I am not sure that health care can profitably be discussed in the context of rights. For one thing, it is a term of many and shifting meanings, and thus virtually guarantees some degree of misunderstanding and confusion. For another, the very uttering of "rights" carries tones of ethical seriousness, if not outright superiority, that gives its advocates a substantial and unearned advantage in debate. Contemporary political scientists, as a result, have tended to feel more comfortable with "claims" (cf. [82]). Yet "rights" is what this book is about, and so "rights" must set the terms of the discussion.

What I hope to do in this paper is to discuss two kinds of rights to health care and how assertions of each has implications for reform proposals that, in turn, are tied to macroallocative resource allocations.

In one sense, this may suggest talk of apples and oranges, for rights and macroallocations would appear to occupy rather different planes of thought. Rights, after all, at least in the United States, normally are announced as attributes of individual persons (e.g., Regents of the University of California v. Bakke [98], while macroallocations concern large populations, perhaps entire societies. An instant's reflection, though, is enough to establish the connection: accepting or rejecting the principle of a right to health care may have important consequences regarding the allocation of resources necessary to enforce that right.

I. THE RIGHT TO HEALTH CARE

What, then, is a right to health care? The answer necessarily is of two parts. It is an obligation on the part of society, negatively or procedurally, not to interfere with the individual's pursuit of health care and, positively or substantively, to provide that care when the individual demands it (cf. [34], pp. 243–244; [120]).

This view of rights is connected with the notion of obligation in three senses. First, a right is seen as simply an obligation perceived from the beneficiary's perspective; to switch metaphors, rights and obligations are ordinarily no more than opposite sides of the same coin. My assertion of a
right to a liver transplant, for example, is just another way of saying that some person or persons (or society itself) are obligated to obtain the organ, perform the surgery, and so on. As Radin declared of rights and obligations, "The two terms are as identical in what they seek to describe as the active and passive forms of indicating an act; 'A was murdered by B'; or 'B murdered A'" ([96], p. 1141).

Second, the enjoyment of a right is generally seen as creating a duty to meet one's own obligations. For rights do not exist in isolation but are part of a vast web of rules that, certainly in the liberal democracies we are most familiar with, presuppose some significant degree of reciprocity. Thus, I may not wish to fulfill my obligation to you, but I have an interest in your meeting your obligations to me and, indeed, in preserving a whole interlocking structure of mutual obligations, and this compels me to put my short term wishes aside and meet my obligation to you. (Perhaps, this merely restates the Golden Rule). This connection of right to obligation may not be composed of logic but merely prudence (or prudence masquerading as compassion). It is, however, no less strong for that.

Third, the right reflects a moral obligation on the part of the entire society. It is not an in personam right that one person may claim against another, but rather an in rem right that one may claim against the whole community.

II. AN UNQUALIFIED RIGHT TO HEALTH CARE?

Now, I indicated that there were two kinds of rights to health care. The first I call an unqualified right, because the societal obligations are stated in more or less absolute form without mention of conditions or limitations (cf. [125], [86], [117], [76]). With perhaps a few peripheral exclusionary criteria, such as a residency requirement, an unqualified right operates quite irrespective of the personal qualities of the claimant. Age, race, ability to pay, moral worth, contribution to society – these characteristics and dozens more are simply irrelevant. The only decisive variable is medical need (I shall not consider the sometimes vexing question of how this is to be determined).

One argument for this position is that in order for an individual to utilize his political rights fully, he must first be educated, adequately fed, decently housed and clothed, and, perhaps above all, receive good health care. The very existence of political rights, therefore, is said to imply these correlative rights as a collection of necessary preconditions.