Defining Basic Health Care As a Right: An Analysis of Health Care Access and Rights Philosophy in Germany and the United States

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Abstract

At the conclusion of the novel The Healing of America, T.R. Reid challenges the American people to decide whether health care is a human right prior to any appropriate service reform occurring. From Reid’s perspective, the design of any nation’s health service system is primarily dictated by the morals of society. In a response to Reid’s challenge, this analysis looks at the historical development of the human rights construct and how rights language is associated with health and health care access. Specifically, this investigation looks at the nature of negative versus positive rights, and the distinction between human rights and political-legal rights. In an effort to look beyond the health service system of the US, this analysis also investigates how the German Health Service is shaped. In comparing the two nations, the goal of this study was to see whether rights language, particularly the language of human rights, factors into how both nations systems are structured. Using secondary research of academic and philosophical literature, this study brought together a wide array of data to investigate the abstract concepts of rights language and health. Based on the research conducted, there are great difficulties in establishing grounds for health care access as a human right. As it pertains to rights language, it is more efficient to stipulate health care access as a political-legal right based on the societal value of compassionate beneficence. This creates a decent minimum of services individuals have a right to access due to the charity of society. Looking at Germany and US, the German Health Service is a national health service based on health care access being a political-legal right, were the system seeks to provide a decent minimum of service to promote health to a larger degree the “patchwork” system of the US.
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I understand that my thesis will become part of the collection of Oregon State University. My signature below authorizes release of my thesis to any reader upon request. I also affirm that the work represented in this thesis is my own work.

__________________________________________________________________
Jeff R. Wagner, Author
A special thanks to Courtney Campbell for the thought provoking discussions we shared in working on this project. Also, to my mother and father who have supported my desire to learn. I love you both very much.

Lastly, however, I dedicate this study to this generation of Americans who have the opportunity to change the way health care is accessed. It is my hope that many will continue to seek the answers to these tough questions as we strive to improve the livelihood and health of our world for future generations.
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BACKGROUND

In T.R. Reid’s, *The Healing of America*, Reid sets out on a global tour to see how industrialized democracies organize their health services systems. His goal is to learn how other nations have constructed their health systems in the hopes that he will be able to find ideas for how the US can reform its own health service system. In his own words, “The design of any nation’s health care system involves political, economic, and medical decisions. But the primary issue for any health system is a moral one” (10). Through the book, Reid presents his case for what lessons the United States can learn from the health service systems of other nations, and what problems exist with the current system in the US. In the concluding chapter, Reid offers this analysis of how the US should address issues of its health service system.

“Which inequalities will (American) society tolerate? That question encompasses a more basic question: Is health care (access to care) a human right? Professor William Hsiao, a Harvard economist, says the creation of a national health care system involves political, economic, and medical decisions, but the primary decision to be made is a moral one. Do people in your country have a right to health care? If the people believe that health care is a basic right, you design a system that means anybody who is sick can see a doctor” (10).

The above description serves as the basis for this thesis. In essence, Reid’s interpretation is that a health service should be based on the concept of human rights. However, he does not offer answers to the question, “what are human rights?” What dictates what is and is not a human right? In regards to health service systems, do other factors, besides morals and economic interests, provide support for how a system is structured? Such questions allude to the fact that the concept of such rights are complex in nature, and require investigation prior to one’s ability
to determine if access to health care is indeed a human right as Reid challenges Americans to
determine.

Human rights are a construct of the 20th century, and historically stem from the idea of
natural rights. The concept of natural rights was first presented by philosophers John Locke,
Jean-Jacques Rousseau, and Thomas Hobbes. According to Hobbes, natural rights include a
right of self-preservation, which cannot be traded for security under rule of a sovereign in civil
society (12). In essence, the language of natural rights is based on the idea that human beings
have protections by their nature as human beings prior to the formation of any society. These
17th and 18th century philosophers were concerned about the tyranny of kings and rulers over
their subjects, and sought to justify the claims of individuals to preserve bodily security. In an
ideal world, the combination of natural law and natural rights set the limitations for government.
Moving through time, natural rights language becomes ingrained in American public thought
with the Declaration of Independence. When Thomas Jefferson wrote of “unalienable rights” he
was referring to the natural rights each human being possesses. However, the transition of
natural rights to human rights philosophy requires greater distinction.

As noted, natural rights were moral barriers that philosophers used to state claims against
the medieval societal structure where kings exploited their subjects. These claims, that sought to
provide bodily security of the subjects, were claims of noninterference. For example, if I claim
the government should not place video cameras in my house because it was an invasion of my
privacy, it would hinder the government’s effort to interfere in my life. In essence, natural rights
strove to give subjects claims against the wrongful actions of the king, or government. Rights
that serve to protect individuals against others are termed negative rights. The transition of
natural rights to human rights is distinguished by a shift in logic from negative to positive rights.
Human rights are termed positive rights, the opposite logic of natural rights. This is because human rights do not seek to keep others out of an individual’s life, but require others to provide assistance. For example, if I claim to have a human right to health care access, this requires another individual provide care to me, and thus I am relying on that other individual to take action on my behalf. Positive rights are rights to assistance. The greatest question with human rights, and all rights that are positive in nature, is who is required to assist once a claim against such rights is made? This question will be addressed in the discussion section of this investigation.

Historically, as World War II brought the world into a global conflict, many injustices occurred that caused rights language to become common in political and public discourse. In order to evade the tyrannical abuse of power, as witnessed with Nazi Germany, Fascist Italy, and Communist Russia, the democratic powers of the world developed the concept of human rights. The human rights concept is an attempt to instill the philosophy of natural rights in the modern world, and denote that these rights are of global significance. Human rights were the attempt of westernized democracies to create a world society, where every man and woman would have a decent minimum of living guaranteed by government (6). Winston defines human rights as, “a universal moral right that belongs equally to all human beings by virtue of the fact they are human” (12). It is important to note that possessing intrinsic rights as humans does not guarantee an individual will have those rights protected in society. Instances of slavery, racism, and sexism are examples of how equality, based on moral rights, does not always take place in reality. This is because human rights are not always recognized by political systems. Nonetheless, the attempt to define human rights in the post war era strove to globally promote all people have certain dignities they are entitled to.
Another category of rights are those protected by the laws of a particular polity or government. Such rights are known as political-legal rights. Political-legal rights are recognized and exercised under law, where the law is established by the governing institutions of a democratic society (12). This means that when an individual’s rights are violated they are able to make a claim to an institution that is obligated to act on their behalf because it is a violation of law. Additionally a positive right, political-legal rights require others to intervene on another’s behalf. The distinction, however, between human and political-legal rights is that individuals claim a violation of the law in the case of political-legal rights, as opposed to a violation of their inherent dignity as human beings. At this juncture of rights language, as it pertains to Reid’s challenge, the question to ask is whether health is classified as a human or political-legal right? If the maintenance of health is intrinsic to who we are as human beings, and it is recognized that each and every human being has the right to ensure his or her health, then one could argue health is a human right. Prior to determining whether health care access is a right, it is imperative to additionally determine whether health is a human right, since the supposed goal of providing access health care is to ensure preservation of health. Thus, one cannot conclude that health care access is a human right prior to concluding that health is a human right. The World Health Organization (WHO) defines health as the “state of complete physical, mental, and social well-being” (2). With this definition in mind, can health care access provide health to the individuals (patients) that receive care? Are there other factors that dictate health besides access to care, and if so, which factors are most significant in the outcome of an individual’s health? In summary, looking at the concept of human rights related to health care access, access must ensure the preservation of health based on understanding health as a human right.
An argument that has been put forth to defend why health care access is a human right is found in the *Universal Declaration of Human Rights*, Article 25. It states, “Everyone (all humans) have the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing, and medical care”(9). The declaration asserts that health is a human right, and additionally that access to health care services is a determinant of an individual’s health. The argument for why health, and thus health care access, can be defined as a human right is based on the concept of human dignity. Marks states, “Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (9). Thus, the argument identifies the preservation of health as the preservation of human dignity where access to health services help determine the health of an individual.

In contrast, Grace Burdys presents a case that health care access is not such a large determinant of an individual’s health (2). However, she does note that those with access to services have improved health compared to those lacking access (2). The case she focuses on pertains to those with health insurance, a form of coverage to ensure access to health care. The question asked is, if universal access is given to all members of society, does their health improve? Again, if health care access does not improve the health of those that are making a claim to such rights, their claim becomes void as it pertains to human rights language. From her perspective, Burdys sees health care delivery as mismatched with the health needs of the modern world. In citing a study conducted by the RAND Corporation in 1983, Burdys illustrates that access to health care services did not improve the health of those who were not poor, making it so the model in which health services are delivered is unfit to ensure the preservation of health

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1 Human dignity: intrinsic worth, or the special moral status humans possess that separates all humans from inanimate objects, plants, and other members of the animal kingdom (12).
The model of health care was faulted for not improving patient’s health, causing the study to conclude reform was needed in how care is delivered in the US. As far as reform, Burdys asserts that the Stress Model of delivery of care delivery improves the health of all individuals in the population, and not just the poor, making it the best model for a system based on defining health care access as a human right. The model, and its specific details, will be presented in the results section of this investigation.

A third argument has been proposed that does not see health care access as a moral (or human) right, but rather that it is a political-legal right. In Rights to Health Care in a Democratic Society, JF Childress stirs the debate away from arguing access based on moral rights because of the complexity needed to determine morally appropriate policies with in, what he terms, “a flawed system” (4). In his essay, Childress proposes various arguments for why a democratic society could see health care access as a political-legal right. Fairness and the natural lottery are the two most accepted arguments for general rights to health care services. Fairness is the equal opportunity of individuals to pursue their health, which requires the provision of health care to maintain, restore, or compensate for the loss of normal functioning (4). Though this sounds familiar to the logic of human rights, the coupling of the natural lottery with fairness drives the focus toward viewing access as political-legal right. Defined by H. Tristram Englehardt Jr, the natural lottery refers to the various health needs of the population that result largely from impersonal factors which are the result of chance (4). The needs one individual requires to preserve his or her health will differ from another individual, and thus society must choose whether it is a right for those with greater needs to receive care at the expense of society as a whole. In essence, if an individual has increased health needs due to a spectrum of evolutionary factors, the society has to choose whether to let nature run its course, or if it will allow the
individual to receive care based on his or her political-legal right to do so? Answers to this question will be put forth in the discussion section.

As described by Reid in *The Healing of America*, other countries have health service systems in place that provide increased access at decreased cost compared to the US. Reid argues that the US can learn best how to go about its own health service reform by learning from other developed nations. Again, however, the question arises whether other nations provide access based on the human rights each individual possesses or on political-legal rights upheld by the institutions of the state? Reid points to Germany as a nation similar to the United States in many aspects, but that is distinguished by their health service systems. Practically, I believe Germany offers the US a more practical model of health care delivery other nations cannot. Like Reid, I think it wise to look at the broad array of health service systems in place to comprehend the pros and cons of each system structure so problems can be avoided in reform. Germany has the third largest gross domestic product (GDP) in the world as of 2010 at $3,309,669 million (13). The US has the largest GDP, making it the wealthiest country in the world at $14,582,400 million (13). Being ranked in the top three nations economically, both countries have economic interests that govern much of much of their societal norms. Both nations are also part of the western world, with many historical exchanges and cultural norms being correlated between the two. An example would be that both nations were founded under the principles of Christianity (8). I believe cultural similarities would allow an increased likelihood of successful transition for reform to take place because the cultural values of American society will be upheld to a greater degree if another culture has similar interests they desire to protect. In the case of Germany and

2 Gross Domestic Product (GDP): refers to the market value of all final goods and services produced in a given period (2)
the US, I suspect that economic interests will influence the structure of health service systems to a large degree, making their governmental policies more compatible with US than those of Italy for example, which is more socialist in practice. Whether the issue of human rights becomes anterior to those interests as it’s related to health care access will be the basis of analysis between Germany and the US.

*The Healing of America* challenges the American public to answer the question of whether health care access is a human right. Based on the information and questions proposed above, the objectives of this thesis are to demonstrate that access to health care is a human right that best operates within the Stress Model of health care delivery. In conducting the analysis of the German Health Service and US Health Service, the objectives are to illustrate that Germany has a system that provides access to health care more closely aligned with the logic of preserving human rights.

**METHODS**

Performing an investigation of human rights and health care access is different than research of a scientific nature. In science, steps in an experiment generate factual data that serve as the basis for which the investigator can draw conclusions on his or her hypothesis. However, scientific data is unfortunately not the result of the analysis conducted in philosophical investigation. This is because the nature of the questions this project seeks to answer are not scientific, but abstract. With this being said, there are a variety of ways this study could answer the questions presented. I have chosen the direction that the investigation has been conducted, and thus, the conclusions that can be drawn based on my understanding and research of these abstract concepts. The literature presented, in the defense of the conclusions drawn, reflects a representative number of sources published on the topic. This is important to note due to the fact
other sources will offer points not discussed in our investigation here, and future studies may focus on other logical arguments. Again, the nature of abstract thought gives this study an increased degree of complexity, and I do not wish the reader to conclude that these methods presented are the sole avenue to perform an investigation on this topic. Nonetheless, I have broken this research study into two parts. Both parts utilize secondary research from the literature of the human rights philosophy, health and human rights, health system structure, as well as health care access related to human rights. Sources used are solely those from academic articles and academically reviewed literature.

The first part, related to the first stated hypothesis, involves the investigation of human rights related to health care access. It is essential to clearly define what a human right is prior to concluding rights logic is correlated with health service access. To become ingrained in rights philosophy and language, I researched various texts and chose to use Morton Winston’s The Philosophy of Human Rights for my basis of understanding the history and concept of human rights. Following this train of thought, defining political-legal rights as a concept is next. For the comprehension of political-legal rights I additionally referred to Winston, but also used Rights to Health Care in a Democratic Society by JF Childress to highlight the differences between the two rights concepts. With an overview of rights philosophy, the correlation between health and rights and whether health care access is human or political-legal is the subsequent subject of investigation.

Research regarding defining health as a human right can lead to many abstract ideas. First, we need to define what health is in and of itself. Many definitions exist, and thus I sought to find the most used definition in the literature. Traditionally, health has been defined as the absence of disease (2). Literature sources included those primary documents from institutions, such as
WHO, which have a global presence to promote health worldwide. The predominant definition used during the status quo is that of WHO (given in the background section)\(^3\). Being that this is the most widely used definition for health in the literature, I feel it is the most appropriate to use for our purposes. If there are problems with this definition, however, it will be important to identify them, as certain issues will dictate whether the concept of health is indeed correlated with the concept of rights. It is worth note that many individuals, such as Grace Burdys, see that there are issues with the WHO definition. To investigate certain aspects of health not included in the WHO definition, I referred to *Unequal Health: How Inequality Contributes to Health or Illness* by Grace Burdys. Additionally, I also referred to the Childress article for insights on this issue.

The subsequent research step is to investigate whether health care access is a determinant of health. This is based on the assumption that health is *human right*, and not ensuring access to health care compromises an individual’s health, thus violating their *rights*. The primary source I used was the Childress article. With health care access being a determinant of health, a subsequent question is what model of health care delivery should serve as the basis of a health service system? The model of delivery reflects the philosophy of access and rights in society because the services that are accessible reflect the health needs of individuals society is willing to meet. Texts that discuss the needs patients require of health systems provide a platform to analyze service models for whether they are able to meet those needs. These provide our study with a delivery model of care that is based on *human rights* or *political-legal rights*. Organization, management, and financing information of this model system will be based on literature that identifies the health needs of the modern world and how they can best be met, such

\(^3\) WHO definition of health: the state of complete physical, mental, and social well-being (2)
as *The Spirit Level* by Richard Wilkinson and Kate Pickett. If it is determined that health care access is not a *human right*, the system will reflect whether health care access is a *political-legal, right* or that individuals have no claim regarding access to services. This will conclude the research for the first part of the thesis investigation.

The second part of the research looks at the health services of both Germany and the US. The framework of the study looks at the historical development of their systems. If *rights* language and debate played a role in the structuring of either system, that should be realized in the practice of how individuals claim rights to certain services. Thus at this juncture, the main goal of each system should be identified. To accomplish this, I will look at the organization, management, and financing of each system. These three factors will provide a basis to outline whether access is a priority and what restrictions maybe present to an individual achieving access to health care.

Bruce Fried and Laura Gaydos in *World Health Systems* is the source I used primarily to obtain this information, as well as information from P.L. Barton and Richard Knox. With an overview of each system’s health service philosophy and structure, as well as the general health of each nation, the next step is to look at the health needs of each nation. Statistics of the most common causes of mortality and categorized counts of various reasons individuals seek certain services will serve as the basis for this information. I will utilize information available in the literature from Fried and Gaydos, Knox, Barton, statistics from the Center for Disease Control and Prevention 2011 Report, and *The Spirit Level*. Comparison between these two health services and the *rights*-based system articulated in part one will conclude part two, and will hopefully point to potential changes that can be implemented in health care reform if health care access is part of the *rights* concept. Additionally, however, I will identify whether one system incorporates more aspects of the model system based on rights language, verifying or discrediting the second
hypothesis statement: that Germany has a health service system that provides access to care more closely aligned with the logic of recognizing human rights.

RESULTS

HEALTH CARE AND RIGHTS

Research regarding rights and access to health care encompasses a vast expanse of literature. In this section, I will present some of the thoughts from academically reviewed texts. However, there are other logical arguments that have been put forth by experts to defend what an individual’s rights, or lack of rights, are to health care access. I encourage you, the reader, to continue your own investigation into this topic outside of the information presented in this study.

Winston defines human rights as “a universal moral right that belongs equally to all human beings by the virtue of the fact they are human” (12). Being positive rights in nature, human rights require, or obligate, another to act on behalf of the individual claiming a violation of such rights. The primary text I located in the literature that supported health care access as a human right was the Universal Declaration of Human Rights. Stipulating that “every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity”, this document asserts “medical care is a moral right all humans possess to ensure a standard of living for adequate health” (9). However, it is important to address the distinction between medical care and health care. Medical care are services that ensure an individual’s physical well-being. A health service system that strictly provides medical care operates within the Medical Model of health care delivery. The Medical Model focuses on the absence of disease by assuming the following. First, there must be observable signs that disease is present (2). This serves as an indication that an individual’s health is compromised. Second, only physicians can diagnose disease (2). This serves the purpose of making physicians obligated to provide care
when an individual’s physical health has been compromised. Recall that human rights are positive rights, requiring a separate party to act on behalf of the individual making a claim. And third, disease is solely a physiological problem (2). This shows how medical care is provided on a strictly physiological basis. If a patient is physiologically healthy, as determined by a doctor, then the individual has no right to claim services be provided since the patients are classified as healthy. This is different than health care, recalling that health is not solely a physical phenomenon according to the WHO’s definition⁴. Health care not only provides services for physiological conditions, but also services to ensure the mental and social well-being of patients. The Declaration solely provides support for the statement that medical care is a human right, but fails to address the issue of health care being a human right. The Declaration does assert that an adequate standard of living is necessary to ensure the right to health, but does not list health care as a specific means to ensure those rights. However, the essay Rights to Health Care in a Democratic Society provides a thorough analysis why health care is or is not a right.

Childress begins the article by describing the problem with trying to decide whether health care is a moral right. Childress states, “Some-and I am among them- hold that the system (US Health Service) is morally flawed and unjust” (4). In concluding the system is morally flawed, Childress argues that it is too difficult to determine morally appropriate policies within a flawed system (4). By introducing the topic in this manner, Childress’ argument in regards to rights to health care access is not based on moral rights. Instead, Childress argues that health care access is a political-legal right. Again, because both human rights and political-legal rights are categorized as positive rights, members of society are required to intervene to promote another individual’s welfare (4). The holder of these rights can justifiably claim actions from others, and

⁴ WHO definition of health: state of complete physical, mental, and social well-being (2)
thus, they are justified by appeals to principles and rules. For Childress, this is a key point to note. In practice, if the rights of individuals are to be recognized by society, those rights must be upheld by the law. Arguing health care access is a moral right does not guarantee that those rights will be recognized by society, and thus is not necessary to bolster support for the realization of improving health care access. With this being Childress’ view on human rights related to health care access, he cites two grounds on which one can claim health care access is a political-legal right. The first is specific rights to health care (4). Childress explains, “This spot zoning or, to change the metaphor, patchwork, of specific rights may be fairly extensive, though still short of universal” (4). This illustrates a model of health care access based on specific groups of individuals in society. Examples would be the poor, veterans, and other groups of individuals society deems should have access to services protected by the law. This is currently the only justification the US has to ensure rights to health care access, except in instances of emergency care where universal access is given⁵. The second is grounds for general rights to health care⁶. A general right to ensure health care access, based on the fact it is a political-legal right, encompasses a wide array of arguments that Childress cites. I have summarized them in the flowing paragraph.

The first appeal for general health care access as a political-legal right is fairness and the natural lottery. The major argument for such rights, as Childress points out, it hinges on the principle of fairness applied to the health care needs of society (4). By stipulating that health crises are generally undeserved, randomly distributed, unpredictable, and overwhelmingly important

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⁵ Emergency care in the US: Emergent care, or crisis, medicine is the only care in the US where universal access to health services is ensured
⁶ General rights to access care are the same as universal rights. Meaning all individuals have the rights to make a claim to ensure access (4)
when they appear, the patient has a right to claim others provide care to prevent such crises from occurring. Another argument Childress addresses for general access to health care is the principle of fairness in relation to the nature and source of health needs. Childress explains, “Differences in health status, and thus differences in health care needs, are largely undeserved because they are, for the most part, not within the individual’s control” (4). In essence, both these first two arguments put forth place the fault of an individual’s compromised health on external factors, appealing to the health care profession to act on behalf of these individuals. A third argument proposed is termed *compassionate beneficence*. Its focus is on compassion, benevolence, and sharing, rather than on fairness, and views health as unfortunate rather than unfair (4). The appeal is to charity on the patient’s behalf, rather than correcting the injustice committed against those with compromised health. There are two ways that this argument can be extended to the state, or societal level, making it become law. Through social virtue, Childress argues that extending compassion into law can be used to represent the type of society in which we (IE. Americans) wish to live (4). Another way Childress cites as a way to extend *compassionate beneficence* to the state is through the need of coordination in effective realization of individual and associational goals (4). This *enforced beneficence* argument supports stipulating that access to health care is a *political-legal right* because it assumes care cannot be delivered effectively without a coordinated effort on behalf of the state (4). These arguments serve as the basis for our understanding of why health care access should be a *political-legal right*. Yet, as Childress goes on to discuss, another important question needs to be addressed once assuming access is such a right: What services does society have a right to based on their health needs?

Childress believes that health needs are heterogeneous, meaning not all needs are equally basic, important, or urgent (4). With the nature of health needs being highly variable within
different societies and cultures, the idea of a *decent minimum* is proposed as one solution to the problem. A *decent minimum* is a standard of care that is *adequate* in level, kind, and quality to preserve the rights of individuals to be healthy (4). Standard care should be based on the health needs of society, where other desires for services fall outside the scope of basic needs. In other words, the *decent minimum* meets the most basic health needs of a population and creates a distinction between what society defines as a need and a desire. In correspondence with ensuring access to health care because it is a *political-legal right*, the system allows fair and equal opportunity to access services for needs, but does not entitle individuals to access care that satisfy wants and preferences (4). At this juncture, Childress defines access to health care based on it being a *political-legal right*, where the services provided based on that right are to meet health needs. What constitutes these basic health needs of a system is a subject of debate addressed in *The Spirit Level* and *Unequal Health*.

Needs are separate from desires, and thus services that meet the health needs of society should ensure the rights to the preservation of health. Since health preservation includes physical, mental, and social well-being needs, the services provided by stipulating health care is a *political-legal right* should meet those needs. In *The Spirit Level*, Richard Wilkinson and Kate Pickett look to defend their thesis that greater equality makes society stronger (11). Relating to our topic, ensuring equal access to health care serves as one example of improving society according to their argument. One of the services provided by health care professionals once individuals have access to health care are those for mental illness. Mental health, as it pertains to the WHO definition of health, is defined by Wilkinson and Pickett as something you do, it is to value and accept one’s self (11). Though a topic that requires ongoing research, providing care to those who lack mental health helps meet the needs of a population by ensuring our definition of
health is maintained. Social well-being is connected with mental health, according to Wilkinson & Pickett, when “others are kept at a distance, we (humans) get trapped in a vicious circle of loneliness” (11). Social well-being is an abstract construct that requires further investigation. For simplicity, our understanding of social needs to ensure well-being will be based on the description provided in The Spirit Level. Lastly, Wilkinson & Pickett point to stress as a major cause of chronic disease that compromises an individual’s physical well-being (11). Thus, the physical needs of modern society can, in part, be addressed by reducing stress in people’s lives. The Spirit Level argues that stress is largely due to socioeconomic inequality, and that creating a society where wealth is more evenly distributed would reduce stress, and thus reduce the incidence of chronic disease (11). Next, with the health needs of developed nations discussed, what model of delivery should these services be structured in when needed?

Grace Burdys asserts that the Stress Model of health care delivery best meets those health needs described in The Spirit Level. As opposed to the medical model, where the focus is on the absence of disease, stress modeled delivery focuses on a general feeling of well-being (2). An excerpt from Unequal Health gives a more thorough description of the Stress Model’s philosophy.

“This model assumes that well-being depends on the situational context, which can only be determined by an individual’s own view on the situation. That is, what ultimately establishes whether the person experiences stress and whether that experience will have detrimental health effects is the individual, or patient. The model acknowledges the importance of feelings, specifically of well-being, as indicated by the amount of stress a person experiences” (2).
Despite Burdys’ assertion that the Stress Model of delivery is the best way to improve the overall health of individuals once they access health services, she additionally cites two problems that currently exist for the implementation of such a model. First, efforts to measure stress levels are not well enough developed to produce an objective measure of stress that would permit comparison of one person’s stress level versus another (2). Second, the model does not pinpoint who is sick and what kind of treatment will take care of the problem (2). Refer to the discussion section for conclusions drawn from the above results in regards to whether health care access is a human right that best is delivered using the Stress Model.

**German Health Service System**

Richard Knox gives a thorough review of the development of the German Health Service. I will summarize the parts I find pertinent to the topic of rights and health care modeling. The German system was established in 1883. The German Chancellor Otto von Bismarck persuaded Parliament to enact a national system of health insurance that has lasted to the modern day, though various changes and reforms have taken place to modify specific needs of the general population (8). Pressures that led to the adoption of compulsory health care in the German nation were linked to a changing societal and economic landscape that was transitioning from an agrarian society to an industrialized power. This transition made many people no longer self reliant, but rather made a living by being employed and consuming produced goods. Much social unrest was generated by poor working conditions, causing many citizens to call out to the government for help. As a way to meet the cries of his people, von Bismarck pushed for increased access to health care for the whole population (8). It is important to note, it was not a universal coverage
system that was proposed, but one that strove to make access available to all individuals participating (or who had participated) in the labor force.

In the realization of the health service, a compromise between the interests of government and individuals from the private business sector was made. Bismarck desired that government have a more administrative role in peoples lives, while those in the private market wanted some control of the funds allocated for the provision of health services (8). These two conflicting interests lead to the following compromise: the government prescribes policy of the health service system but autonomous private parties finance and deliver these services (8). Through much debate, the German system was developed under the sickness fund model, which operated under compulsory funding. Compulsory funding means all wage-earning employees were required to pay into their sickness fund regardless of their income (8). These funds are administered by employers and employees where each fund is equally arranged, thus giving German society a standard of welfare coverage.

This brief history alludes to the issues that lead to the development of the German Health Service. Though the idea was to increase access to care for many citizens (88% are covered by sickness funds today), the issues of human rights were not of primary concern. However, there is much talk of the economic interests involved in the health system. By establishing funding for coverage based on employment of Germany’s workforce, the system met the civil need citizens called for. Also, by serving as a hybrid between the desires of the government and private industry, the German system attempts to promote a standard of care attained for all German workers and those that are dependent upon those workers. In essence, the system thus seeks to provide a decent minimum of access by mandating employers and employees pay into the sickness fund. However, an important issue at this point has not been addressed-health care
costs. Theoretically, if costs for care increase to a value greater than the funds allocated for care, the system would fail to be sustainable. In 1977, a provision was added by the federal government that limited the cost of care to a level no greater than the reimbursement of the average German wage earner. Thus, the overall goal of the German system at this juncture becomes economic stability, limiting cost while ensuring access, while improving the health of the population. This serves as our basis for understanding of the German Health Service structure, which will be reviewed next.

Germany has a highly complex system in place. By the nature of the compromise discussed above, the classification of Germany as having either a public or private health service does not work since it is a hybrid of the two. An example of a system that can be classified as solely public is the United Kingdom’s National Health Service, or NHS. The NHS provides health care for all citizens on the basis of need, rather than ability to pay (7). Inversely, an example of a system that is truly private is the Congolese Health System of the Democratic Republic of the Congo. The Congolese system requires patients to pay for all their health care, where the price scale is unregulated (7). Classifying the German system as a hybrid between these two, I would like to label it as a social-based system in an industrialized economy that seeks to provide health care at reasonable cost for the entire population. This means that the government has set up a welfare-based system that is run by private industry and defined by government regulation. Here is a simplified version of how Germany’s system operates within this definition as discussed in World Health Systems.

“The focal point of the social insurance system are the sickness funds, which are administered by employers and employees in accordance with the arrangement of equally divided financing among them. The health of the
population is primarily the responsibility of the Länder, but mandatory health insurance and hospital financing are controlled by federal laws. The Länder is a different entity than insurance companies because its mode of distributing funds is not based on risk, but rather on need ” (7).

This illustrates how the system is both part public and private. The Länder is effectively a separate entity apart from the federal government that receives and distributes sickness funds to its members. The role of the federal government is then to regulate how the Länder operates. Utilizing this system concept, more than 750 sickness funds have been set up that provide health care to about 90 percent of the population (7). Care covered by the sickness funds includes all of the following: unlimited ambulatory physician care without copayment, unlimited hospital care limited to a 10 day stay, maternity care, prescription drugs with minor copayment, medical supplies and devices, preventative care, family planning services, rehabilitative services, and periodic rest cures at certified health spas (8). All these services establish a decent minimum of care, and they are included as part of the systems structure with a goal of remaining economically stable. The other 10 percent of Germans receive access to health care by buying private voluntary insurance (7). These private insurance plans are more expensive, but offer an alternative to the government mandated system. As an incentive for people to buy this voluntary medical insurance, plans include a wider array of services and strive to provide an increased quality of care. Thus, the German system increases the competition of the private sector by forcing companies to increase the quality of care provided to patients. This transitions into the next research question of how these services are delivered. In this aspect, the US and Germany are very similar excluding some structural details.
Knox explains the delivery of care in the German system, focusing on the distinction between ambulatory doctors and hospital physicians. Ambulatory doctors are private entrepreneurs who are paid on a fee-for-service basis, where the fee amount is established by the Länder (8). Hospital physicians are a mixture of publicly employed, private non-profit, and private for profit practitioners. A line is drawn between these two, making it so physicians who practice in hospitals cannot treat patients on an outpatient basis, and office-based physicians may not treat their patients once they’ve entered the hospital. This is due to the different style of care offered between the two. Inpatient care in Germany is less intensive due to state control over the inpatient infrastructure that is seeking to increase efficiency and reverse the overcapacity problem. This is because German hospitals have a high occupancy rate and patients spend an extended amount of time under the care of hospital physicians once admitted (7). Moving patients out of hospitals and putting them under the care of ambulatory doctors allows the system to decrease spending, while focusing on more preventative measures to meet the needs of patients to improve their health. Like most industrialized powers of the modern world, the greatest health needs of the German population are those pertaining to chronic illness—heart disease, cancer, and mental illness (7). As of 2002 cardiovascular disease was the leading cause of mortality (7). Conclusions drawn for the analysis of the above information for health care as a right will be presented in the discussion section of this paper.

**THE UNITED STATES HEALTH SERVICE SYSTEM**

In looking at the US system, one feature greatly separates it from others in the world: high costs. Americans have traditionally paid more than any other nation for access to health care. The US health service is a market-based system in an industrialized economy that was established in the early 1900s. The complexity of the system arises from its founding principle,
which is that access to care in the United States is provided by the private sector, which has only slightly changed over time (7). Though the private sector provides the majority of insurance to most Americans, thus providing access, some government programs have been established to help those without insurance. However, political and macroeconomic factors still greatly dictate whether individuals have access. In 2010, there were 48.6 million Americans without health insurance (3). Human rights language is used in public debate for why the US should adopt a form of universal health coverage, as it is identified in the Universal Declaration of Human Rights. Historically, the human rights debate, however, has had little to do with the development of the system’s structure. As Burdys defines in Unequal Health, the US Health Service (like most systems) has goals of accomplishing the following: providing access, reducing cost, and increasing the quality of care provided (2). However, as mentioned above, macroeconomic and political factors dictate whether access is available to individuals, despite the goals the system strives to achieve. She attributes this to the fact, “The US has no National Health System” (2). In the post World War II era, all other democratic westernized nations adopted a national health service (The UK, France, Germany, Spain, Canada, etc). This was an attempt by western civilizations, as is illustrated in the construction of human rights language, to create a decent standard of livelihood worldwide. A logical question at this point in history is why did the US not do the same? In the wake of New Deal politics, which had increased the government’s ability to regulate the free market and the private sector, the American public was weary of the idea that the government would become increasingly involved in their lives (6). America was founded on the idea of reduced government, as seen in the language of natural rights used by the nations forefathers, and any expansion of government was viewed as widely unpopular. Also, immediately following Word War II, the Cold War began between the US and USSR. The red
scare, or fear of communist expansion, increased Americans fear of increasing government regulation in the lives of Americans (6). Despite these American ideological blocks to the development of a national health service, three attempts were made to make the main priority of the system to provide access, rather than protect the interests of free-market economics. The first is Health Maintenance Organizations or HMOs. HMOs were supposed to encourage people to seek care before problems became more serious, structuring the health service system around preventative care (1). Also, HMOs are privately run and not managed by the government. The second occurred in 1993 when the Clinton administration tried to pass a law allowing for universal health care coverage. This initiative eventually collapsed once the details of the plan took shape. Lastly, the only true form of universal access that has come to exist in the US is emergency care. All hospitals receiving funding from the government are obligated to provide care regardless of whether an individual can pay. This is not ideal because providing services only during the greatest instances of emergencies limits the type of care the patient can receive. Emergency care is a highly specific type of health care, and in looking at our operating definition of health, it fails to encompass all three aspects of health. Also, emergency care is one of the most costly forms of health care services provided. Economically, it is not reasonable to think the entire population will be able to pay for all emergency related expenses as a result. This highlights an important distinction between the German and US heath services: the German system increases access to services prior to the onset of illness, where the US solely gives access during times of crisis. With background on the historical developments and restrictions of the US system, the next step is to analyze the basic system structure. As noted, this is an analysis that provides information about the system pertinent to any conclusions drawn regarding rights language and health care access.
The organization and management of the US Health Service System is dynamic; an interaction between financing structures and reimbursement mechanisms. The vast majority of Americans are insured by the private sector, meaning the government does not ensure access for its citizens. Of all Americans, 61.2 percent have private coverage according to 2010 CDC statistics (5). Private coverage can either be for-profit or non-profit. The following four modes of financing health care make up that whole 61.2 percent. The first 48 percent received private insurance through employer benefits. These benefits are provided by the employer to the employee through Preferred-Provider Organizations. Preferred-Provider Organizations are “a type of managed care in which the plan contracts with medical care providers and offers incentives to individuals who use these providers” (7). Another 23 percent of Americans are enrolled in HMOs. Individuals who enroll with a HMO provider pay a monthly premium and then a small copayment for each instance of care provided (includes ambulatory care and prescription drugs) (1). To reiterate, HMO care is preventative based medicine, attempting to reduce the instance of disability and costly care. A third segment of those privately insured acquire coverage to help ensure access through point-of-service plans (1). These plans allow a person to choose to receive services from participating or nonparticipating providers, but benefits are usually limited if a nonparticipating provider is used. Lastly, seven percent of those who receive private insurance have fee-for-service plans, also called conventional health insurance plans (1). For these plans, both the employer and the employee pay a monthly premium for insurance coverage, and the coverage pays for services as they are needed. Such a model of financing care is in some ways similar to the German Health Service System. With these four methods allowing access for solely 61.2 percent of Americans, there are other methods to discuss pertaining to the public sector.
Medicare, Medicaid, and the Veterans Health Administration are programs that are run by the federal government, serving as a type of publicly funded care in the US (1). Medicare is a national health insurance program for any citizen ages sixty-five and older who has contributed to the social security system. According to World Health Systems, 15 percent of the American population is covered by Medicare (7). The program covers some hospitalization and home health costs. Additionally, enrollees can elect to pay a premium for outpatient services and coverage for equipment costs. Next, Medicaid is a government sponsored health insurance program financed by federal and state contributions to provide basic healthcare for low income Americans. Fried and Gaydos describe the system as, “Participating states (in the Medicaid program) must provide a mandatory set of preventive, acute, and long-term health care services” (7). Medicaid covers about 19 percent of the population (7). However, because not all states participate in this program, there can be gaps in the Medicaid safety net. This means Medicaid only exists as an option for individuals in participating states, leaving those in nonparticipating areas without this option to get access to health care. Lastly, the Veterans Health Administration administers care to veterans of the US Armed Forces (7). Access to certain services and preventative education is provided by the Administration, and VHA functions are the closest example to a universal health care system operating the US. The remaining thirty percent either pay out-of-pocket for their health care or are funded by other public means (7).

With a basic overview of how Americans access health care services, it is important to establish the health needs of the population to see if the system structure meets the needs of the individuals when care is provided. In 2009, cardiovascular disease was the largest cause of mortality in the US followed by malignant neoplasms, chronic lower respiratory diseases, and cerebrovascular diseases (3). Other predominant causes of death are diabetes, Alzheimer’s, and
Accidents (unintentional injuries). Such diseases are classified as chronic disease, and like most industrialized nations, the US is seeing increased incidences of these (3). Conclusions drawn from the analysis of the above information of health care as a right will be presented in the discussion section of this paper.

**DISCUSSION**

This discussion will be broken up into two parts. The first part, as indicated in the methods section, deals with the results gathered from the health care and rights investigation. The second part will discuss the two health service systems of Germany and the US, and whether rights philosophy plays a role in the structure of either’s health service.

Looking for support for Reid’s challenge that health care access needs to be defined as a human right, *The Universal Declaration of Human Rights* does not serve as the best grounds for such an assertion. This is because the Declaration solely defines medical care as a provision individuals should be given in order to ensure their human right to health. Medical care, however, is different than health care because it solely focuses on the physical aspects of health. Health care access, in order to improve the health of individuals as we have come to understand the abstract concept of health, requires that the delivery of health care be for physical as well as mental and social components to an individual’s well being. In further investigating arguments for the rights of individuals to health care access, the Childress article asserts that health care access is a political-legal right. Like Childress, I believe it is difficult to determine morally appropriate policies in regards to health care for complex reasons. First, with health being an abstract concept that differs between individuals, if a health care system provides access to services that meet certain health needs, it would require that certain needs take priority over others. Health care access as a right, by nature, is limited in its capacity to provide care since it is a positive
right. There are only a certain number of practitioners to see a certain number of patients at a
given time. However, for Childress, the rights discussion does not hinge on the rationing of care
due to the limited capacity of practitioners (4). Yet, I assume health care must be rationed to
some degree, excluding some individuals from accessing services to meet their health needs.
Though rationing of care is a separate issue than discussing rights, the relationship between the
two makes stipulating health care access as a moral right problematic. Having access as a human,
or moral, right means everyone by nature of being human is able to claim services be provided
for their specific health needs; health needs that the health care profession could be unable to
meet. Second, arguing health care access is a human right does not ultimately lead to the
realization that such rights will be recognized. Reid’s challenge has the goal of provoking
change in the US Health Service by establishing access as a human right, yet Childress notes that
this is not only option. Thus, in using rights language related to health care access, the language
of human rights is misplaced. It is rather the language of political-legal rights that should shape
the debate around access related to rights language.

In light of viewing health care access as a political-legal right, Reid’s statement, “The
primary issue for any health system is a moral one,” is still applicable. Despite not establishing
health care access as a moral right, Childress describes how society has to answer morally based
questions prior to defending access as a political-legal right. Establishing the right to access due
to fairness and the natural lottery\(^7\) seeks to do justice on behalf of the individual whose health has
been compromised. In arguing that fairness and the natural lottery serve as the basis for saying
individuals have a political-legal right to access, society views those that are ill as innocent

\[^7\text{Fairness and the natural lottery: argument for access to health care being a political-legal right that hinges on doing justice, assuming all individuals who have compromised health are innocent. (4)}\]
victims. Thus, it is the obligation of society to act on that individuals behalf. However, one of the principle complaints I have heard amongst practitioners is that many health issues are the result of life style choices individuals have made throughout their life. An example would be a patient who smoked for thirty years and now has emphysema and chronic obstructive pulmonary disease (COPD). Does this individual have a right to access services to meet his health needs even though he contributed to the state of his health? Based on the logic of fairness and the natural lottery, the answer is no since the individual is to blame for his or her condition (4). Similar questions arise in regards to obesity. If an individual over eats, with the health risks of this lifestyle being known, should they be denied access on the same basis as the smoker? A larger number of examples could illustrate the problem with establishing rights to access based on the fairness and natural lottery perspective. To avoid further investigation into these additionally abstract topics, I do not find that fairness and the natural lottery serve as practical justifications for why health care access is a political-legal right. Awarding access to the claims of solely innocent individuals would require a Health Police to ensure those that were guilty of compromising their own health could not access services. The idea of a Health Police is not a construct I believe modern society is ready to establish.

Another appeal to the morals of society Childress presents is that of compassionate beneficence (4). I think this is much more practical for the realization of access based on rights language because it focuses on charity, rather than justice as with fairness and the natural lottery. This means that individuals can have rights to access care due to the moral claim provided by the “goodness” of society, which is distinct from an individual have an inherent claim based on virtue of being human. In constructing health care access as a political-legal right based on compassionate beneficence, society shows empathy and social virtue to those who fall ill. Such
values appeal to the morals of society, nurturing a sense of care for other individuals in the community (IE. citizens of a nation). As Childress states, “A society’s commitment to health care reflects some of its most basic attitudes about what it is to be a member of the human community” (4). In regards to rights language, I believe this is what Reid is attempting to make a point of. Society needs to figure out if it has the moral values of character and empathy in regards to the health needs of individuals. If society decides it does value such qualities, then the coordinated development of a national health service is required to ensure effective realization of the charitable goals established by society. This system will ensure a decent minimum of services the population can access. This addresses the issue of health needs being heterogeneous in nature. Contrary to human rights, having political-legal rights to health care would allow the system to specify what needs of the population it will ensure access for. Again, rationing of care in this manner is practical because health needs are so numerous and health care professionals are limited in their ability to provide care. Additionally, Childress leaves the option for those with health desires, or demands for care that fall out of the category of being a political-legal right, to still gain access. However, it would be on their own accord and not be a societal commitment to meet those desires. The decent minimum concept allows adequate care to be delivered to ensure a minimal standard among society. This minimum standard of access to care will best ensure health by promoting physical, mental, and social well-being. The model to deliver such care is the subsequent subject to address.

The Stress Model of care delivery is the optimal architectural framework to design a health service system in the developed world if the main goal is to help ensure the health of a population. I note the developed world to mean those industrialized nations where infectious disease is no longer among the leading causes of death. Health, in being abstract, is in a new era
where the greatest threat to an individual’s well-being is not an infectious agent. Rather, it is the ailments of chronic disease and daily stress that have become the greatest obstacles for life long health in modern society. Health care is more than pharmaceutical and surgical interventions; it is the care given by practitioners to help reduce the stress patients experience on a daily basis and improve lifestyles that will best treat the health needs of the modern world. In looking at the top fives causes of death in both the US and Germany\(^8\), they all have been correlated with lifestyle and stress (12, 7). Changes in the health needs of the modern era require the care individuals have rights to access shift from being solely those that are medical to care that is health based. It is important to note that before a system based on the Stress Model could be realized, further research into stress medicine and ways to interpret stress levels between individuals are required. Without a standard tool of evaluation, I argue that the system would be too easily exploited by those with illegitimate needs, and be inefficient. Nonetheless, the system should be organized at the national level, or as Burdys asserts, as a national health service (2). Being national ensures that society, as a whole, has the political-legal right to access care. The concept that one community can have such rights and another cannot, where both communities reside in the same nation, is undemocratic in regards to health care access. All human beings are vulnerable to illness, and although some individuals will have greater needs required for them to remain healthy, every member of society faces the threat of having their health be compromised at some point. Because it is a universal threat, shared among all members of society, it should be a national system that seeks to help address threats to health by ensuring access. Management, however, of such a system should occur at a more local level. This is because the specific health needs of local communities will be different. Rationing of care will occur to some degree, and by

\(^8\) Top 5 causes of mortality in the US: Cardiovascular disease, malignant neoplasms, chronic lower respiratory diseases, cerebrovascular disease, and accidents (5)
managing care at the local level, the idea is to best ensure access to care for the needs of a specific community. Health needs are not standard, though they may be similar, and thus the services provided by practitioners for those needs should not be standard either.

Lastly, how to finance such a system? Returning to our question of whether society possess the moral values and empathy to justify giving individuals to right to access care, the responsibility for funding such a system would fall on society itself. This would require the use of public funds, acquired mostly through taxation, to support the initiative to ensure access to the system. Thus, based on the investigation into rights language and access to health care, the system structure would be defined by societies sense of altruism and concern for community members that would best provide support for defining access as a political-legal right.

The second part of this thesis investigation was to look at the two health service systems of the US and Germany. Germany has a health service better aligned with the basic system laid out in the discussion based on access being a political-legal right. First, Germany has a national health service, where the US does not. Historical reasons for why this did not occur are given in the results section, but I argue the contemporary public debate using rights language in the US should center on the creation of such a system. From the information reviewed, it is the most logical instance where such language is appropriately applied in debate to the pro-argument for ensuring people’s right to access care. Another reason that Germany’s health service fits with the rights-based system described is that it was founded on society’s moral empathy for its community members. Von Bismarck adopted the policy to ensure access based on the suffering the German population. Though the US does have public programs, they are solely for certain members of the population. This excludes a large proportion of the population, usually based on income level, from claiming such rights to access services. The German system does not
exclude people based on cost or pre-existing conditions, making it so that is nearly 100 percent of citizens. However, the German system does not offer universal access. Those that are unable to access services, based on being unable to afford the cost of care for various reasons, are excluded from the system. Still, from society’s perspective, it does not violate the rights of the German populace. Since employment, through both the private and public sectors, is the way the German system is funded, access is given solely to those that contribute to the betterment of society. By being employed, an individual pays into the sickness fund to ensure other members of society can access care for their health needs. In reciprocal fashion, those other members of society pay into those same funds to ensure that individual has access. This is why I believe the German Health Service is a more practical system for the US to adopt than other system structures. Americans are traditionally opposed to increased taxes and government regulation, making support for a national health service funded on taxation problematic in reality. Also, Americans value employment over citizenship in regards to access to health care, as illustrated by the fact the majority of those with health insurance acquire their insurance through being employed, like the Germans. However, by having a national health service, Germany is able to keep the costs of services down to ensure access for a greater proportion of the population than the US. Lastly, the services covered by the German System provide an example of how their society has created a decent minimum of access to ensure the health of others. Including care options, such as day spas that are aimed at limiting the role stress has on an individual’s life, the German system promotes health to a larger degree than the US. The US delivers care strictly in the Medical Model, which is why I believe studies in the US that look at whether access increases the health of a population end up concluding access is not a determinant of health. Recall, in order for an individual to have a right to services, those services must provide some
benefit or there is no point in establishing such a right. In essence, the German model increases the access of its population by establishing a national health service based on its society view that access is a *political-legal right*. In doing so, the services the system offers better care for what we have defined as health, rather than solely physiological phenomena as in the US. The German system is not based on *moral rights*, as was proposed.

Reid challenges the US to decide if health care is a *moral right*. In concluding this investigation based on that challenge, I would like to offer a different challenge to the American people. I challenge Americans to answer whether they believe the morals of society include empathy for the health and well-being of the community? If American society believes compassion is a defining principle of what it means to be American, then it is reasonable argue access to health care is a *political-legal right*, and that a national health service should be adopted to ensure such rights are recognized.
REFERENCES


