VOLUME 2 ISSUE I IJSARD ISSN 2455 4049

ACCESS TO HEALTH CARE - A HUMAN RIGHT

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Many societies including the developed and wealthy countries provide universal access to a wide range of personal, medical and public health facilities. Whether such access to health care a prerequisite of social justice or is it simply a matter of social policy that some countries accept and others do not? If it is a necessity of social justice then we must be clear about the kinds of care we owe people and also determine what care is owed if we cannot meet every health requirements. We must be clear about what forms an appropriate access to that care when there are diverse barriers to the access. We should also be able to answer why one owe these things as a matter of justice.

The researcher first describes what some societies do to secure universal access to health care. Though health care is distributed equally in these societies than any other social goods, still health inequalities exist across demographic groups. Here implies a question we shall have to address that if universal access cannot ensure equality in health due to other important social determinants then is universal access a requirement of justice? The researcher then examines the concept of access to health care. The difficulty of measuring health care access and the concept of equitable access that depends in a more complex way on which inequitable access are permitted. Further the researcher examines different lines of arguments for universal access. The researcher then considers what kinds of care these views imply that we owe each other especially the opportunity based account. Lastly the researcher concludes by arguing whether we have a right to health in light of the views of justice and what authority follows from such rights if there is one.

What societies do to access to care?

We might look for a guidance of how some societies guarantee access to care knowing that what societies actually do may not agree with what they should do as a matter of justice. However there is a widespread belief that people owe one another access to certain care this belief is incarnated in institutions that make an effort to do that. It might give us some idea about what people owe and think about each other. It is true that we find different institutional provisions of access in different scenarios and the differences may not be differences in belief as much as differences in social history or resources.

Almost all developed countries provide their residents with access to set of public health and medical institution. Access to care in these countries is guaranteed despite wealth and income inequalities through universal health coverage systems. The financing method of the Universal access system and their organisational structure varies considerably. Some systems are funded through general tax revenues as in Canada while others through payroll taxes as in several European countries and the others through a mix private and public insurance scheme as in Germany. Therefore, some systems are more progressively financed than the rest since general tax revenue are more advanced than insurance premiums. Some systems have public ownership of hospitals with nurses and physicians as salaried employees of the public system as in Norway or United Kingdom. While others contain a mix of private and public institutions with extensive public regulations of the benefit packages available to people as in Germany. Some systems do not allow insurance schemes except the Universal coverage scheme as in Canada and Norway and others allow supplementary insurance as in the United Kingdom.

Even though all these health care systems guarantee universal access to every citizen their benefit packages still vary. The variations sometimes occur at the level of specific treatments and sometimes the differences involve whole categories of service. The Universal Coverage System exclude certain services like cosmetics surgery, then in general where system provide universal access, it is access for all to a particular set of benefits that varies from country to country, not every service people may want or need.

It is not only the Industrialised and wealthy countries that guarantees Universal access to a wide range of personal medical services. Also the middle-income countries such as Taiwan and South Korea recently have adopted Universal Coverage Insurance Schemes. Mexico and Thailand have also adopted insurance schemes aimed at covering half of their populations that had not been covered in social security schemes and other insurance

schemes are used by large employers or civil servants. In these different schemes the benefit package is not equal across these components of health system but the goal is to close gaps in access and incrementally to approach equality of access.

Apart from financial barriers there are several kinds of non- financial barriers to access which include forms of exclusion and discrimination such as gender bias, racism, language, geographical barriers and cultural barriers like cultural attitudes toward medical and disease care. For example- in the United States, the prevalence of certain health conditions is much higher among African Americans than Whites. Controlling for income, education differences and insurance coverage, the African Americans are still less likely to receive treatment of serious illness like heart disease and certain organ failures. To explain these inequalities in utilization is a matter of ongoing research which focuses on conscious and unconscious attitudes and racial stereotypes. Until the advocacy groups for women like National Breast Cancer Coalition attempted successfully to alter research funding policy, some of the women's diseases were systematically underfunded in the United States. Likewise, there are notable differences in access to care that derive from the geographical mal distribution of providers including services and physicians. Therefore, physicians continue their practices in wealthier urban and sub-urban areas leaving poor rural and urban areas undeserved. Also many hospitals face the problem of overcoming large barriers because of the diverse and large immigrant populations that they serve and abound of failure to meet health needs because of cultural views about medical care and disease.

All these barriers to access act as obstacles in providing adequate health care both in the United States and the developing countries. If justice demands providing Universal Access to health care then the barriers must be addressed as a matter of justice. All of them must be particularly addressed to move the system toward the provision of universal access.

Measuring and conceptualising access to care

The goal of universal access to health care is to secure equal or at least equitable access to needed care. Measuring and conceptualising access to health care is more complex a task than it might seem, because health care is non-homogenous in its function as it does quite different things for us. Also there is disagreement about the nature of health care as social good as some think it is accommodating to be purchased in a market while others claim it has a moral importance that distinguishes it from other market goods. When we are to make sense out of claims that we owe each other equal access to care then this means we must overcome barriers to access to care that create inequitable access, then we need to clear how to determine when access is unjustifiably unequal.

When is access to care equal?

It is appealing to think that we can give a totally non-controversial definition of equal access to health care as much as we can do for income equality and reserve all controversy for debates about which desertion from equality confirm to acceptable principles of justice. The condition is debatably different from the notion of equal health care access. To reach at the notion of equal access we must have made various decisions about what consideration is likely to count in judging when there is equal access. These decisions reflect our purpose or interest in making the judgement about equality and these discriminations are them self moral. Therefore, moral considerations are embedded in the specifications of equal access and are not held at bay until we get decisions about equity.

Similar point applies to judgements about equal health care access. Such judgements pre assume some views about the moral importance of health care. Nonetheless, it is fair to say that all that people have in mind when they talk about equal health care access is a negative criterion particularly that certain traditional restrictions on access mainly geographical, financial or discriminatory should play a minimal role in determining whether people who need health care actually get it. There might not be anything so schematic in anyone's mind at all. There might only be a moral complaint against a specific inequality. Therefore, in many cases there is an agreement about what to call an equal access for the only reason there is an agreement not to accept a particular kind of inequality.

Does justice require universal access to health care?

Here we shall examine the arguments that aim to show that universal access to health care is a requirement of justice. When one or more of these views establish its claim then the practice that we have noted in many countries in financing institutions aimed at providing can be interpreted as an effort to meet, though imperfectly, but a requirement of justice.

Health opportunity and universal access

The argument in favour of universal access to health care builds on the contribution made derivatively by health care to the opportunities people can exercise. The argument on fair equality of opportunity for universal access can be sketched as follows-

I. Assuming that health consists of functioning normally for some reference class of a species, in effect health is absence of significant pathology.
II. Maintaining normal functioning that is health makes a notable contribution to protecting the range of opportunities individual can reasonably exercise.
III. The socially controllable factors provide to maintaining normal functioning in a population and fairly distributing health in it considering traditional public health and medical interventions and also distribution of social determinants of health as wealth and income, education and control over work and life.
IV. When we have social obligations to protect the opportunity open to individuals and some theories of justice, then we the obligations to protect and promote normal functioning for all.
V. Providing universal access to a reasonable array of public health and medical intervention to meet our social obligations to protect the opportunity for individual even though reasonable people might not agree about what is included within the array of interventions, given technological limits and resources.

Access to a decent minimum of health care

Arguments in favour of universal access to a decent minimum of health care does not turn on in support of general principles of justice but rather on a pluralism of moral considerations and an argument for a state coordinated beneficence.

The arguments can be sketched as follows-

I. There is a set of special rights to a decent minimum of health care held by the groups such as- Native Americans and African Americans that owed compensation for the injustice done to them, individuals harmed in their health by corporate or private actions such as exposing workers to toxins or polluting public spaces and the group members that have made exceptional sacrifices for the good of the society such as wounded veterans.
II. Access to some preventive services derived from a harm prevention principle that justifies the use of public funds for public health measures and a constitutional argument that require equality of protection from harms that the public acts to prevent.
III. Access to some beneficial services is justified by the prudential considerations as the importance of some health care to producing productive work force and citizenry fit for national defensive.
IV. Together the considerations would justify legal entitlement to some kind of health care.
V. There are two arguments for state enforced beneficence that can be used to support a legal entitlement to a decent minimum of health care.
    a) Enforcing contributions can lead to producing public good of a decent minimum of health care for all while not enforcing contributions would lead to choose alternative ways of maximizing the good they can produce through the actions of individuals undermining the production of public good to many.
    b) Enforcing contributions produces an assurance that others will contribute to decent minimum and one's own contribution to it is worth making since others will do the same.

Justification for universal access

Several lessons can be learned from the justification for universal access to care and one such lesson is the rationales for universal access derived from more general considerations of justice. They borrow their justificatory force from arguments of general considerations. Also they bring with the general theories specific considerations that might affect the content of the claim of universal access. Therefore, a family of equalitarian theories that talk about equality opportunity in several ways might all support universal access to health care because of its influence on opportunity but they justify various kinds of access because they view the obligation to promote opportunity in different ways.

Second lesson that can be learned is that the rationales depend on the highly idealised assumptions and may

provide less clarity about the design of benefit packages that might be hoped.

Third lesson that can be learned is that avoiding a theoretical account of universal access to care may cost more than it gains. Eschewing appeal to a theory that justifies health care because it contributes to the importance of social justice and appealing rather than a pluralism of considerations risks losing clarity regarding what care is a part of decent minimum as it purports to provide legal entitlements.

Kinds of health care we owe each other

In the view of fair equality of opportunity in meeting the health needs of people viewed as equal and free citizens is of comparable and moral importance. Since meeting health needs protect the opportunities people exercise then any social obligations we need to protect opportunity imply obligations to promote and protect health to every people. Certain theories of justice despite their differences concur that we have such social obligations to protect opportunity and therefore they cover on the importance of protecting health.

Based on opportunity, justice requires that we protect people's shares of normal opportunity by treating illness by reducing the risk of disability and disease before they occur and by distributing the risks equitably. In the medical system this means that we must give every people access to reasonable array of services that restore and promote normal functioning and that we must not ignore preventive measures in favour of the curative ones. This means we must look beyond the health sector to the wider social determinants of health and its distribution. Since all the health needs cannot be met that arise inside and outside the health sector we must be liable for all the reasonableness of the resource allocation decisions we make.

Considering more specifically what opportunity based account of justice and health care requires by way of preventive services that requires-

I. Reducing risk of disease
II. Seeking equitable distribution of risks.

The first requirement is understood. Often it is more effective to prevent disability and disease than it is to cure them. Since it is better to avoid the burdens of disease than to reduce them many types of preventive measures will be given prominence in a system governed on account of opportunity based.

The second requirement also should seem understood in light of what we know about the importance of social determinants of health. Assuming that a health care system is heavily weighted toward acute care and it provides equal access to its services. Therefore, anyone with severe respiratory ailments like emphysema, asbestosis, brown lung, black lung and so on is given adequate comprehensive medical services as needed but only the little is done to reduce exposures to risk in the work place. Now does system reduce the demand of justice?

Such system is unjust and incomplete according to fair equality of opportunity. If some people in the population are differentially at risk of getting ill it is merely not sufficient to attend to their illness. Where risk of illness differs in a systematic manner that are avoidable guaranteeing equal opportunities require that we try to eliminate the risks and prevent excess illness. Otherwise the risks and burdens of illness will fall differently on different groups and the risk of opportunity for these groups will remain despite the efforts to provide acute care. Care is not equal to prevention. Some diseases might not be detected in time for it to be cured. Also there are some that is not curable even though it is preventable and treatments will vary in efficacy. We can protect equal opportunity best by equalising and reducing the risk of the arising conditions. The fact that we get equal chance of being cured once we fall ill because equal access to care does not compensate us for our unequal chances of becoming ill.

Because of these reasons the fair equality of opportunity account places some special importance on measures aimed at equitable distribution of risks of disease. The public health measures such as water and water treatment have general effect of reducing risk. Historically, they have also had the effect of equalising risk between groups living in different geographical areas and between socio economic classes. The other environmental measures such as pesticide regulations and clean air laws both have general effects on risk reduction and specific effects on distribution of risks. For example- pollutants that are emitted from smokestacks have different effect on people who live upwind from those who live downwind. Gasoline lead emissions have greater effect on urban population than rural. Other health protection measures primarily have an effect on distribution of risks. While some group of workers are at risk from hazards of workplace many workers face risk or other especially in manufacturing settings. Only health

requires the stringent regulation in all of these ways must be a part of the health care system.

Right to health or health care

Only if health care were the most important determinant of population then opportunity based account of health and justice would be right to focus solely on a right to health and care and to ignore the more possibly and continuous misleading right claim to health. Then right to health care would be a special case of a right to fair equality of opportunity. Such right to health care is understood as system relative. The entitlements that are involved are contingent claims to an array of health care services that protect fair share of opportunity under reasonable resource constraints. This picture of a right to health care should be modified in two ways to accommodate points made in our discussion.

I. Since the socially controllable factors determining population health and its distribution is broader than health care, the point of claiming a right to health cannot be to claim that others owe us certain kinds of health care. Does this give us reasons to talk about a right to health?
II. Whatsoever sense we can make out of a right to health the particular entitlements it involve cannot be determined except through a fair deliberative process.

The expression 'Right to health' appears to personify confusion about the kind of thing that can be the object of a right to claim. Health is not an appropriate object whereas, health care is. If our poor health is not a result of anyone's doing or failing to do that might have prevented or cured our conditions then it is hard to see how any right of ours is violated.