
Realigning Our Thinking in Health Care: What Are Our Rights and Responsibilities?

by Larry R. Churchill

Is access to health care a right that belongs to all our citizens? And if such care is a right, are we entitled to unlimited care, whatever the expense? In a world of finite resources, such an expectation is unrealistic. So how do we deal with questions of how much care? Do we put the burden on individuals to be responsible for their own behavior and allocate resources based on maintaining a healthy lifestyle? Or should we focus more on redefining our expectations about what the health care system can deliver, based on our needs?

Do we have a *right* to health care? Most Americans think so. Opinion polls show that more than 80 percent of U.S. citizens think of access to needed care as a right.¹ And 91 percent say they believe that "everybody should have the right to get the best possible health care—as good as the treatment a millionaire gets."² This is not surprising. Every industrialized democracy except the United States and the Republic of South Africa recognize the right to health care. In all other countries, universal access to basic health services is assured as a matter of public policy, and care is financed through general revenues.

Though not always called a *right*, health care is seen as a basic good no one should be without. In the United States there is no general, legal right to health services. Still, most U.S. citizens see health care as central to their concept of a good, or

even a minimally tolerable, life.³ Being denied health care services is hazardous to a person's well-being. But of equal importance, denial of health services is an assault on one's self-respect.

In short, while most Americans believe health care is a right, and should be a right, this moral conviction is not reflected in the law or in any organized government program to provide the general health services to the population. The North Carolina Constitution, for instance, guarantees certain rights—to a free education, or a clean environment—but not to health care.⁴

If health care is to become a *tangible* right in the United States, a way must be found to define the scope of that right. A system of health care

Larry R. Churchill is professor of social medicine at the School of Medicine at the University of North Carolina at Chapel Hill.

which entitled all citizens to all possible services would be financially infeasible. We spend 11.5 percent of our Gross Domestic Product (GDP) on health care, yet 25 percent of the population is unserved or underserved. If we were to provide health coverage to everyone, health expenditures would consume roughly 18 percent of the GDP. No one believes this is economically possible, let alone practical. Hence, greater equity in coverage can be achieved only if we limit health care services.

A variety of ways to limit services can be imagined—by a person's age, by the effectiveness of services, by their cost, and so on. Whatever ways are chosen must be ethically coherent. That is, a *right* to health care must be correlated with some sort of *responsibility*. For example, Richard Lamm, the former governor of Colorado, has suggested that age could be used as a limiting criterion for a right to health care. If that were the case, the elderly would have a duty not to use expensive resources near life's end.⁵ While many have disagreed with Lamm's proposal, he is correct in suggesting that *duties* or *responsibilities* are critical to any workable health care system.

Simply affirming a right to health care is of no help. The critical move is to discern what a workable right would be, which means specifying the limitations on that right and what those limits require of people morally. This discussion will examine two ways of aligning rights and responsibilities, and will argue for a Response Model over a Good Behavior Model. These are only two of many possible ways to consider the issue, but examining these two ways will help clarify what values we should consider in thinking about allocating resources in our health care system.

The Good Behavior Model

Rights, we typically think, have corresponding responsibilities. We have a right to an education in the public schools, but we must abide by a code of conduct as we pass from grade to grade. We have a right to freedom and liberty in our daily dealings, but we must abide by sets of ordinances,

statutes, and rules that govern our behavior. Not surprisingly, some parts of our society increasingly perceive a similar responsibility in health care—as a responsibility for good health practices. This notion holds that accountability for our health is justified by what we know about the effects of individual lifestyle choices on health status.⁶ Let's call this way of thinking the Good Behavior Model, because in this model *the*

right to health services is forfeited, or at least weakened, by indulging in behavior damaging to one's health.

The attraction in this way of thinking is obvious. Individuals clearly do have some control over their own health status and their need for medical services. The extent of this control marks the extent of individual responsibility. Many illnesses and injuries are seen as problems that persons inflict upon themselves through bad health behaviors. Smoking, excessive alcohol consumption, overeating, and high-cholesterol-and-low-fiber diets are only the chief examples. Driving without seat belts, riding a motorcycle without a helmet, and unprotected sexual activity are additional examples of lifestyle practices that are associated with disease and disability.

The problems which result—lung cancer, emphysema, cirrhosis of the liver, coronary artery disease, gastrointestinal cancers, motor vehicle injuries and fatalities, and a variety of sexually transmitted afflictions—are perceived as caused by choices to live in an unhealthy way (see Table 1 for more on mortality rates related to lifestyle choices). Such diseases add both to societal ill health and to health care expenditures.

In the Good Behavior Model, smokers, for example, would have a lesser right to treatment for lung cancer than non-smokers enjoy. They might lose their claim to these resources altogether. Alcoholics would relinquish any claim to liver transplants, helmetless motorcycle riders would be denied access to emergency medical services, drug abusers to coronary care units, and so on.

A central problem with the Good Behavior Model is its exaggerated notion of control. While the Good Behavior model has its roots in the American reverence for self-reliance and individual

**. . . to base allocation or
financing decisions on
Good Behavior thinking is
unwarranted and would
result in a system that is
punitive to the sick.**

responsibility, control over one's health status and the extent of one's need for medical services is far from complete. Some behavioral factors in ill health may be only partially voluntary—for example, addiction to cigarettes, alcohol, or controlled substances. Other behavioral risks are embedded in cultural dietary traditions, or in poor nutrition or living and working environments associated with socio-economic status.

For example, Americans are notorious over-eaters, and the traditional Southern regional diet is hardly conducive to good health. Eating grits with butter and fried eggs and bacon or ham for breakfast *every morning*, year in and year out, will produce adverse health consequences. So will working in jobs handling toxic wastes without proper safety precautions, or repairing hydraulic lines near gas-fired chicken-frying vats without turning off the fuel.

An individual's responsibility cannot exceed his or her ability to choose. Hence, assignment of responsibility for health status and the need for medical care must take account of the multiple factors involved in disease causation, whether behaviors contributing to ill health are voluntary or non-voluntary, and whether they are individually chosen or socially sponsored choices.

Efforts to base access to health care (or payment for health services, to be more to the point) on individual responsibility for one's health care are very slippery. Such efforts frequently exaggerate our knowledge of causes or ignore multiple factors in the causes of diseases. They also run the risk of blaming the victim. Dan Beauchamp argues, "Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims."⁷

In sum, responsibility for one's health status should be the focus of substantial educational and public health efforts. For example, U.S. Health and Human Services Secretary Louis Sullivan's

In the face of limited resources, the key individual responsibility in health care is for realistic expectations and wise use of the health care system.

Table 1. 1988 Mortality Rates in U.S. and N.C., per 100,000 Population, Related to Lifestyle

Cause	U.S. Rate	N.C. Rate
All Deaths	535.5	570.8
Heart Disease	166.3	173.1
Cancer	132.7	134.7
Liver and Cirrhosis	9.0	9.2
Auto Accidents	19.7	23.9
Other Accidents	15.3	20.1
Suicide	11.4	10.9
Homicide	9.0	8.8

Source: N.C. Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources

desire to create a "culture of character," or a way of thinking that actively promotes healthy lifestyles and health habits, is altogether laudatory. Yet to step beyond this educational mission to base allocation or financing decisions on Good Behavior thinking is unwarranted and would result in a system that is punitive to the sick.

Responsibility for individual health-related behaviors is only one dimension of a just overall health policy. If taken by itself, and as way of curtailing rights, it will lead us in the wrong direction.

The Response Model

In the face of limited resources, the key individual responsibility in health care is for realistic expectations and wise use of the health care system. This is the health-related responsibility of citizenship.⁸ It is the obligation to think of health care services not only as an individual and private good but as a social and public good as well.

This connection of a right to health care with responsibility for judicious use can be called the Response Model of linking rights and responsibilities. *Rights to health care are granted by a society, and in response the individual takes re-*

sponsibility to use only his or her fair share. Responsibilities are individual expressions of response toward maintenance of the social or common good. Rights cannot stand alone without responsibilities, just as individuals cannot stand alone without social support.

What the Response Model requires is a new way of thinking. It requires assent to the idea that a health care system must give priority to the health needs of the population over personal individual needs and preferences. In many countries, this means tolerance for waiting periods for non-emergency surgery, and curtailment of treatment for some conditions which satisfy personal needs but have no bearing on the health of the population. This includes, for example, treatments for baldness, cosmetic procedures, and other very ex-

Rights to health care are granted by a society, and in response the individual takes responsibility to use only his or her fair share.

pensive treatments of marginal utility.

Consider Canada: There, the supply of hospitals, surgeons, and intensive care units is limited, so there are fewer solid organ transplants. Or consider the United Kingdom: There are waiting periods for elective surgeries such as hip replacements, and a limited supply of money and facilities for CT scanners. There is less aggressive chemotherapy and radiation treatment for advanced cancer. Yet all citizens of both Canada and the United Kingdom are provided access to a primary care physician. Ultimately, deciding which health services to provide and which to forgo is a public policy question. The point is that in any system, some services will have to be limited if there is to be funding left for schools, roads, defense, and the like.

A viable and fair health care system is something in which all citizens have a stake. We all share a common human vulnerability to disease, disability, and death. We are all poor predictors of the time or extent of our need for health services. We all support through tax dollars the creation and maintenance of the various institutions of health care, including hospitals, nursing homes, and the education of health professionals. And we all have a stake in a healthy populace above and beyond the stake we have in our personal health.

This shared vulnerability and investment in creating the means of medical and social assistance point to a responsibility for judicious use of the resources for health that we possess. The responsibilities individuals have is not only for healthy lifestyles but also for their general

MEDical Treatment Effectiveness Program Poem (MEDTEPP)

To treat, and how to treat —

Two of many hard questions.

*Does appropriate care involve the stings and perils of
invasive tactics?*

And how shall we reduce those variations in practice?

Which patients, and why, come out the best?

What was done, when, and what was the test?

What personal virtues and values were risked?

And, on the other hand, which ones got fixed?

Use this drug or that one? That procedure or none?

How long did s/he live, and did s/he have fun?

What function was gained? What function was lost?

And, you may wonder, how much did it cost?

In Boston, New Haven, and small areas too.

Treatment options are plenty — but data are few.

So doctors, patients, and health policy makers

Want findings, and guidance, and disseminators.

Care providers and payers all want to know

Which alternatives are best, and how best to show.

So Congress made MEDTEP, whose goal is to state

When to aggressively treat, and when to watchfully wait.

—CLAIRE W. MAKLAN

REPRINTED BY PERMISSION OF THE MILBANK QUARTERLY.

expectations and specific demands on a system that is finite.

This responsibility of individuals must be grounded in their awareness that health resources will *always* be scarce relative to needs. No modern society has yet devised a way to meet all the health needs of its citizens. Individuals can help by adopting prudent health habits, but even more so by accepting more realistically priced health insurance, co-payments for the costs of care, and by forming more realistic expectations for what the system can provide.

Individuals will assume responsibility for using and supporting a health care system only when that system is seen as equitable and just. In short, this health-related citizen responsibility will be impossible without a general right of access to adequate health care for all. The current patchwork system which allocates health services by price, by age, and by employment status, and leaves a quarter of the population underinsured or uninsured, cannot inspire a sense of responsibility, either individual or collective. The result is a consumer-oriented approach to health care, one that encourages us to satisfy all of our personal health needs without regard to what effect this has on the well-being of others.

Conclusion

Developing a viable and fair health care system does not mean simply providing coverage for the medically indigent, important as that is. Given the escalating costs of health care, more of the same for more people is a recipe for economic disaster. Reforms to the system must be accompanied by reforms in our thinking.

One reorientation needed is linking rights to health care with responsible use of the resources, and avoiding the erroneous and punitive Good Behavior Model. The notion that a right has to be earned by good behavior, as this forfeiture model portrays it, undermines it as a right and makes it ultimately a commodity granted to the behaviorally worthy. Such a health care system would be just as wrong as granting a right to health care on

the basis of race or gender. The Good Behavior Model, in sum, focuses on the grounds for disqualification, whereas the Response Model focuses on the civic virtues to be exercised in receiving care.

The Response Model allows us to talk of health care as a social good, and not just as an individual good. This opens the way for a non-commercial concept of health care as part of the social and public world—the world, as Hannah Arendt says, which we all hold in common without anyone owning it.⁹

During the next decade, we will likely see profound changes in the organization and financing of health care in North Carolina. Some believe that national health insurance will prevail, while others—looking at the initiatives of Oregon—believe that each state will become its own organizational unit for health policy. In either case, it is clear that realigning rights and responsibilities is essential. □

FOOTNOTES

¹ Louis Harris, *Inside America*, Vintage Books, New York, 1987, p. 40.

² "Making Difficult Health Care Decisions," Louis Harris and Associates for the Harvard Community Health Plan Foundation and the Loran Commission, June 1987, p. 8.

³ Arthur Barsky, "The Paradox of Health," *New England Journal of Medicine*, Vol. 318, No. 7, 1988, pp. 414–418.

⁴ For more on these rights guaranteed under the N.C. Constitution, see Katherine White, "North Carolina's Constitution Comes of Age," *North Carolina Insight*, Vol. 10, No. 2–3, p. 118.

⁵ Richard Lamm, "Critical Decisions in Medical Care: Birth to Death," *Southern Medical Journal*, Vol. 82, No. 7, 1989, pp. 822–24.

⁶ An earlier form of this discussion of rights linked to individual responsibility for health was published in *Innovative Partnerships for Affordable Health Care*, program and background papers for the National Governors' Association meeting, Sept. 23–24, 1990, Washington, D.C., p. 48.

⁷ Dan Beauchamp, "Public Health as Social Justice," *Inquiry*, Vol. 13, No. 1, pp. 4–6.

⁸ This emphasis on citizenship as an essential aspect of a health care ethic is developed in detail in Marion Danis and L.R. Churchill, "Autonomy and the Common Weal," *Hastings Center Report*, January/February 1991, pp. 25–31.

⁹ Hannah Arendt, "Public Rights and Private Interests," in Michael Mooney and Florian Stuber, eds., *Small Comfort for Hard Times; Humanists on Public Policy*, Columbia University Press, New York, 1977, p. 104.

Given the escalating costs of health care, more of the same for more people is a recipe for economic disaster.
