? Resolution of these questions necessarily causes other formats to be abandoned. Therefore, if preference is given to development of the nuclear-powered heart, then a policy choice has been made to forego advancement toward early detection of cervical cancer. Ultimately, if a utilitarian approach is adopted, then the nuclear-powered heart project development may be terminated and patients requiring such a device face almost certain death. This example highlights some of the important issues related to implementing any policy which is based on health as a human right.

II. THE CONCEPT OF HEALTH AS A HUMAN RIGHT

The use of dictionary definitions to understand the practical implications of a single word frequently is a mistake. As a starting point, a simple definition of a right is something that one properly may claim as due. This seems clear enough. But the right to health care is not as clear as the definitions and terminology may indicate. Oftentimes health and medical care are defined only when illness occurs. Nonetheless, the right to health care may include preventive measures as well as diagnostic and curative treatment. Furthermore, establishing an individual claim for health rights as well as ensuring proper enforcement poses significant problems. A determination must be made as to whether the state or the private market mechanisms will be responsible for guaranteeing a health care right. In all of these inquiries, there is no mention of the effectiveness, the equality, the efficiencies, and the accessibility of that health and medical care. Unfortunately, there is a void in the Constitution, the laws, and other instruments of social policy frameworks concerning the health of the citizenry. There is a clear right to life, liberty, pursuit of happiness,

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speech and other rights. Health, however, has been omitted. It should be encompassed under the life, liberty, and pursuit of happiness language, as well as other phrases found in the Constitution.

Allocation of resources in order to provide for a guaranteed health care right necessarily involves a level of choice between health and other goals. As one commentator has stated,

The most basic level of choice is between health and other goals. While social reformers tell us that "health is a right," the realization of that "right" is always less than complete because some of the resources that could be used for health care are allocated to other purposes. This is true in all countries.

Complications arise when one considers the difference between the optimum and the maximum levels of health and medical services. If we aspire to have the maximum, then a society will devote all the needed resources to that end. On the other hand, once the issue of the optimum arises, it implies that there are limits. Social selections and political decisions must be made. Unless the incremental benefits of an expenditure exceed the marginal costs, then that program or service is a likely candidate for termination. Even the most needed program that is underutilized or too costly is subject to these same criteria.

Today there is a plethora of rights: gay rights, human rights, child rights, equal rights, rights of handicapped, rights of the poor, nudist rights, rights—of the unborn and so on. "Like obscenity, political language loses energy through repetition. This is the case with our current inundation in the language of rights. There are just too many claims to rights these days and this torrent of rights in the end endangers important rights themselves." The thrust of the commentary is that by abusing the concept of rights, we in effect diminish the legitimate claims of those groups that seek to address grievances against their rights. Like freedom of speech, there are both incumbent responsibilities and limitations on usage. To address past injustices against the right of any group, like those denied medical care, two important elements require review. The first is the assurance that there is indeed a right. If the right does not exist, then the case should terminate. The second issue is even more important. It focuses on the practical issues of implementing change. Can there be a change? What are the costs and benefits? Are there alternatives? Often it is necessary

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to seek remedies in courts of law. While this is a most appropriate mechanism, the courts are often without power to remove the problem other than by compelling others to do so. "The language of rights is an invocation of the legal order."

The distinction emerges between the legal obligations of rights and society's ideals for these rights. Clearly, a series of rights are defined in the Constitution and the Bill of Rights. These are the highest level of rights. If one takes a narrow view, these are the only true rights of our society. The alternative view can be equally supported: that these rights provide the operational framework for many others. Such an approach appeals "to the convictions of good sense, decency, magnanimity, tolerance and large-mindedness in the people at large." This is a very different approach than the stricter legal path to understanding human rights.

If one adopts the perspective that health care is a right for all the members of a society, there are additional consequences of this view. On the somewhat conservative side, Fried points out that if health is a human right, it must be coupled with equality. That does not imply that health care be the very best, only that it be equal for all citizens. Using the analogy of free speech, there is no greater freedom for one person than another. But, as common knowledge tells us, medical care is not equal today. In a semipersonal narrative, Abraham Ribicoff wrote that American medical care is a machine. The specific cases he noted are poignant and sad, a running commentary of the sometimes inhumane, often tragic, instances of poor, inappropriate or too costly care.

But, when dealing with the microlevel issues of health care, a mistake can be made. "It is monstrous if an individual physician thinks like a budget officer when he cares for his patient in need; but it is chaotic and incoherent if budget officers and voters making general policy think like physicians at the bedside." Fried's point is well taken. When the political leaders of a nation begin to adopt a myopic perspective, they may tend to lose the larger view. If there has been any single trend making health legislation of the United States

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8 Id.
9 Id.
9 Fried, supra note 7, at 49.
during the past thirty years, it could be the disease-specific remedies of Federal programs. There is no single coherent policy.

The impact of the range of programs and policies is to create a patchwork of money-program-service components in a huge, fragmented body. This is the rhetoric of the 1970's; unfortunately, it is both true and likely to continue for the immediate future.

There are competing views as to whether health care is a human right. When adopting the policy of human rights in health, two impacts are possible. Thomas Dye has delineated the symbolic and tangible aspects to policy development. The symbolic impacts of a policy focus on the values, perceptions and, perhaps, the aspirations of a country and its population. Establishing a policy never has eliminated a social problem. Passing a law never has corrected an injustice. But these events can be viewed in terms of their message and their thrust. Policy sets the framework for social planning and action. Therefore, the symbolic impacts are essential. They provide the guideposts for the tangible impacts. This second category of policy focuses on the actual programs and activities that accrue to a given population as a result of a policy, i.e., new money, services and organizations.

The acknowledgement of health care as a human right has both components. At the symbolic level, it is an awareness both of the facts that deficiencies exist and of the effort to ameliorate them. At the tangible level, that actions speak louder than words is an adage of importance. Rhetoric without remedy is static. Pomp without program is problematic.

The inherent assumption thus far has been that governmental policy is central. This may not be as widespread a view as it appears on the surface. "Life, liberty, and the pursuit of happiness" never mentions health care. What should the government's role be in a single nation? In the community of nations? What are the options?

John Stuart Mill's basic concepts of utilitarianism include the spreading of happiness to mankind under the axiom of the greatest good for the greatest number. Moving from philosophy to politics, there are trade-offs to be made. Agreements are not universal. In the same way that artificial, nuclear-powered hearts compete with cervical screening, health competes with defense. Medical care competes with...

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housing. Health research struggles against education. Societies rarely have rank-ordered priorities, a system where need number one is met before resources are utilized in need number two. The contemporary reality is that all needs receive a portion of the resources.

The essential basis for this political, competing-needs, resource argument is rooted in our forefathers' traditions. As Hume, Bentham, and others have noted, redistribution of resources and wealth in a society is controlled by the principle that benefits to the "have-nots" outweigh the minimal loss to the "haves." The Federal income tax system in the United States is an illustration of this principle in action. The sales tax is not. In the latter case, all people pay the same rate of tax. Social policy accounts for this through its mechanisms for collecting and then distributing its resources. In our political system's embryonic state, the compromise that established the House of Representatives and the Senate gave credence to both views. The all-citizens-are-equal approach points toward the Senate; the some-are-more-equal view leads to the House of Representatives.

The competition in health care has had several predictable consequences. When looking through the filters of social class, there is a serious problem. There is different treatment for the rich than the poor. Strauss contends that "the poor will never have anything approaching equal care until our present medical organization undergoes profound reform. Nothing in current legislation or planning will accomplish this."12 The thrust of his perspective is that health care is an unfulfilled human right, especially for the poor. If valid, his argument belies the notion that symbolic policy in the United States has been complemented adequately by a tangible one. For some, yes, but for others, no. This raises the issue of how to develop and implement health policies for an entire population, not just a portion of the whole.

Of interest at this point is the reality in the United States that there is neither a health system nor a health policy. There is a collection of health systems: Medical care programs, federal, state, regional, county, city, neighborhood, and organization health services. There are policies within but not across these different levels. Each may have different funding mechanisms, different emphasis and incompatible programs.

Each health and medical facility can be a combination of this triad of aims: education, treatment and research. Viewing health as a

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12 Strauss, Medical Ghettos, 4 TRANS-ACTION 7 (1969).
human right centers on the treatment aspect. For a person without adequate medical care, the research component is of little meaning. For those excluded, education of health professionals for the future is of less value than meeting the current needs for basic care and treatment.

Contemporary observers of the health services in the United States have reached similar conclusions. Milton Roemer summarized the problem most succinctly:

The basic fault in American health service is the discrepancy between our assertion of health care as a basic human right and our practice of treating it is a market-place commodity.13

After proposing a "perhaps utopian or unrealistic" system, complete with structural and financial components, Roemer notes that any change in "the health care system . . . could not be achieved short of a social revolution."14 As shall be documented later in this article, such a social revolution has been achieved in our lifetime in other countries. And, as Roemer stressed, these social movements most often occur within the existing political structures and processes of the countries.

III. CATEGORIES OF HUMAN RIGHTS

T. H. Marshall, in his famous essay on social development, outlined three types of human rights: political, civil and social.15 The right to vote, and thereby participate in a political decision-making process, is a political right. Originally, voting was a right of upper class whites. Grønbjerg has estimated that "in 1860 only about 17 percent of the United States was eligible to vote."16 By 1960 this figure increased to 60 percent,17 showing an upward change in the exercise of political rights.

Civil rights are those rights which are "necessary for individual freedom; liberty of the person, freedom of speech, thought, and religion, the right to own property and to enter into contracts, and the right to equal justice,"18 which overlap with political rights. In a recent

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14 Id.
17 Id.
essay, Chatterjee clarified and differentiated between civil and social rights in the following manner:

Civil rights may be theoretically defined as *right to certain behavior patterns*, whereas social rights are rights to various tangible goods and services.19

Marshall himself differentiated social rights from other kinds of rights by calling it "social citizenship" which is

the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage of a civilized being according to the standards prevailing in the society.20

It follows from the above discussion that rights to a minimum income, housing, or health care are social rights. In most if not all industrial countries they become institutionalized under the term social security programs. Joseph Schumpeter, in his famous thesis published nearly three decades ago, observed that the development of such social security measures is not determined by the capitalist or socialist ideologies of a nation-state, but is a function of advanced industrialization.21 Rimlinger in a recent study affirmed this thesis.22

IV. CONTEXT OF HUMAN RIGHTS

Three different socio-economic settings for industrialization were identified by Rimlinger:

The first is industrialization by private entrepreneurs; under the aegis of the liberal state, with the entrepreneurial class achieving a dominant power position. This situation was achieved in the United States and approximated in England and France. The second context is that of an authoritarian political and social structure; industrialization is still primarily the work of private entrepreneurs, but their interests and ideas do not become dominant; the class interests of the industrialists remain subordinate or must compromise with the interests of the monarchy, the state bureaucracy, and the landed classes (Imperial Germany and Tsarist Russia). The third setting is the one

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of socialized industrialization directed by a ruling totalitarian party (Soviet Russia). These three contexts or settings guarantee human rights in varying ways. The first setting guarantees civil rights through its political system but does not agree on what social rights are. Social rights emerge in the first context as the liberal state begins to move in to support dependent populations whom the entrepreneurial class has abandoned. The second setting guarantees certain social rights in exchange for loyalty to the dominant interests, and civil rights here are the rights of that dominant class. The third setting guarantees certain social rights, and there is agreement on what these social rights are, but civil rights are not as prominently present.

It would seem to follow that guaranteeing social rights must occur at the expense of civil rights. However, this is not the case. Goods and services offered as a gratuity, whether such offer comes from the entrepreneurial class, the liberal state, the monarchy and the landed interests, or a socialist collective, create a history of their own. Once the provision of such goods and services becomes institutionalized, they cease to become gratuitous and become rights. Harold Wilensky, in a recent work, proposed that the evolution of such social rights are dependent on two factors: (1) age of the population (because their needs are coupled with their political power) and (2) age of the social security system (because it develops a history of its own).

Health care as a social right, therefore, emerges in all industrial settings, though its pathways of emergence vary. It also assumes a certain degree of technological innovation which makes it feasible. Even when it is technologically feasible, it necessitates a social organization which makes mass manufacturing possible. Age of the population and the age of the social security system then determine whether health care is seen as a human right. Table I shows the path of these developments.

V. TWO LEVELS OF TECHNOLOGICAL INNOVATION

Before any technological innovation becomes a right, availability through manufacturing is required. Technological innovation leading to the development of a social right, therefore, requires two levels of innovation: (1) technological innovation as such, and (2) the innova-

\[^{23}\text{Id. at 334.}\]
\[^{24}\text{H. WILENSKY, THE WELFARE STATE AND EQUALITY (1975).}\]
tion of a social organization created by mass-production of that technology at a cost borne by one or more parts of the organization. For example, the internal combustion engine was a technological innovation, whereas the mass-production of the automobile created a certain kind of social organization. Health care, which is achieving a social right status, has many technological innovations which cannot be mass-produced now.

This social organization of technological innovation means a combination of cost, access, structural facilities, and restraints, as well as competition among group interests.

A. Theoretical and Philosophical Perspectives

John Rawls, who has written a most stimulating and provocative essay proposing a theory of justice, distinguishes sharply between socially oriented goods and those focusing more on the individual. One of his basic conceptual and philosophical distinctions centers on the difference between social primary goods and natural primary goods. The former goods are granted and guaranteed by a social system, whereas the latter goods are more individually focused. In the application of these principles, Rawls stresses the need for a basic structure of the social system, rather than the merits of specific choice points. Inevitably there are inequalities in any system, but these can be reconciled. The realities that such problems will most severely touch the poor, the disenfranchised, and the less powerful groups in a society will be rectified by the development of a priority scheme.

There have been many critiques of Rawls' work. Ronald Green's is of special relevance here because "not only does Rawls fail to devote any space to this topic in [his] lengthy book, but the index itself contains not a single reference to health, sickness, medicine or medical care." Given the void in A Theory of Justice, Green has attempted to fill it. He proposed "four very general questions [which] would likely confront contract parties as they consider the matter of health care." The focus of these interrogatories is as follows:

1. The importance of health and of health services.
2. Reasonable allocation of scarce health resources.

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27 Id. at 111.
28 Id. at 116.
3. The proper relationship between health care and other socially-demanded objectives.

4. Implementation of any of the above choices.

The major contributions of these questions lie in several areas. To begin with, a set of values probed will, if analyzed, force decisions. The debates on the possible alternatives will serve to add clarity to the eventual outcome. A good analogy is the United States Constitution and the *Federalist Papers*. While the signed document is the rule of law, the papers present the consequences, values, approaches and arguments on the issues, which purposely were omitted from the Constitution. Second, Green's focal areas provide a framework from which debate becomes assessment, and idea becomes implementation. Since Green's position implies the need to deal with "how to" issues, the full cycle is espoused. This becomes critical, given Rawls' stated limits. Third, the contentions posed by Green can be used in conjunction with Rawls' work. They are not mutually exclusive. Since these two are complementary perspectives, their additive impact can be significant. Finally, Green states the principle that "each member of society, whatever his position or background, would be guaranteed an equal right to the most extensive health services the society allows. This equal right would extend, presumptively, only to equal access to health services."²⁹

The Rawls' view and the Green commentary are important advances over the early philosophers. This is mainly because they both are cognizant of contemporary realities. Their perspectives, while rooted in sound philosophy, are applicable to the strengths and problems of contemporary medical care. An important part of their arguments are the notions of health as a human right. Whether health falls into the natural primary or social primary category, it is an important primary good and service.

The negative view of society's guarantee of adequate health care can be traced to Nietzsche.³⁰ He predicated his views on the assumption that inequalities were an inherent part of the nature of man and of man's social dealings. Using something akin to force field analysis, this perspective is rooted in the strong-weak dichotomies: the strong must rule the weak, and the state must survive at any costs. Nevertheless, for the state to perpetuate itself, it must allow this struggle to continue. Any efforts to share wealth and to assert equality must be

²⁹ *Id.* at 117.

³⁰ S. Frost, supra note 11, at 74.
resisted by all. This view is complemented by Herbert Spencer who acknowledged the struggle in nature (and therefore in man) for preservation. The role of the laissez-faire state would permit this struggle to continue in ways that benefit society. The ultimate outcome of these approaches is that the ruling class will set the conditions and the limits for social action. Injustice is almost a forgotten concept; the natural struggles between people use the competitive model. The ends seem fully to justify the means.

B. Humanism

The concepts and practices of humanism have a bearing on the discussion of health care as a human right. Although specific in their view that the individual, the human, is more important than the deity, the humanists do focus, almost exclusively, on the need to live a good life here on earth. Their twelve specified arts are the guide to achieving this life. One of these is the Art of Health: the understanding of and adaption to individual physiology and personal health habits. This view is comprehensive; it includes physical and mental health care. The humanists see the interrelationship of the twelve arts. Without good health, it would be more difficult to accomplish any of the other eleven.

This perspective is not congruent with humanitarianism. While there are definitely many overlapping areas, the humanists perceive the individual at the center. The humanitarian view is more third person oriented. One of the tenets in the latter view is the reaching out to others. When these two concepts are linked, they form a powerful couplet. Health is both an internal, individual responsibility as well as an integral part of the society's structure to reach out and assist those in need.

C. The Right to Refuse

Like all complex issues, the debate about health has another side. Is there a right to refuse health care? As noted earlier in this paper, once health is a human right, there are certain societal obligations. The medical services must be of equal quality; they must be fairly accessible and available to all when needed. This holds true for those services that are highly used as well as those more sophisticated, but less utilized, services. But, what if an individual decides not to seek

31 Id. at 203.
32 J. FREDERICK, HUMANISM AS A WAY OF LIFE 216 (1930).
medical care? What if someone wished to have medical care discon-
tinued? Do those same people who advocate that health is a human
right also have the right to refuse to seek or to continue care? The law
is not totally unidirectional, although there is evidence of a such a
trend. In a detailed review of some of the constitutional principles and
related standards of practice, Cantor notes that the trend appears to
be that the patient has the right to refuse extraordinary life-saving
measures.\textsuperscript{33} Other articles seem to support this view, especially when
informed consent is analyzed. If the individual is required to give con-
sent prior to treatment, then it is also an inherent right for that person
to refuse to give the consent. Thus, short of legal interventions to
preclude a person from giving consent, the mandatory nature of this
process indicates that a person may refuse to seek or to continue health
care.

The potential problems— legal, professional, moral and personal—
that can arise because of this uncharted area have not been a detri-
ment to many state legislatures. On the assumption that a state law
can clear up the matter, over 40 states have attempted to resolve these
issues. Thus far, the available evidence is that these state laws have in
fact compounded the issues. In a review of state laws, Robert
Veatch\textsuperscript{34} has stressed that there is much confusion. The eight states which have
acted thus far have little common ground in principle; it is too early to
test the commonalities in practice.

One of the interesting apparent contradictions between health as a
human right and the social rights of a society comes to the forefront
when considering the roles of public health and individual liberties.
Civil rights of the individual are subject to the society's need for pro-
tection. The potential quarantine of an individual for a prolonged
time, on the basis of potential communicable disease, is a longstanding
action with deep roots. The rights of the person are subjugated to the
needs of the people. The same society has demanded that innocula-
tions of the newborn be given. It is only under exceptional and infre-
quent circumstances that this does not occur. And, even on these occa-
sions, alternatives must be found.

The other side of this partial refutation of the civil rights of an in-
dividual is the view that this is a mandatory health measure. Society in

\textsuperscript{33} Cantor, \textit{A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily
Integrity Versus the Preservation of Life}, 26 \textit{RUTGERS L. REV.} 228 (1972).

\textsuperscript{34} R. Veatch, A Review of the Legislation (Monograph, Hastings Center,
this instance is demanding positive action for improved health status. Using its powers of protection of the populus, the state in these cases will mandate action for health. This has been the tradition in mental health for many decades. The legal system has intervened to place some individuals in the medical-psychiatric arena rather than the criminal justice system. This too is an example of the society at large, through its established social control mechanisms, making medical care obligatory for individuals. This occurs even if some of the individual's civil rights are removed or suspended for a period of time.

This role of public health action in search of protection of the society is deeply rooted in history. The Egyptians are known to have employed sanitary measures to remove waste from their cities. The Jewish dietary laws are a result of understanding the link between food processing and health. Therefore, it is not surprising to find the public health of a nation's citizens dominate, when needed, the civil rights of those involved.

VI. HEALTH POLICIES AND POLITICAL ISSUES

Whether or not one believes that health care is a human right, there is almost universal acknowledgement that the current United States health delivery mechanisms are in a state of crisis. While the dramatic implications of the critical conditions are alluring, a different perspective may be needed. Rather than viewing the single case of the health crisis, one can gain increased understanding by analyzing the process of defining social problems.

"A social problem is a condition which is defined by a considerable number of persons as a deviation from some social norm which they cherish."\(^{35}\) This view, as presented by Fuller and Myers, has two interdependent elements. First, there must be a condition in existence, which when objectively measured, is not at a level of expectation. Coupled with this evaluation is a subjective component, a subjective determination that a substantial portion of society will use this evaluation as a basis for problem definition. The "cherish" is akin to the rights of society’s members to medical care. Therefore, in this view, if society does not acknowledge a problem, that area of social interaction is, in effect, not a problem. The idea of an inconvenience or a problem for individuals does not always translate into a societal problem.

The concern must be acted on by a considerable segment of that society where the problem is noted.

A middle ground exists that integrates the schism between problem recognition and action to alleviate the condition. The perspective of systemic costs acknowledges that the specific problem exists, that it has an impact on a group within the society, and that remedies are needed. The focus is on defining the costs of the problem to the society. Using an expanded view of the concept of costs, Kenneth Westhaus includes money, values, and costs of nonperformance as some of the indicators. In this case, the costs of the problem are to be weighed against the costs of solutions. If there are acceptable costs associated with needed benefits, policy and program initiation are in order. This view returns us to the choice raised at the outset of the article: a single heart or a program of 9,000 screenings?

In many nations, questions such as these are raised by a number of different constituent groups: Consumers, philosophers, private agencies, social critics, and journalists. Recognizing current realities, these consciousness-raisers are not the solution-givers. The solutions to social problems increasingly are housed in the political sphere. Given the United States' elective process, top national leadership changes personalities, if not parties, at least once every eight years. Given the problems and pitfalls of the legislative process and divergent philosophies about the concept of human rights in health, it will require a rather large and vocal portion of this society to mobilize the federal government into action.

The rhetoric is present; the results are not. Senator Edward M. Kennedy believes "that in America today, health care is a right of all, not just a privilege for the few." Unfortunately, this reference was only on behalf of a bill in the United States Senate, not on the occasion of a program implemented to this end. In an editorial in the Health—PAC Bulletin, a different view is presented. "As long as barriers to care can be raised or lowered at institutional or . . . legislative whim," is health care a human right? If the winds of "whim" blow in a different direction, will the rights of today become the privileges of tomorrow?

A provocative discussion about the definitions and implications of human rights comes from Maurice King. In an article entitled Per-

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sonal Health Care: The Quest For A Human Right," he noted the following as central to any definition: "The right to personal health care can be considered as a group of interventions that an individual will only sometimes need, may not always want, which are not to be imposed on him, but which must be available." This is an important statement for it spells out in rather precise terminology the implications of the health-as-a-human-right issue. Members of a society do not always need medical care. When needed, those same individuals may not really want it. Many public health measures, like the swine flu vaccine in 1976-77, are resisted even though they exist for the public's health. Nonetheless, in both cases, these same health care services, unneeded and unwanted, must be there. They must be accessible, high quality and affordable, must meet professional standards and must not be fragmented. Thus, the debates continue between the moralists and the managers, the philosophers and the planners.

VII. IMPACTS OF MEDICAL TECHNOLOGY

Technological advances in the biomedical field over the last fifty years have catapulted this country into a revolution of unprecedented proportions. Twenty-first century biomedical knowledge and techniques can
cure or eliminate diseases which formerly proved fatal to the perfection of organ transplant techniques, artificial organ parts and eventually entire artificial organs. Heart-lung machines can now keep air and blood flowing even in a patient whose brain has died. Hemodialysis is available to the victims of end-stage kidney disease as they await the availability of a donor kidney.

The development of sophisticated X-ray machines (e.g., the CAT-Scanners) and other clinical laboratory equipment (e.g., electrocardiograms) have significantly enhanced the diagnostic skills of the health care providers in the early detection of illnesses once considered fatal. Biomedical technology has produced vaccines against polio. The medical community now has the ability to prevent measles, influenza, and diphtheria, once major killers of young children. These are only


Id. at 227-28.

samples of the recent advances in medical science that have changed our lives.

Revolutionary developments in the area of biomedical technology have significantly improved the general health status of every American. Since 1900, twenty-plus years have been added to the average life span.\textsuperscript{42} The infant mortality rate, a primary index for determining the health status of a defined population, has declined from 47 deaths per 1,000 live births in 1940 to 15 deaths per 1,000 in 1974.\textsuperscript{43} Epidemic diseases, such as tuberculosis, diphtheria, polio, and measles, have decreased significantly and are no longer the feared sicknesses they once were. In 1950, these diseases claimed almost 2,800 lives, but less than twenty-five years later, the figure dropped to under 50.\textsuperscript{44} Similar trends can be found in pneumonia, arteriosclerosis, and kidney disease.

Despite these technological advances which affect our health status, however, the statistics show that there are still specific groups within the country that benefit far less than others. There are significant differences in health status and health care utilization patterns between the more affluent and the low to middle income groups, especially Blacks and native Americans. The statistics show a shocking difference in the manner in which these biomedical advances are used by different segments of our society. The causes of such discrepancies can be related to how our health system manages its growth.

\textbf{VIII. SOCIAL MANAGEMENT OF TECHNOLOGY}

There are two identifiable levels of biomedical technology. On one level are the technological innovations which have been spectacular and far reaching. The second level relates to the development of the social technologies needed to implement and augment the first level. Once scientific knowledge and techniques have become a reality, they must be complemented by organized, efficient systems in their implementation. Every segment of society, without regard to social status, should have the opportunity to share in these benefits. The skills of the scientific community ought to be at the same high level when development ceases and implementation begins.

\textsuperscript{42} U.S. DEP'T OF HEW, NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES—1975, at 147 (HEW Pub. No. 73-1232, 1976).
\textsuperscript{43} Id. at 219.
\textsuperscript{44} Id. at 239.
There is a great demand for changes in the current state of health and medical affairs. This demand comes from within the medical community as well as from forces in the government and the general population. However, progress has taken the form of incrementalism. The approach to change has been to attack single issues in American health and medicine: Catastrophic illness, renal dialysis, hospital cost containment, and alleged abuses in programs such as Medicare and Medicaid. There has not been a unified approach to problem analysis. As a direct consequence, there is not a coherent problem solution.

What will be documented in the sections to follow is that the technologies have not been complemented by the social management structures that are required. There are many differences in the accessibility and quality of medical care in the United States today.

A recent report by the Congressional Budget Office revealed shocking health status differences between white and non-white Americans (non-whites in this report are defined as Blacks, Native Americans and Orientals): non-whites are more than three times as likely to die of hypertension than white Americans in the same age group. The report also stressed that non-white Americans are twice as likely to die from diabetes, and nearly four times as likely to die of chronic kidney disease. Non-white children are more likely to die from the traditional killers, influenza and pneumonia. Also, non-whites are five times as likely to die of tuberculosis as the white population. The irony in this statistic is that tuberculosis is a disease that presumably has been conquered by advances in biomedical technology.

Despite the decreasing infant mortality rate of all Americans, the rate for non-whites in 1975 was 24.9 per 1,000 live births, in comparison to a rate of 14.8 per 1,000 for white Americans. Even after the first year of life, the differences in mortality statistics between white and non-white children remain. For children aged 1 to 4, non-whites die at a rate 70% higher than whites, and in the 5 to 9 age group, non-white children die at a rate 40% higher than white children.

These trends appear to continue through adolescence. A study of the health status of adolescents in Harlem, New York, focused on

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45 CONG. BUDGET OFFICE, HEALTH DIFFERENTIALS BETWEEN WHITE AND NON-WHITE AMERICANS 3 (1977).
46 Id. at 4.
47 Id. at 5-8.
Blacks and Spanish American teenagers twelve to fifteen years of age. A significant number of the youngsters were suffering from heart conditions, problems of blood pressure, asthma, and anemia. Two-thirds of these youths had at least one medical problem representing a deviation from what would be considered normal.

It is not only in Harlem, New York, that ethnic minority children display extraordinary health problems which illustrate the differences that exist in our society. In a Chicano community in California, children suffer four times as much amoebic dysentery, and twice the incidence of measles, mumps, and tuberculosis as the national average. In 1971, approximately 10 million American children under 16 years of age had received no medical care at all.

Does adequate health care make a significant difference? According to numerous studies the answer is yes. For example, mothers who have had no prenatal care are three times more likely to give birth to infants with low birth weight. It has been documented that at least half of all infants who die during the first year of life were born with low birth weight complications.

The differences in health status also are reflected in the number of bed disability days per year per person: nine for non-whites and six for whites. In reference to those over age 65, the number rises to 25 for non-whites, but only 12 for whites. The above data indicate that health problems of non-whites are usually in a more advanced stage at the time of admission to a medical facility.

It also should be noted that the life expectancy for whites in 1975 was about 73 years, as opposed to 67 years for non-white Americans.

Class distinctions between Americans, which transcend ethnicity, are just as pronounced with regard to health status.

A child's destiny in Sweet Water (Alabama), if he is black and poor or white and poor, is to be born to a mother who had received no

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51 HEALTH DIFFERENTIALS, supra note 45, at 4.
52 Id.
prenatal care, to be born outside of a hospital, in a rural cabin attended either by a mid-wife (with various degrees of experience and training) or simply by a relative. Then the newborn infant gets no pediatric examination, no injections or "shots" to prevent this or that disease, no vitamin supplements, no evaluation, no treatment of any kind. The heart is not heard, nor the lungs. Abnormalities are not noticed, nor are attempts made at correction. Advice is not given, nor reassurance. Worst of all, accidents and injuries and illnesses are part of life, and either "take" the child or "spare" him or her. Fractures heal or they don't, often without the benefit of splints or casts. Infections go away or they don't. Burns and lacerations and cuts and sores and rashes either "clear up" or "stop themselves" or "leave the child" or they don't, with obvious results: worse and worse pain, more and more incapacity and disability.53

A report from the Department of Health, Education and Welfare54 analyzed health statistics in poverty and non-poverty areas of large cities. It indicated that the United States had made little progress in closing the health gap between poverty and non-poverty Americans. The data stress that people in urban areas, especially those in the designated poverty areas, continue to have significantly higher death rates.

According to Miller and Roley, there is a significant relationship between maldistribution of health services and income. Historically, it has been very difficult for low income individuals and/or families to purchase medical services within a fee-for-service dominated system. Historically, too, low income families have had to rely on charitable institutions, which for the most part have been fragmented and crisis oriented.55

IX. HEALTH RIGHTS, COSTS AND DISTRIBUTION

Two major factors have influenced the differentials in health status: the cost of health care, and the maldistribution of health care professionals and medical facilities.

A. Costs

There are several factors to consider in relation to health costs. The astronomical rise in the cost of health care has created serious ac-

cess problems for most Americans, especially those with low to middle incomes, as well as the aged. This situation exists despite federal aid programs such as Medicaid and Medicare. Since 1962, medical costs have risen almost 60% faster than any other major category of personal expenditure. Since 1965, medical costs have risen at more than double the rate of increase in the cost of living. Prior to the enactment of Medicaid and Medicare legislation, physicians' fees were increasing about 3% annually. Since the passage of these pieces of social legislation, the annual increase has averaged more than 6%. The average cost for one day in a hospital before 1965 was approximately $44, not including physicians' fees; today, it is over $175. In 1950, the cost of health care nationally was $12 billion, or 4.5% of the GNP; in 1977, the cost was approximately $160 billion, almost 9% of the GNP.

On a more personal level, medical care costs now consume 11% of the average worker's earnings. Health and welfare plans by management and labor for the most part are being used to cover inflationary increases in benefit costs. The Teamster who earns $9 an hour for a weekly gross income of $360 has to pay $28, or 8%, for health and welfare services.

The government has reported that health costs increased 14% from 1975 to 1976, an average of $638 for each man, woman and child. The increases in costs have led to some predictable consequences. Some illustrations of recent Medicaid cutbacks are the following:

Oklahoma dropped coverage of families with unemployed fathers; physician visits have been restricted to one visit per month in Alabama and Georgia, and Michigan is considering a similar move; Louisiana has restricted physician visits to 12 per year; some mental health benefits have been eliminated in Maine, Minnesota and Texas; eyeglasses have been eliminated in Georgia and Florida (where hearing aids also are eliminated); physicians, dentists and other health providers have had

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56 HEALTH INSURANCE INST., MEDICAL CARE COST IN THE UNITED STATES 52 (1974).
57 5 WEEKLY COMP. OF PRES. DOC. 968 (July 10, 1969).
58 Id.
60 NEW REPUBLIC, supra note 59, at 23.
62 Id. at 25.
HEALTH CARE

reimbursement levels cut by 10% in New Jersey and Tennessee, and by 5% in Georgia; payments for laboratory services have been cut by 40% in New Jersey.64

The increase in the cost of medical care has had a serious impact on the elderly. Last year the Department of Health, Education and Welfare increased the hospital deductible and other health related charges by approximately 20%.65

Not only are those classified as low income affected by the cost of health care, but a new class has emerged — the medically indigent. These are low-middle to middle income working class Americans. The number of medical indigents is increasing because of inadequate health insurance. They cannot cope with the rising cost of medical care, but have incomes too high to qualify for federal programs. This growing number of Americans is finding it extremely difficult to gain access to the medical care system.66 For a family who earns approximately 10% above the poverty level (presently $5,800), the annual medical costs, disregarding any major illnesses, would represent approximately 14% of their family income. In this case, the family will have to cut back on other necessities such as food, shelter, and clothing.

A Department of Health, Education and Welfare study has pointed out that as income decreases, a family has a tendency to seek fewer medical services. As family income approaches the poverty level, the family is less able to afford medical care; therefore it seeks less care.

Despite reports from the health insurance industry67 that most Americans have some form of health insurance, a report from the Congressional Budget Office68 has revealed that approximately 101 million Americans have either no insurance protection or inadequate insurance protection to cope with the current cost of health care. Another 127 million Americans have protection ranging from the level of "adequate" to that of "good."

64 CHILDREN'S DEFENSE FUND, supra note 49, at 17.
67 HEALTH INSURANCE INST., supra note 56, at 7-12.
Most insurance plans have "deductibles," forcing families to pay the first $50.00 or $100.00 before the insurance takes over. But think what a negative incentive deductibles are for families to develop good preventive health habits. 90% of children's health care needs are taken care of outside of hospitals, involving routine procedures, tests and examinations. All the services a child would need in a year may not exceed the deductible, which would mean no help from the insurance plan. Yet, to a poor family, $10.00 for a lab fee, $15.00 for a visit, or even $5.00 for one round of a prescription medicine may be enough of a strain on the family's budget that it foregoes using health services.\(^6\)

Therefore, it is an important conclusion that the rise in the cost of health care has presented numerous barriers to many citizens' efforts to take advantage of the technology of modern medicine.

Schorr began his chapter on "Bringing the Poor into the Health System" by noting that "nowhere does the Constitution guarantee a right to health, as it does provide for an educational system... Because (the right to health) implies a commitment to serve all Americans, it implies a commitment to change the health system so that it can serve all Americans."\(^7\) While this is an accurate reflection of the feelings of most political leaders today, it has not always been the case. During the early 1970's, the Federal government began a process to curtail the programs and policies that characterized the Great Society. While technological development continued, the social management of these technologies was being directed at reducing their scope, funding, and utility. While these actions proved legal, they were not without debate. From this contemptuous political stance, the curtailment principle in health and human services guided the social management process from January 20, 1969, through August 9, 1974, often called the Nixon years.\(^8\)

Such a view puts health care funding in direct competition with other social welfare, human service, defense, labor, and agricultural needs of the social fabric of the 20th century United States. While there is nothing inherently wrong with this, it sets the stage for the same rich-versus-poor, have-against-have-nots battles that have occurred in the past. Such situations almost inevitably lead to mandatory

\(^6\) CHILDREN'S DEFENSE FUND, supra note 49, at 20.

\(^7\) D. SCHORR, DON'T GET SICK IN AMERICA 132-33 (1970).

\(^8\) R. Ritvo, Theoretical and Administrative Implications of Technological Decision Making (Summer 1978) (unpublished manuscript in Hospital and Health Services Ad. office, Am. C. & Hosp. Ad., Chicago, Ill.)
HEALTH CARE

compromises, which ultimately reinforce the status quo. If one remembers the recent Congressional deadlock over funding for abortions, policy was attached to emotion, program was held hostage to hyperbole. This had to occur, given the piecemeal political approach to health issues.

B. Maldistribution

Another major factor creating numerous barriers for certain segments of the population is the maldistribution of medical facilities and services. The Great Plains of the United States, as well as some rural and urban areas, increasingly are becoming medical wastelands. The number of physicians in these areas continues to diminish. It has been suggested that if one lives in the so-called designated poverty areas, or in rural America, it is not necessary to eat an apple a day to keep the doctor away. Physicians have discovered other methods to stay away. Physicians have been a part of the geographical movement of the American middle class. According to Lankford, physicians locate in order to maximize their income, resulting in a migration from the larger cities and rural areas to the wealthier suburbs. A Chicago urbanologist stresses that downtown Chicago has already become a medical wasteland. In 1950, there were 1,779 physicians in the Loop area, but by 1974 this number was down to 542. Nearly all of the Chicago physicians practicing in the two noted ghetto zones in 1960 have moved out. Chicago is not unique in this regard. Between 1950 and 1970 the city of Newark, New Jersey lost almost 200 physicians to the suburbs.

Low income and low-to-middle income families often find themselves concentrated in urban and rural areas where physicians and facilities are not readily available. Studies in Buffalo and Cleveland have revealed a significantly lower ratio of physicians to families living in low income areas in comparison with families who reside in the more affluent suburbs. There was only one physician per 2,222 persons in the low income areas compared with one physician per 885 persons in Cleveland's middle income areas. A study by the Cleveland Health Department revealed that three planning areas in the concentrated

73 Id.
75 U.S. DEPT OF HEW, supra note 66, at 12.
poverty section of the city had only one physician for every 3,548 residents.76

One very interesting consequence of the current patterns of physician distribution is that while it is difficult for consumers residing in poverty areas to gain access to basic medical care, in wealthier suburbs physicians are competing for patients.77

The maldistribution of physicians and services is a problem that has been with us for many years. In the now-famous 1932 report from the Committee on the Costs of Medical Care, Medical Care for the American People, strong emphasis was placed on this problem of poor distribution of physicians and medical facilities. The report also stressed the increasing imbalance between primary care and more specialized practice in the United States.78 Although numerous legislative efforts have been put forward, the problem of distribution still remains a very serious one for many segments of the population. As a result, many Americans do not have adequate access to a physician and/or medical services.

Although there are other barriers standing in the way of a comprehensive medical care system, the factors of cost and of availability and accessibility of medical services are the two that will have to be confronted if health care is ever to become a basic human right for all Americans.

The point has been made that for the technological advances in medicine to become a reality, they must be complemented by organized systems to assure that they are managed effectively and efficiently. There are segments of our population, in particular low income Americans, who have not felt the full impact of much of the available technology.

The technology is available, but the level of social management necessary in order to make many of these innovations available to all segments of the population has not become a reality. The following example is illustrative:

Experts agree that if strep throat were detected and treated adequately, rheumatic fever and chronic rheumatic heart disease would be almost non-existent. Yet, in 1972, approximately 68,000 children

76 Id. at 12-13.
77 C. LEWIS, R. FEIN & D. MECHANIC, A RIGHT TO HEALTH: THE PROBLEM OF ACCESS TO PRIMARY MEDICAL CARE 12 (1976).
78 COMMITTEE ON THE COST OF MEDICAL CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE (Public Health Service reprint 1970).
under age 17 suffered from these two conditions. Where organized health services have been made readily available to families, their impact is striking. In Baltimore, Maryland, where four comprehensive care programs were established in the most underserved areas of the city, the incidence of rheumatic fever was reduced by 60% among children in the census tracts eligible for any of the programs, while in the surrounding areas its incidence increased by 20%.19

The cited projects employed social management techniques to cope with some of the structural barriers to medical care. In conclusion, they have pointed out that if those restrictive barriers are removed, the utilization by low income families of preventive and curative services will increase. Therefore, through proper social management of today's advanced technology, health as a human right for all Americans can become a reality.

Of all the various parts of the health care delivery process in this country, the hospital is the most visible and also the most subject to criticism. In the next section of the article, discussion shifts to this organizational form and to its changing role and potential.

X. HEALTH RIGHTS AND HOSPITALS

One of history's strengths lies in its ability to teach us about yesterday in order to anticipate the possible lessons for tomorrow. But the health-as-a-human-right issue that has become dominant today was non-existent in the public's mind at the turn of the century. There are a host of reasons, most prominent of which is the emergence of the hospital as a treatment facility for all people, rather than as the last place for the indigent to go where they could rest and die in comfort. If anything, the poor today often feel excluded from the health and medical services of the large, urban health complex. There are many reasons for this change: financial, technological, and the private practice demands of physicians. The contemporary result of these trends has been to make American medicine, and that of most industrialized nations, highly visible. The trappings and artifacts of our ability to provide services often stand in stark contrast to the realities of the poor and the excluded, who so often live in the very shadows of the edifices that provide the medical care they require.

There is evidence that the hospital as an organization has undergone a number of changes in the past fifty years. Alterations in the hospital's physical configurations are attributable both to increased

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19 CHILDREN'S DEFENSE FUND, supra note 49, at 12.
scientific knowledge concerning infection control as well as advances in building design and construction. The number of hospital employees (both as a total figure and on a per patient ratio) has increased as a result of new medically related professions and modern technologies. In this section of the paper, the focus is on the social conditions and changes that have affected the hospital.

In the early years of this century, hospital care was paid for mainly by the patient, if that individual could afford it. Otherwise, the hospital rarely received money. The costs of care were less than they are today, both in actual dollars and as a percentage of disposable income. While patient revenues were enough to keep hospitals open, there was never enough surplus to expand, to add new programs, or to pay employees a salary commensurate with what their peers in other industries were receiving. In the mid-1930's, the health insurance industry began to expand. This growth altered one portion of the hospital's financial situation. Instead of operating on a fee-for-service basis (if any money at all), both the hospital and the individual now had a mechanism to cover and receive financial commitments. An additional shift in the financial situation was the dramatic increase in governmental funds allocated for health care delivery programs and facilities' construction. There are currently a myriad of federal, state, county and city health programs.

While these financial changes were occurring, there was a growth and expansion in medical knowledge and technology. New research findings had direct application to the patient treatment process. These technological strides had a direct impact on the hospital's role in society. Instead of being a refuge for the poor and homeless to spend their dying days in comfort, the medical facility was able to provide treatment and cure. People from all socio-economic backgrounds began to use the hospital for care and cure.

As the hospital's role began to shift, physicians began to make better use of the institution. Part of this attraction was that an individual or group practice could not afford the cost or space needed to house the increasing numbers and varieties of expensive equipment that were becoming an integral part of their treatment repertoire. As an expanding structure, the hospital was able to absorb these costs and to provide the needed space for such items. It also became advantageous to have several patients under one roof for visits, treatment and follow-up.

One of the major forces in the health care paradigm is the individual. As a single entity, the predisposition, needs and values of the
HEALTH CARE

consumer are an important variable in understanding the utilization of health services. In the larger context of a society, the cohort of individuals' norms and aspirations are an integral part of the framework. There are two major themes in the current analysis of health care as a human right. One of these is that the costs of medical care have risen to such a point that it has a significant impact on many different segments of our society. The poor, almost by definition, have always found medical care expensive. The rich, upper classes, have not needed to worry about cost. However, it is only in recent years that the vast middle class has felt the impact of these rising costs. In the political arena, this is the group with the loudest, if not most organized, voice. The second trend, over a longer period of time, is that the level of health care quality has risen. While specific variables in the United States may not compare favorably with those of other nations (e.g., infant mortality rates as a common, but overworked, illustration), the level of science and delivery is probably at one of the highest points in the history of man.

These two factors, high quality and rising expenditures, have combined to make a third voice felt in medical care — that of the consumer of service. Not only has the consumer been excluded from the decision making process, but this group has, until recently, been seen as having little to contribute. But, as Bob Dylan noted so poetically, "The Times They Are A Changin'." Consumers now have been given seats on hospital governing boards. Special advisory committees are no longer unique.

One of the more interesting developments in the field of "rights" for care has taken place in Ohio. The Ohio Legislature recently enacted legislation that substantially revises the State's civil commitment procedures by defining four situations when a mentally ill person may be subject to hospitalization by court order. The rights of patients, while under in-patient treatment in a state facility, are also defined. These developments are occurring in other states as well. What is of interest is that advances have occurred in the field of mental health. One of the reasons for this is that the traditional abuses and "custodial" nature of mental hygiene facilities are no longer

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80 Ohio Rev. Code § 5122.01(B)(1)—(4) (Page Supp. 1976). Generally, the circumstances are when the risk of harm to the person or to others is "substantial and immediate" or "grave and imminent" or when the person "[w]ould benefit from treatment in a hospital. . . ." See also Ohio Enacts New Commitment Law, 1 Mental Disability Law Rep. 37-38 (1976).
tolerable in the contemporary era. The rights to access and to treatment have been legally certified. In the Ohio statute, there are provisions for periodic recertification of need for further treatment. An additional reason for this law in the mental health field is that there is an interplay between the patients' right for treatment and the patients' civil rights. Without delving into all the legal complexities of the issue, this law represents a convergence of the societal, legal, judicial and individual's need and rights. The obligations on the institutions, the medical community and the individual-at-risk have been defined. This has placed new demands for accountability on most health institutions and health professionals. It is an assertion through law that health is a right.

There are a number of important problems which currently impede the development of patients' rights and consumer education. These assume greater importance because they are a prerequisite for health as an inherent human right. The major issue is a lack of health knowledge attributable to a major proportion of the population. The myths concerning personal experiences often cloud the transmission of educational information. The media has a potentially strong role, but has been rather unsympathetic to these forms of mass education. It is better "copy" to report the abuses in health. There is also a concern that the benefits derived from such efforts do not justify the costs. This could be proven true or false by systematic research. However, there is also the strong possibility that the single approach would be negative, while the cumulative impacts of these educational efforts would be more effective. The medical establishment and health professionals are not trained to respond to this need. Until very recently, there had been little demand, and even less interest, in this area of practice, but the movements in the field of health rights bode well for the future. It will not be an easy goal to accomplish for many of the same reasons that have contributed to the current situation: High costs, unquantified benefits, diffuse impacts, and a patchwork of duplicated health programs.

A. A Sample of International Perspectives

As an international body, the United Nations has been interested in human rights issues since its inception. This concern is most clearly articulated in its founding documents. "The right to a standard of living adequate for health and the right to medical care" is one of the social rights proclaimed in Article 25 of the Universal Declaration of
Human Rights. The definitions of "health" and "medical care" are broad; they include both physical and mental illness, prevention, environment, and much else. It is, perhaps, one of the most all-encompassing views in existence. The United Nations took the next major step. In an effort to practice these precepts, the General Assembly created a separate organization to coordinate its efforts in the health sector. The World Health Organization is the unit which has this mandate. Through the W.H.O., the U.N. reaffirms its commitment to the view that health is a human right.

The rhetoric that health care is a human right is not bounded by the geography of the United States or the role of the U.N. The Soviet Union, not often viewed as a haven for human rights action, is also involved in the issue. The government "stresses the right of (its) citizens to expect from the state 'social justice' in the form of housing, education and health care." Yet, the same rigor in analysis that we have applied to the United States leads to some of the same conclusions in the Soviet approach.

"In Russia, all government programs are geared to one concept — namely the victory of the Soviet system in the world. This aim must never be compromised; therefore health standards are to be held to an economical level. Beyond that is a waste of resources. The regime is not interested in providing medical care for the population, but only in that medical care essential to its goals."

Clearly, health care in Russia is in competition with defense, education, and housing. This same competition exists throughout the world. Given the limitation of ideology in the Soviet approach, the competition is defined. The United States has less clear-cut guidelines. If the United States were to adopt a policy for action within which programs could be selectively accepted or rejected, then the propaganda could be replaced by program, and the rhetoric would yield to action.

B. Denmark's Social Reform in Health

International and cross-cultural comparisons can be a mixture of assistance and confusion. First, such efforts may serve to highlight issues that transcend geographic boundaries. They can illuminate potential problems and solutions to the impediments. Comparisons also may serve to give guidance to those administratively and program-

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82 N.Y. Times, June 14, 1977, at 70, col. 1.
atically involved in almost any facet of the topic under scrutiny. On the other hand, however, there may be a set of limitations that undermines the impact of such comparisons. The culture, the values, the structures, and the laws of different societies could render such efforts useless. Different demographic characteristics may have strong programmatic implications without regard to any comparative data. Yet in the broadest terms, the health-as-a-human-right concept may benefit from such efforts as international study.

Health care in Scandanavia has been the topic of much research and analysis in recent years. Denmark is a small nation in comparison to the United States, but one where the human right to health care is being implemented and, more recently, strengthened. It warrants some detailed discussion.

By Royal Decree in 1806, uniform hospital services were made available to all Danes and visitors to the nation. These were to be free services. While the quality of early 19th century health care is not near today's standards, the notion of equally available medical treatment is deeply embedded in the history of the Danes. The development of the "sick clubs" predates by over 100 years the Health Maintenance Organization (HMO) concept in the country. The physician is paid through these local community or neighborhood clubs to provide medical care to a population group. Money is paid to the doctor by the club in the form of a salary; services are rendered to the sick without the patient directly paying the physician.

One of the strongest principles of the Danish system was that the state must be the intervening force to assure that financial considerations did not interfere with the medical delivery system. The model worked well for many years. But, one almost predictable consequence of the community- and neighborhood-based "sick club" pooled insurance system was the proliferation of these entities. Although the Danes have regulated charges of the medical community since the 1600's, the benefits of the local clubs varied greatly from one to another. By the 1950's there were over 1,100 of these clubs, a situation that was rapidly becoming deplorable to most of the members and to the national governmental leaders. In 1960, the state formally entered the health benefits area and began a drive to reduce the number of clubs and to gain a greater equity between the benefits offered by each.

In 1973, the "sick clubs" formally were abolished after a history spanning several centuries. The functions of these clubs has been vested in the local counties (equal in many ways to our States) and
municipalities. Without delving into all the complexities of the division of tasks and responsibilities across these geopolitical units, it is important to realize the health care trend in Denmark has a long tradition of being community-based. Health care is rooted in the principle of spreading the financial burden across a large population group to benefit all members of that group.

Elizabeth Johnson concluded a review of the Danish health delivery system by noting that

[in Denmark, the necessity for the government to intervene and assume responsibility for the delivery of total health care to all people is recognized today. The implementation of the principle that quality medical care as a right is on the threshold of realization.]

In that same article, Johnson compared the United States approach to the Health Maintenance Organization and the Danish Public Health Security Act of 1971. Whereas the HMO is financed by those who voluntarily enroll in a predefined geographic boundary, the Danish approach is to provide complete coverage to all citizens, funded through the national tax system with participation based on citizenship. These are important differences. The HMO concept and organization becomes another part of the current marketplace approach to medical delivery. The Danish approach is much more structured toward the human right perspective. It is not undermined by the financial status of its specific beneficiaries. The treatment is guaranteed equally to all. There does not appear to be the same class distinction that we have seen as an ongoing characteristic of the United States approach. The Danes have a system; the United States has a collection of semi-interdependent nonsystems.

The social reform in Denmark is rooted in the concept that health care is a human right. But it goes beyond mere verbiage. The Danes are attempting to reform their system to provide health care at reasonable costs, with a minimum of duplication, in an accessible manner. These are the same principles that we seek in this country. In Denmark, the national government is using its power to establish a social management system to insure program implementation. This lesson may be important as policy and program pronouncements develop in the United States. Even with the caution that the Danish reform is still in its formative stages (it began in the 1970's) and the research on its

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impact only now is beginning to emerge, it may provide some important guidelines for reform in this nation.

XI. CONCLUSION

As a review, the theme of this article has stressed several interrelated social phenomena. As society has developed new technologies in health and medical care, its inherent ability to improve life span, health status and the quality of life has increased. There are two clear levels of this technology. The first is the scientific technology. These advances have been both spectacular and expensive. The second related piece is the development of the social technologies to augment the first. Once these innovations have become reality they must be complemented by systems to assure that they are managed effectively and efficiently. Our ability to handle the innovations and adoptions must be at the same high level of implementation as the technologies themselves. The health care technologies have not been complemented by the needed social management of that technology that is required. There are distinctive differences in equality, accessibility, quality and quantity of medical services and health in our society today. These are not tolerable if health care is to become a human right in practice.

As has been demonstrated, the growth and development of the modern hospital has been rapid, and should continue for the foreseeable future. Of all the factors mentioned as contributing to this change, the most important one is the development of technology. It is this development that will be the catalyst for continual reinforcement of the hospital as the center of medical treatment. Two related issues emerge, both of which are in need of independent analysis: how to manage the current and future technologies, and how to complement these with the needed social technologies.

Throughout this article, the view has been consistently expressed that health care is a human right. This is one of the foundations of a strong society. The principle has not been translated effectively into action in this country. The requisite social management technologies are not yet in place. The issues of cost, distribution, accessibility, utilization, and the equality of medical care services demonstrate this. Where a void in national pronouncements once existed, a renewed interest and movement to assure that health services are available to all now thrives. This will move health care from its status of a privilege to a more expanded role: a human right for all.
ERRATA
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Please replace page 357 in the article *Health Care as a Human Right* with the attached corrected page.
The *Journal* wishes to apologize for this error.

TABLE I
**PATHWAYS TO HEALTH CARE AS A HUMAN RIGHT**

- TECHNOLOGICAL INNOVATIONS
  - SOCIAL MANAGEMENT OF TECHNOLOGIES
    - SOCIAL SECURITY SYSTEMS
      - GUARANTEE OF CIVIL RIGHTS
    - MASS MANUFACTURE OF INNOVATIONS
      - NEEDS OF THE POPULATION
        - GUARANTEE OF SOCIAL RIGHTS
          - HEALTH CARE AS A HUMAN RIGHT
  - INDUSTRIALIZATION