Introduction

Widespread agreement now exists on the need for health care reform that provides greater access to those who now lack insurance. Yet the public and academic debate over how best to increase access has a superficial quality. It focuses almost exclusively on mechanics and details while unquestioningly accepting two fundamental premises.

First, the undesirability of the current allocation of health care is assumed. Frequent mention is made of the statistic that approximately 37 million Americans lack health insurance. Although the mention is invariably disapproving, an explanation of the basis for the disapproval is generally not forthcoming. Reasons exist for wanting such explanation. Surely not all of the uninsured are denied all access to care. What, then, is the level of care available to the uninsured? If that level is inadequate, is it merely undesirable as a matter of policy or unjust as a matter of principle? The answer to this question makes an important difference in the resolution of any trade-offs that may exist between the two principal goals of health care reform, increasing access and controlling cost. If the existing distribution is undesirable but not unjust, then it becomes far easier to choose controlling spiraling costs over increasing access, should the two conflict.

Second, another unquestioned premise holds that legislatures are the sole forum for any reform of the distribution of health care, and that the Constitution, as interpreted and enforced by the judiciary, has virtually nothing to say.1 It is understandable that this premise should be taken for granted. As a practical matter, the current Supreme Court will not significantly involve itself in this issue, and any reform must emerge from Congress. Yet scholars should explore the best understanding of the Constitution, whether or not the Supreme Court is likely to embrace it. It is important to decide whether the allocation of health care is a matter of legislative grace or constitutional principle. In the short run, perceptions about how well the existing distribution comports with constitutional values affect the likelihood and shape of legislative reform. In the longer run, such perceptions influence the prospects for judicial involvement should legislative reform fail.

This article subjects these two premises to critical scrutiny. It attempts to put the debate over health care reform into a larger, more theoretical framework that explores the links between distributive justice, the Constitution, and the proper role of courts. Part I discusses empirical evidence on the influence of insurance status on the level of care. All of this evidence points to the conclusions that the uninsured have a lower level of access to health care, that they receive a lower level of care once access is

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The Courts, the Constitution, and a Just Distribution of Health Care

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It is important to decide whether the allocation of health care is a matter of legislative grace or constitutional principle.
gained, and that these lower levels of access and care to some extent shorten life or diminish its quality. Part II evaluates this evidence in light of differing theories of distributive justice. It concludes that the current distribution of health care violates all such theories, with the probable exception of libertarianism. Part III argues that under a proper understanding of the role of the judiciary in enforcing the Constitution, courts defensibly play an important part in redressing this injustice.

I. The Current Allocation of Health Care

This section examines the allocation of health care among what the empirical literature shows to be the most important axis: a patient’s possession or nonpossession of medical insurance. That literature indicates that a sizable segment of the approximately 37 million Americans who lack public or private insurance can expect to receive a significantly lower level of care as compared with the insured. Many persons, based upon their lack of insurance, do not receive health care likely to prolong or improve their lives.

A. The Extent to Which the Uninsured are Legally Entitled to Care

As a matter of legal entitlement, access of the uninsured to the health care system largely consists of emergency treatment in hospitals. State and/or federal law frequently, but not always, gives the uninsured a legal right to receive emergency care from hospitals. Hospitals generally do not have an obligation to provide nonemergency care to uninsured patients. Physicians practicing outside of hospitals generally have no legal duty to render even emergency care. Of course, once the uninsured gain access to care, the care generally must be non-negligent.

If the legal requirements were determinative, we would expect the following results. The uninsured generally would receive neither preventive care nor nonemergency treatment. They would generally receive emergency care at hospitals, although many might have to travel longer distances than do the insured. Whatever care the uninsured did receive would be non-negligent, although not as fulsome as that provided to the insured.

Such an allocation of health care would be quite disturbing. Preventive care and nonemergency treatment often prevent or shorten periods of pain or disability and sometimes avoid emergency conditions having consequences ranging from temporary disability to death. Uninsured patients would be denied much nonemergency life-improving or life-prolonging care that the insured receive, even when the benefits of that care greatly exceed its costs.

B. The Extent to which the Uninsured Actually Receive Care

The actual allocation of health care is somewhat different than legal requirements alone would indicate. Still, the uninsured do not receive a significant amount of life-improving and prolonging care that the insured receive.

Given the financial incentives governing health care delivery, this conclusion is hardly surprising. Doctors and hospitals are not directly reimbursed for treating the uninsured. In the past, health care providers routinely obtained indirect reimbursement by inflating charges to the insured. Yet the incidence of such “cross-subsidization” has declined sharply as insurers and employers have taken measures to reduce their costs. Because providers are increasingly unable to recoup their costs, it is thus entirely predictable that uninsured would receive a significantly lower level of care.

The available studies confirm this prediction. Although no one study is conclusive standing on its own, the numerous available studies all point in the same direction. They persuasively indicate that insurance status is probably the most important factor determining the allocation of health care and that significant numbers of the uninsured receive a markedly lower level of care.

Consider first the uninsured’s access to the health care system, ignoring for a moment the level of care received after access is gained. Because many physicians and hospitals provide charitable emergency and nonemergency care, the uninsured receive greater access than the law requires. But such charity care stops far short of filling the gap between the legally required access of the uninsured and actual access of the insured.

The evidence strongly indicates that the uninsured have considerably less access to preventive and nonemergency care that prolongs or improves life. Even though the uninsured tend to be in poorer health, they use medical services at a significantly lower rate. A disproportionate number of the uninsured are admitted to hospitals with conditions or ailments that could have been treated routinely or prevented if treated earlier. According to one study, even though the uninsured are at particularly high risk for preventable illness, “lack of insurance was the strongest predictor of inadequate receipt of preventive services.” To take one example, breast cancer can be diagnosed and treated effectively early in its
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course. A recent study found that, among women with breast cancer, the uninsured were diagnosed with more advanced disease and had a 49% higher chance of death during the seven years following diagnosis.\textsuperscript{16} Another study found that, "In 13 of 16 age-sex-race-specific cohorts, the uninsured had a 44% to 124% higher risk of in-hospital mortality at the time of admission than did the privately insured" and "[a]fter controlling for this difference, the actual in-hospital death rate was 1.2 to 3.2 times higher among uninsured patients in 11 of 16 cohorts."\textsuperscript{12} Other research finds or suggests a link between lack of insurance, delayed access to preventive or nonemergency treatment, and increased incidence of adverse outcomes.\textsuperscript{13} Factors other than insurance status no doubt play some role.\textsuperscript{14} The evidence, however, strongly indicates that, as a result of their lack of insurance, significant numbers of persons do not gain access to care until their ailments reach more advanced stages. This delayed access, in turn, translates into higher rates of illness, disability, and death.

In addition to lacking access to nonemergency care, significant and increasing numbers of the uninsured lack ready access to emergency care, especially in poor urban areas. Instead of shouldering the financial burdens of providing emergency room care to uninsured patients, many hospitals simply have closed their emergency rooms.\textsuperscript{15} Particularly in urban inner cities, hospital emergency rooms available to treat uninsured patients are badly overcrowded.\textsuperscript{16} Consequently, some uninsured patients do not receive emergency care, at least not in a timely fashion.\textsuperscript{17}

As Professor Watson has observed, a vicious cycle develops as the result of the unavailability of prompt primary and emergency care:

\begin{quote}
[O]vercrowding and long waits cause patients to delay necessary care, which causes health conditions to worsen; more serious conditions, in turn, require more intensive and more expensive treatment, which, to close the circle, increases demand on the limited resources of the public hospitals. The consequences are needless suffering and death as many poor patients do not receive any medical care until they are beyond help.\textsuperscript{18}
\end{quote}

Consistent with these observations, the empirical evidence shows a significant correlation between the uninsured’s lack of access to prompt emergency care and adverse outcomes, such as death or disability.\textsuperscript{19}

Once the uninsured do gain access to the health care system, they tend to receive a lower level of care. According to one study, for example, the uninsured were 29% to 75% less likely than the insured to receive high-cost and/or high discretion procedures, such as cardiac angioplasty, bypass surgery, and knee or hip replacements.\textsuperscript{20} The same study found that the uninsured also tend to be discharged sooner.\textsuperscript{21} Another illustrative study showed that, controlling for ethnicity and severity of illness, sick newborns without insurance received significantly fewer hospital services than either publicly or privately insured newborns.\textsuperscript{22} Even with the controls for other factors and even though medical need was shown to be greatest for uninsured newborns, these newborns had "length of stay, total charges, and charges per day that were 16%, 28%, and 10% less, respectively, for the uninsured than for all privately insured newborns . . . ."\textsuperscript{23} The available evidence thus indicates that upon gaining access to the system, the uninsured receive a lower level of care.

Although this differential to some extent might reflect the existence of "luxury" low-benefit, high-cost treatments available only to the insured,\textsuperscript{24} it also reflects the unavailability of cost-justified care to the uninsured. In the study of sick newborns mentioned above, for example, uninsured newborns received fewer services than even those insured through pre-paid insurance plans, such as HMOs, which have strong incentives to eliminate unnecessary services.\textsuperscript{25} Another study found that uninsured patients have a higher relative rate of in-hospital death, even controlling for severity of illness, age, and ethnicity.\textsuperscript{26} Still another study found that the "uninsured have a twofold greater risk of negligent care than those with insurance, even when patient race, income, and gender are controlled for in the analysis."\textsuperscript{27}

C. Summary

Taken as a group, the uninsured have a lower level of access to the health care system than do the insured, and, once they do gain access, they receive a lower level of care. The lower levels of access and care are both associated with an increased incidence of death, disability, and serious illness. The relative unavailability of high-cost, low-benefit care to the uninsured does not explain this differential; the uninsured also have less access to cost-justified preventive, primary, and other care. This inequitable distribution of health care does not result solely or even primarily from ethnic and socioeconomic differences; the evidence suggests that it cuts across them.\textsuperscript{28} In effect, treatment that significantly prolongs life or improves its quality is rationed out according to the ability to pay. It is worth noting that the financial pressures prompting hospitals and doctors to restrict the care of uninsured are becoming worse, not better.\textsuperscript{29}

II. The Injustice of the Current Allocation

The evidence discussed in the preceding part reveals that significant numbers of persons, primarily because they lack insurance, do not receive health care that can be expected to prolong or improve their lives. This part demonstrates that this distribution of health care is unjust under virtually all conceptions of justice.

A conception of justice must take into account the special
nature of health care. As Norman Daniels and others have observed, health care has a fundamental bearing on the range of one's opportunities to realize one's life plans.\textsuperscript{30} It helps determine how long one lives and whether one has disease or disability that greatly restrict life opportunities. \textbf{[T]here is no need to know what a particular person's other ends, preferences, and values are in order to know that health is good for that individual. It generally helps people carry out their life plans, whatever they may happen to be.}\textsuperscript{31} In this sense, health care is special; it is not like most other goods.

Given the special nature of health care, those who subscribe to liberal rights-based theories of justice argue that individuals possess a right to health care.\textsuperscript{32} One strategy has been to ground a right to health care in John Rawls' influential theory of distributive justice. At a minimum, health care qualifies as one of Rawls' "primary goods," which "normally have a use whatever a person's rational plan of life"\textsuperscript{33} and which every person is presumed to want. The distribution of such goods is subject to the "difference" or "maximin" principle, which holds that inequalities are permissible so long as they benefit those who are worst off.\textsuperscript{34} Alternatively, as Norman Daniels has argued at length, health care can be viewed as essential to Rawls' principle of fair equality of opportunity.\textsuperscript{35} Opportunities falling under this principle may not be distributed unequally, even if the inequities benefit the worst off.

Other rights theorists have employed a different strategy, eschewing the labyrinth of Rawlsian theory. They argue that philosophical liberalism's core premise of individual autonomy presupposes access to an adequate standard of living, which includes the provision of a decent minimum level of education and health care.\textsuperscript{36} Absent a minimally adequate standard of living, they observe, persons cannot exercise the rational autonomy that liberalism prizes.

However grounded and formulated, the right to health care these theorists recognize cannot be reconciled with the current distribution of care. Rawlsian and non-Rawlsian rights theorists disagree over whether access to health care ought to be distributed equally or whether some adequate minimum will suffice.\textsuperscript{37} Yet the current distribution is unjust under either view. The uninsured certainly do not have equal access. And the evidence discussed in the preceding section indicates that the uninsured often lack access to an adequate minimum, however defined. Surely an adequate minimum encompasses cost-justified care that significantly prolongs life or improves its quality. Even if the right to receive such care may be forfeited,\textsuperscript{38} the uninsured by and large cannot be said to have forfeited that right through laziness, freeload-}

The current allocation also seems impossible to justify on utilitarian grounds. No matter how formulated, utilitarianism would seem to recommend that health care be allocated according to the costs and benefits of particular treatments or levels of care. On the cost side of the equation, the uninsured do have lower levels of access to some high-cost treatments. A utilitarian might regard these treatments as unwarranted, depending on their benefits. Yet, a utilitarian would be hard-pressed to defend the uninsured's lower level of access to relatively low-cost preventive and primary care.\textsuperscript{40}

On the benefit side, the current system, which rations significant amounts of care according to insurance status, greatly understates the utility of providing care to the uninsured.\textsuperscript{41} Lack of insurance or the ability to pay for particular treatments cannot plausibly be viewed as a proxy for benefit.\textsuperscript{42} It is absurd to believe that most of the uninsured lack insurance because they do not value health as highly as the insured and that the benefit of providing care to them is therefore lower. Children account for approximately one-third of uninsured.\textsuperscript{43} Their lack of insurance surely says nothing about the benefits of providing health care to them. Over 80% of the uninsured live in families whose head is employed.\textsuperscript{44} Given that in the overwhelming bulk of these cases employers decided not to offer health insurance and low-paid employees frequently cannot afford to purchase health insurance individually,\textsuperscript{45} lack of insurance says virtually nothing about the value these individuals place on health generally or on particular treatments.\textsuperscript{46} In light of the radical disjunction between insurance status and the cost-benefit ratio of providing various levels of health care, utilitarianism cannot support the current allocation.\textsuperscript{47}

For somewhat obvious reasons, the significance our system
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While it is hard to say exactly what is a just distribution of health care, it is not hard to conclude that the present distribution is seriously unjust.

assign their natural right of punishment to it.\textsuperscript{58}

Nozick’s theory would seem to preclude government taxation to furnish general medical care to the uninsured. Under Nozick’s scheme, taxes arguably could be used to furnish medical care for illness that results from risks knowingly imposed by others (e.g., lung cancer caused by exposure to secondhand smoke). Because some victims of such illnesses will not voluntarily relinquish their natural right to punish the offending parties (e.g., smokers) to the government, they must be compensated. Such compensation, according to Nozick, may take the form of the provision of services, presumably including health care.

Many illnesses and disabilities, however, do not result from risks knowingly imposed by others. Indeed, some disease results from a person’s own risky conduct, not risks imposed by others. Government does not deprive persons of their natural right to “punish” such causes of ill health. There is no other person to punish. Furthermore, government does not prevent persons from taking whatever measures they think will protect their natural rights of life and property from such illnesses or disabilities (e.g., research into causes and development of a treatment). Because government does not deprive anyone of a natural right to punishment or protection, no one is owed compensation. With respect to illnesses of this sort, the only justification that Nozick accepts for redistributive taxation vanishes.

Nozick’s theory, then, can support the use of tax revenues to subsidize treatment of illness caused by the risks others have knowingly imposed on the patient. But the theory seems hostile to the use of tax revenues for the treatment of illnesses resulting from a person’s own conduct or from unknown causes.

In short, because reformation of the current distribution of health care would entail redistributive taxation, because health care does not fit the classic definition of a public good, and because most illnesses cannot be attributed to the conduct of others, libertarianism seems generally adverse to a conclusion that the uninsured receive an inadequate and unjust level of health care.

Given their radically conflicting implications, one must choose between libertarianism and other theories of justice. The choice should not be difficult. Libertarianism’s theoretical shortcomings and inability to account for widely shared convictions of justice have been amply explained elsewhere.\textsuperscript{59}

Even though the other conceptions of justice differ over what constitutes an ideally just distribution, they unite in condemning the relative unavailability of cost-justified care that can signifi-
cantly prolong or improve the lives of the uninsured. While it is hard to say exactly what is a just distribution of health care, it is not hard to conclude that the present distribution is seriously unjust. As Charles Black has written, “When we are faced with these difficulties of ‘how much’ [justice requires], it is often helpful to step back and think small, and to ask not, ‘What is the whole extent of what we are bound to do?’ but rather, ‘What is the clearest thing we ought to do first.’”60 Under virtually all conceptions of distributive justice, one of the first and clearest things we ought to do is ensure that the uninsured have greater access to cost-justified, life-prolonging or improving care.

III. The Role of the Judiciary and the Constitution in Promoting a More Just Allocation of Health Care

One unquestioned premise in the current debate holds that it is unjust that 37 million Americans lack health insurance. The first two parts of this article ask whether this conclusion has persuasive empirical and theoretical support and concludes that it does. This part examines another unrefuted premise, the view that the proper distribution of health care is almost exclusively the province of legislatures and that the Constitution as interpreted by the courts is largely irrelevant. It concludes that this premise should be rejected. Under a proper understanding of the Constitution and the judiciary’s limited institutional competence, courts may play a significant role in promoting a more just distribution.

This part outlines two such conceptions of the judiciary’s role. Under the first conception, courts would not recognize a constitutional “welfare right” that gives government an affirmative duty to provide persons with the basic necessities of life, including health care. Rather than requiring government to raise and spend tax dollars on health care, this conception would require that the government allocate whatever funds it chooses to spend on health care in a way that promotes rough equality of access. Such a judicial role, it will be argued, can be derived from the Fourteenth Amendment’s guarantee of equal protection. The second conception does entail judicial recognition and enforcement of welfare rights to some minimally adequate level of health care. Although such a role finds arguable support in the Constitution’s text, this part argues that textual support is not crucial. Both conceptions respect the judiciary’s limited competence by having courts prod legislatures to develop a more just distributional scheme, rather than doing so themselves.

A. Making the Distribution More Just Without Recognizing Welfare Rights

Rightly or wrongly, opponents of constitutional “welfare rights” have won the day. They deny “that [such] welfare rights derive in any sense from the Constitution or that courts may legitimately place them there.”61 They further argue that recognition of welfare rights would overstep the proper limitations of the judicial role, because courts would be involved in deciding appropriate levels of spending and taxation and in resolving a host of controversial empirical issues.62 During the latter years of the Warren Court and for a decade thereafter, a lively debate could be found in the academic literature over whether the Constitution, as enforced by the courts, obligates government to provide persons with minimally adequate levels of food, housing, education, and, presumably, health care.63 The Supreme Court has now rejected the notion of a constitutional welfare right to health care and other basic goods, such as education.64 When scholars now mention welfare rights, it is almost always merely to note the existence of the prior debate and the Supreme Court’s rejection of such rights. Academic advocacy of judicial recognition and enforcement of constitutional welfare rights is almost nonexistent.65

Even if the Court and scholars correctly deny the existence of constitutional welfare rights, courts may still play a significant role under the Constitution in promoting a more just allocation of health care. Instead of recognizing and enforcing welfare rights, which would affirmatively require government to devote resources to health care, courts can play the more limited role of assuring a more equitable distribution of whatever resources the government chooses to expend on health care. On this view, government would be free, so far as the Constitution is concerned, to devote resources to health care or not. But once the government chooses to devote resources to health care, it must do so in a way that promotes rough equality of access, at least to some minimally adequate level of care.

The substantial expenditures that the government now makes on health care do not effectively promote access to a decent minimum. The Federal government, principally through Medicare and Medicaid programs66 and tax subsidies for employer-sponsored health care insurance,67 accounts for more than 40% of the nation’s health care expenditures.68 In part, these expenditures promote equal access. The Medicaid program assures that a substantial but ever diminishing portion of those below the poverty
line have greater access to care. Medicare and tax subsidies also act, in part, to insure access to persons who otherwise would not have it. In substantial part, however, Medicare and the tax subsidies also subsidize relatively affluent persons who could purchase insurance without such subsidies. In fact, the affluent receive a larger tax subsidy. Meanwhile, the federal government spends virtually nothing on those who lack health insurance, while the percentage of those below the poverty line covered by Medicaid has decreased from 75% in 1965 to approximately 38% in 1991. The federal government appears to spend more on providing health care for those having middle to high incomes than it does for those in the lower income brackets, including the poor. As the President’s Commission has written:

On the one hand, care is extensively subsidized (through the Federal tax system) for people who could take more financial responsibility for their own care without an excessive burden. On the other hand, stringent limits on publicly funded services cause others to be denied adequate care, or to obtain it only at great personal cost. Public health “insurance” programs, such as Medicaid, fail to secure adequate care for many low-income people while providing care for others that is more than adequate.

Taken as a whole, this scheme of financing does not effectively promote rough equality of access. In important part, it fosters unequal access by subsidizing care for the affluent while letting the uninsured depend on the vagaries of charity.

Courts can help reform this inequitable distribution of federal support in a manner consistent with the Constitution’s text. On the view advanced in this section, courts would hold that when government spends its resources on goods that greatly influence a person’s life opportunities, such as health care, it must do so in a way that promotes rough equality of access to at least some minimally adequate level of opportunity. Such a judicial role can be traced to the Fourteenth Amendment’s equal protection guarantee. A core purpose of equal protection was to give African-Americans equal access to basic opportunity-shaping institutions, such as property ownership and courts. As Professor Cass Sunstein has observed, “equality in basic life prospects is a clear theme of the Civil War amendments.” Because the Equal Protection Clause, by its terms, is not limited in its application to African-Americans or to the institutions of courts and property ownership, its concern for equal opportunity plausibly can be generalized beyond this narrow context.

This view of equal protection finds support in modern equal protection doctrine. Existing doctrine has two strands, addressing, respectively, intentional government discrimination against societal groups and obstructions to equal enjoyment of fundamental rights. The conception of equal protection sketched above has little affinity with the first, “societal groups” strand, which rests on distinctions between “suspect” and “nonsuspect” groups and between intentional and unintentional governmental acts. This doctrinal strand generalizes the equal protection guarantee’s concern with race, presumptively condemning all intentional governmental discrimination against African-Americans and sufficiently analogous societal groups, whether or not that discrimination blocks access to basic opportunity-shaping institutions. Yet, the view of equal protection urged here does fit naturally with the “fundamental rights” doctrinal strand, which generalizes the equal protection concern for equalizing access to institutions strongly influencing the availability of basic life opportunities. It condemns blocked access to certain basic opportunity-shaping institutions, such as voting, courts, and interstate travel, whether or not the obstacles result from race discrimination. Some of the Court’s decisions even impose an affirmative obligation upon government to furnish the poor with the means for access, thus seemingly recognizing welfare rights. The fundamental rights cases thus affirm a vision of equal protection which emphasizes equality of access to institutions having a fundamental bearing on life opportunities.

The Court’s seeming rejection of a “fundamental right” to health care can be criticized as an arbitrary limitation upon this vision. Access to basic health care, as a general matter, exerts a stronger influence on a person’s life opportunities than do access to courts, voting, or interstate travel.

In support of a fundamental right to health care, one can point to state decisions respecting the public financing of education. In the wake of the Supreme Court’s rejection of a fundamental right to education, an increasing number of state courts have interpreted their own constitutions to invalidate inequitable methods of financing public education, whereby some districts, usually those encompassing the relatively affluent, receive per pupil funding greatly in excess of that of other districts, usually those encompassing the poor. There is a strong analogy between health care
and education: both strongly influence a person's basic life-opportunities. These state cases reinforce the notion that when government spends its money on institutions that have a fundamental bearing on persons' life opportunities, the Constitution requires that it do so in a way that promotes roughly equal access, at least to minimum level. Even those state decisions rejecting challenges to inequitable school financing affirm that state or federal constitutions require equal access to a minimally adequate level of education. If these cases and the Court's decisions recognizing fundamental rights to voting, courts, and interstate travel are rightly decided, then the Court's refusal to recognize a fundamental right to basic health care is wrong.

In addition to consistency with text, history, and precedent, the judicial role proposed here need not overstep the judiciary's proper institutional bounds.

Once again, the state cases involving public financing of education are instructive. In those cases, courts do not prescribe the proper level of overall resources the government must spend on education. Nor do courts require the use of a particular method of financing. Rather, the courts require that whatever resources government chooses to spend on education be allocated in a more equitable fashion. Rather than devising plans themselves, courts let the legislative and executive branches to do so. In effect, courts remand the issue to the other branches with the admonition to take greater account of equality. A judicial role of this kind allows other branches of government to retain a wide range of discretion in deciding how much to spend and how to spend it more equitably.

Courts could play a similar role in the health care arena. Courts would not decide the truly difficult questions of what constitutes an adequate level of health care or what the government should spend on health care. Congress, in turn, could satisfy its equal protection obligations in any number of ways. The obligation to spend equitably theoretically could be satisfied by withdrawing funding for health care altogether. Or Congress could satisfy its obligation by retaining its existing spending on Medicare, Medicaid, and tax subsidies and spending additional funds to increase the access of those who are now uninsured. Congress could also retain the present level of funding and simply distribute it in a way that better promotes more equitable access. Congress might do this through a single-payer system, managed competition, tax vouchers, a play-or-pay plan, or yet in some other way.

A judicial role thus limited should substantially answer worries about the judiciary's institutional competence. It remains true that courts are ill-equipped to resolve the many difficult empirical questions concerning the efficacy and consequences of various methods of delivering education or health care. It is also true that judicial action sometimes tends to diminish the attention a particular issue receives in the political sphere, thereby sacrificing whatever benefits would otherwise flow from public deliberation and resolution. Judicial efforts at institutional reform can also be ineffective. But these limitations furnish insufficient grounds for concluding that courts should play no significant role whatsoever in promoting a more equitable distribution of education or health care.

One must also consider the judiciary's special competence and the comparative competencies and incompetencies of other branches. Courts, by virtue of their relative insulation from direct electoral pressures and their obligation to justify and explain their decisions, are better situated to identify and give adequate weight to constitutional values, such as equal opportunity. As state courts have discovered in the realm of school financing, legislatures, in the absence of judicial goading, may fail to give adequate weight to equal opportunity. Judicial inaction may well mean that constitutional values essentially are ignored. Although courts frequently lack access to relevant information and expertise, one must be realistic about the extent to which legislatures resolve or even address difficult empirical questions sensibly. Legislative and executive action respecting health care, for instance, is most often more responsive to influential interest groups than to a careful evaluation of the likely empirical consequences of various courses of action. The judicial role described above strikes a sensible balance between the competing considerations of enforcing constitutional values and respecting the comparative competencies of the three branches of government.

The current likelihood that the political process will produce reform in the next few years supplies a powerful prudential reason for the judiciary to stay its hand. But, consistent with the school financing cases, judicial patience should have its limits. In the last
year, health care reform has come to occupy a prominent place on the national political agenda. Yet legislative efforts to equalize access to a decent minimum of health care have looked promising before, only to be derailed by coalitions of powerful interest groups. Should the current political dialogue fail to produce greater equality of access, courts should be willing to step in, as state courts increasingly have with respect to school financing. A perception that the judiciary will act if the legislature does not may well improve the prospects for meaningful reform. At the same time, the widespread public support that now exists for reform enhances the prospect that judicial intervention will be effective should interest group pressures subvert meaningful reform.

Courts may play the limited but important role of ensuring that whatever the federal government spends on health care be allocated in a way that promotes roughly equitable access to at least an adequate minimum of health care. Such a role is faithful to the equal protection guarantee’s concern for equality of opportunity and a proper understanding of the judiciary’s competence vis-a-vis other branches of government.

B. Recognizing A Welfare Right to Health Care

May courts play the more expansive role of imposing an affirmative obligation on government to furnish access to an adequate minimum of health care? This section outlines a case for judicial recognition of a constitutional welfare right to a minimum level of health care. Such a right bears a plausible connection to the Constitution’s text, and, in any event, this section argues that fundamental precepts of justice may be accorded constitutional status even absent textual support. Furthermore, the courts’ role in enforcing welfare rights can be circumscribed so that it respects the judiciary’s institutional limitations.

No one can doubt that a connection exists between the access to health care and the exercise of textually specified rights. The preceding section argued that a core concern of equal protection is to afford equal access to basic opportunities. Without health care, many persons will be denied access to such opportunities in all realms of life. Health care does seem less important than a subsistence level of food and shelter. Everyone needs a certain amount of food and shelter to subsist but only those persons who develop treatable life-threatening or debilitating illness have that same need for health care. Yet, given a subsistence level of food and shelter, health care may well be more important in assuring access to basic opportunities than a more generous level of food and shelter. In addition to its link with the equal protection guarantee’s concern for equal opportunity, health care is correlated with the exercise of other textually specified rights, such as freedom of speech.

No matter how strong, the connection between health care and specified rights does not suffice to establish a constitutional right to health if, as opponents of constitutional welfare rights maintain, the Constitution’s text creates only negative rights. On this view, constitutional rights sometimes require the government to refrain from acting but never to compel governmental action in the first instance.

The thesis that positive rights are incompatible with the Constitution’s text can be challenged on a number of grounds. One response is that the text explicitly creates a number of positive rights and erects no general bar against their recognition. Another denies that the distinction between negative and positive rights makes sense because any given negative right can be viewed as positive and vice versa. These responses have been developed adequately elsewhere.

A final and more fundamental response, one generally not explored in the literature on welfare rights, denies that the text should be treated as binding. The Constitution’s meaning should be related to the reasons why it deserves its status as law. Originalists point to the legitimacy of the Constitution’s enactment. Yet the Constitution’s claim on our allegiance does not derive from the fact that it was enacted in conformity with then existing legal forms. The Constitution’s enactment was fundamentally illegal in that sense. The Constitution’s authority also cannot be justified on the grounds that it was democratically approved by the People. The “People” who approved the Constitution excluded blacks, women, and propertyless males. Further, it is decidedly undemocratic for political majorities of the late Eighteenth Century to circumscribe contemporary majorities. Because features of the Constitution’s enactment do not explain its authority over us, its meaning for us need not hew to the meaning it had for those who made it law.

The best basis for the Constitution’s authority is that it is morally justified. This does not mean that the Constitution loses its claim as law and cannot legitimately bind unless each and every rule attributed to it is morally justified. Other potential bases of legitimacy, such as consent or reciprocity, may make binding even those aspects of constitutional law that lack persuasive moral justification. The argument outlined here need assert only that
the moral justifiability of constitutional rules is the best, not the sole, basis for their legitimacy. Given a choice between a Constitution whose legitimacy derives from, say, implied consent to an overarching scheme of government, on the one hand, and the moral justifiability of its particular rules, on the other, we should choose the latter.

If the best basis for the Constitution's claim to authority is that the Constitution's principles are morally justified, then the Constitution's meaning ought to be determined in accordance with what is morally justified.110

This point can be made more concrete by relating it to the contemporary literature on constitutional interpretation. Constitutional theorists have advanced several competing theories of the Constitution's meaning: originalism,111 representation-reinforcing review,112 law-as-integrity,113 and dualism.114 Yet how should we choose among these various theories? The best argument to be made in favor of any one of them is that, if followed, the chosen theory will lead indirectly to a more just society than the alternatives.115 If the best argument is that we will be led indirectly to a just society, an even better approach would focus directly on the fundamental requirements of justice.

The idea that the Constitution's meaning ought to be determined in accordance with fundamental precepts of justice does not imply that courts should act as Platonic Guardians, making all important political decisions. Any acceptable theory of justice will leave most decisions to representative institutions. But, on any plausible view, decision-making by democratically elected officials is not an end in itself; it is rather a means to the end of attaining a just and good society.116 Generally speaking, the best available means to this end is to let representative institutions make decisions. Yet representative institutions will sometimes lead to immoral or unjust results. To minimize this danger, it makes sense to have a Constitution that renders fundamentally unjust outcomes off-limits.117 One aim of courts under the Constitution is to identify fundamental principles of justice that ought to constrain representative institutions.118

Under this "noninterpretivist" view of the Constitution's meaning, textual objections to a welfare right to health care lose their decisive force. Text and history may furnish rules that are useful to follow unless and until convincing reasons emerge not to do so. But ultimately, what matters is whether those rules are adequately supported by reasons, not the text. The crucial question, then, is whether a welfare right to health care finds support in the fundamental requirements of justice. Part II argued that it does.

Whether a welfare right to health care is grounded in the text or in principles of justice, difficult problems surround its judicial elaboration. One problem concerns the definition of the constitutionally required minimum. The correlation between health care and the exercise of textually specified rights seems strong when one considers the matter ex post from the perspective of persons who suffer from treatable life-threatening or debilitating illness. But the correlation between health care and the exercise of specified rights becomes much less compelling if one considers the matter ex ante from the perspective of healthy persons before they become sick. Then, the availability of health care does not mean the difference between ability to exercise those rights and their total frustration. Rather, it increases the probability that one will be able to exercise them longer. The impact of health care on the exercise of constitutional rights attenuates still further when one considers the difference between various levels of health care rather than between a high-level and a complete absence of care. Interpretivists must confront the difficult question of how strong must a given level of care impact the exercise of specified rights for it to be constitutionally required. Given the competing theories of distributive justice, noninterpretivists face an equally thorny task, that of deciding the level of care required as a matter of fundamental justice.119 The task that interpretivists and noninterpretivists face becomes further complicated when one recognizes that other goods, such as education, also exert a powerful influence on basic life opportunities. What constitutes an appropriate tradeoff between resources devoted to health care and education to be made?

Once a court has decided upon the required level of care, difficult questions surround the proper method for attaining it. As ways of achieving a wider access to health care, a single payer system, managed competition, a national health service, and vouchers all have their proponents and detractors. In addition, difficult questions surround the proper allocation of authority between state and federal governments in the formulation and implementation of any reform plan.

These difficulties argue for an extremely limited judicial role in the elaboration and enforcement of a welfare right to health care. First, rather than attempting to specify exactly what a just distribution of health care entails, courts should focus on the clearest injustice in the existing distribution. Under every conception of justice except libertarianism, it is unjust that substantial numbers of the uninsured lack access to cost-justified, life-prolonging preventive and primary care. Courts can declare this clear injustice unconstitutional without addressing the truly vexing questions of what justice requires beyond this. Second, as in the school financing cases, courts essentially should leave the method of remedying injustice to the political branches. Any supervisory role retained by the courts should be limited to assuring that the chosen method is a reasonable, good faith means of redressing the injustice. Third, rather than giving each aggrieved individual an enforceable right to health care, courts should limit their involvement to that of assuring that the political branches adopt a serious systemic plan for remedying the clear injustice identified above. Institutional concerns do not justify complete renunciation of a
judicial role in remedying this clear injustice, but they do justify avoidance of a role that would have courts parcel out health care to aggrieved persons on a case-by-case basis.\textsuperscript{120}

Such limited judicial role sensibly accommodates the competing considerations at stake. It recognizes the proper role of the courts and the Constitution in remedying clear injustice. It recognizes that the political branches of government often are insufficiently sensitive to constitutional values. It spurs the political branches to give more weight to constitutional values without enmeshing the judiciary in controversial empirical questions better left to the political process. It gives the political branches flexibility to take into account public sentiment. Finally, it avoids the administrative costs associated with the creation of rights that individuals may enforce on a case-by-case basis.

IV. Conclusion

Significant numbers of persons, based on their lack of medical insurance, do not receive cost-justified care that can be expected to prolong or improve their lives. This allocation of health care is fundamentally unjust, and courts defensibly can play the important role of prompting legislative reform of this injustice.

These conclusions have important implications notwithstanding the current promise of legislative action. On a practical level, the conclusion that the uninsured’s relative lack of access is seriously unjust furnishes a basis for evaluating acceptable legislative reform. In particular, it makes it difficult, if not impossible, to assign priority to the goal of controlling costs over that of increasing access. Unlike lack of access, excessive costs do not in themselves implicate fundamental principles of justice. Controlling spiraling health care costs is undoubtedly a valid goal. But increasing access should not be conditioned on the success of cost control efforts, especially since the government’s health care costs can be addressed effectively in part through measures, such as eliminating subsidies for the affluent and/or for high-cost, low benefit treatments, that do not entail perpetuating injustice.

On a more theoretical level, the conclusion that courts may prompt legislative reform provides a starting point for renewed discussion about the connections between justice, equal opportunity, the Constitution, and the proper role of courts. Contrary to the tacit assumption of most recent scholarship, a good case can be made that such connections exist and should be nurtured. Existing law, the ambiguity and arguably limited authority of the text, and a realistic appraisal of the comparative competence of the three branches of government leave ample room for a debate that does not now exist.

Notes

1. This is the position taken, for instance, by the Progressive Policy Institute, a project of the Democratic Leadership Council, which President Clinton helped found. Jeremy D. Rosner, A Progressive Plan for Affordable, Universal Health Care, in Mandate for Change 360 n.12 (W. Marshall & M. Schram eds., 1993). For examples of largely uncritical academic acceptance of the same premise, see infra notes 61-65 and accompanying text.

2. E.g., Melissa Ahern & H. Virginia McCoy, Emergency Room Admissions: Changes During the Financial Tightening of the 1980s, 29 Inquiry 67 (1992). As of 1986, the uninsured accounted for 17.6% of the non-aged population. Id.


5. But see Fla. Stat. § 768.132(2)(b)(1) (providing that a doctor or hospital providing emergency care to a patient who entered a hospital through its emergency room shall be liable only for gross negligence).

6. The uncompensated-care . . . gap is rapidly worsening. The American Hospital Association estimates that the combination of Medicaid payment shortfalls and unsponsored-care costs jumped from $3.5 billion in 1980 to $13.2 billion in 1989.

This leads hospitals to try to shift such costs to those who can pay, but the increased need to shift costs is unfortunately accompanied by greater difficulty in doing so as hospitals have had to accept discounted payments from large private payers for competitive reasons . . . . [Hospitals are caught between private and public third-party payers — each insisting that it will cover costs only for its own group[.]


7. See Robert L. Ohlsfeldt, Uncompensated Medical Services
It is known that the uninsured are less likely than their insured counterparts to receive prenatal care. Evidence of an association between inadequate prenatal care and adverse neonatal outcomes and of the particular benefits of prenatal care among high-risk women suggests the detrimental health consequences of inadequate health insurance in the prenatal period.


See generally Joel S. Weissman et al., Delayed Access to Health Care: Risk Factors, Reasons, and Consequences, 114 ANNALS INT. MED. 325, 328-30 (1991); Weissman, supra note 9, at 2393; Hadley, supra note 9, at 377 (“the uninsured [admitted to studied hospitals] are consistently less likely than privately insured patients to have a completely normal tissue pathology result” and “have a higher relative probability of in-hospital death”); Ahern, supra note 2, at 77 (noting “other recent studies indicating that lack of access for the poor results in deaths and emergencies associated with illnesses that could have been prevented or would have been routine if treated early.”); Nicole Lurie et al., Termination from Medi-Cal -- Does It Affect Health?, 311 NEW ENG. J. MED. 480, 484 (1984)(six months after termination of public insurance, there was evidence of significant deterioration of health status, particularly with control of hypertension); Nicole Lurie et al., Termination of Medi-Cal Benefits: A Follow-up Study One Year Later, 314 NEW ENG. J. MED. 1266, 1267 (1986) (finding additional deterioration of health status one year after termination of public insurance); John W. Berg et al., Economic Status and Survival of Cancer Patients, 39 CANCER 467 (1977)(“paying” patients have their cancers diagnosed at an earlier stage more often and have better survival rates than “nonpaying” patients). See also 1 President’s Comm’n 53-55 (1983)(discussing evidence that improved access to health care reduces the rate of mortality). The evidence thus does not bear out Ivan Illich’s conclusion that, on balance, medical care does not promote health effectively and that increasing the poor’s access to care would only equalize the delivery of “professional care, illusions and torts.” IVAN ILICH, MEDICAL NEMESIS: THE EXPLORATION OF HEALTH 74 (1976).

14. Ahern, supra note 2, at 77 (“adequate nonacute and nonemergency medical care is either less accessible to indigents, and/or increasing numbers of indigents do not try to obtain needed care.”). America’s Safety Net, 268 JAMA 2426 (1992)(“sociocultural factors may influence the patient’s decision to seek care and
comply with treatment”). But see, e.g., Weissman, supra note 9, at 2393 (increased incidence of disease among the uninsured is “unlikely to be the predominant explanation” for the insured’s higher rates of hospital admission for potentially avoidable conditions).

15. One recent article reports that while suburban community hospitals are well remunerated for treating trauma because victims of auto accidents are usually insured, inner-city hospitals are not because gunshot and stabbing victims are rarely insured. Consequently, in the Los Angeles area “[t]wenty-one of the original thirty-one private hospitals that initially were committed to the countywide trauma program have withdrawn from the system after less than two years of operation because the small percentage of operating costs that was recovered jeopardized the institutions’ solvency.” William Shoemaker et. al., De Facto Rationing of Emergency Medical Services, in RATIONING AMERICA’S MEDICAL CARE: THE OREGON PLAN AND BEYOND 151, 154 (M. A. Strosberg et al., eds., 1992). See also Jack Hadley et al., The Financially Distressed Hospital, 307 NEW ENG. J. MED. 1283 (1982).

16. See Shoemaker, supra note 15, at 153-54; Andrew B. Bindman et al., Consequences of Queuing for Care at a Public Hospital Emergency Department, 266 JAMA 1091, 1091 (1991).

17. At one inner-city hospital in Los Angeles, for instance, “3,014 (8.5 percent) of 35,376 patients left after registering without having been seen by a physician, and about four to five times that number (30 to 40 percent) left without registering, because either the emergency department was closed or the waiting period was too long.” Shoemaker, supra note 15, at 153. See also Bindman, supra note 16, at 1091 (“During 3 months in spring 1990, an average of 627 patients per month left [San Francisco General] without being seen”). Cf. Joel S. Weissman et al., Delayed Access to Health Care: Risk Factors, Reasons, and Consequences, 114 ANNALS INT. MED. 325, 329 (1991)(even when poor uninsured patients receive hospital care, they are nearly ten times more likely than other patients to report delays in obtaining it). Of course, many of the patients who leave emergency rooms without receiving care due to the long wait are there to receive non-emergency care to which they do not have effective access in settings other than an emergency room. The above data thus, in part, reflect the inaccessibility of non-emergency care to the uninsured.


19. “The snowball effect of delays not only increases shock and mortality but also increases the incidence of shock-related multiple organ failures, which can lead to multiple costs before the preventable death. Conjointly, delays tie up scarce and expensive resources and preclude their use for more salvageable patients.” Shoemaker, supra note 15, at 153. See also, Bindman, supra note 16, at 1095 (documenting “a systematic increase in clinically meaningful adverse outcomes among patients who left [the ER] without being seen.”) Andrew B. Bindman et al., A Public Hospital Closes: Impact on Patient’s Access to Care and Health Status, 264 JAMA 2899 (1990)(finding the following the closing of a public hospital, the percentage of patients without a regular provider increased by 13.7%, the percentage who were denied care increased by 6%, and patients’ health status declined significantly). See also supra note 13.

20. Hadley, supra note 9. See also Mark B. Wenneker et al., The Association of Payment with Utilization of Cardiac Procedures in Massachusetts, 264 JAMA 1255 (1990)(finding that the odds of privately insured patients receiving angiography, bypass grafting, or angioplasty were 80%, 40%, and 28% higher respectively than uninsured patients).

21. Hadley, supra note 9, at 377 (for each of ten diagnoses, length of hospital stay was consistently shorter for insured compared to insured patients, with greatest disparities for high-discretion and low-risk-of-death diagnoses).


23. Id. at 3300.


25. Braverman I, supra note 13, at 3307.

26. Hadley, supra note 9, at 378. Also REAGAN, supra note 6, at 41 (“another recent study of hospital-discharge data revealed that among persons hospitalized for heart attacks, the uninsured were 57 percent more likely to die than those with fee-for-service insurance and 48 percent more likely to die than those with HMO coverage.”).

27. Helen R. Burstin et al., Socioeconomic Status and Risk for Substandard Medical Care, 268 JAMA 2383, 2387 (1992).

28. See, e.g., Braverman I, supra note 13; Burstin, supra note 27, at 2387 (“Neither race nor income appeared to be significant risk factors for poor-quality care after controlling for other factors”); Weissman, supra note 17, at 329 (compared with other patients, the odds of delaying care because of cost were “nearly 10 times higher for uninsured patients, and more than 12 times higher for patients who were both uninsured and poor.”). 3 President’s Comm’n, supra note 8, at 65 (“Financial access to care is clearly the most important factor affecting “use” of ambulatory care). See supra note 6.


31. 1 President’s Comm’n, supra note 8, at 16.

32. See, e.g., Doughtery, supra note 6; David Copp, The Right to an Adequate Standard of Living: Justice, Autonomy, and the Basic Needs, in ECON. RIGHTS 231 (Ellen Frankel Paul et al., eds., 1992). One important implication is that the allocation of health care thus cannot be left to unregulated markets when the effect of
doing so is to deny access to many and when alternative arrangements provide fuller access.

37. E.g., Buchanan, *supra* note 34, at 65 (advocating right to a decent minimum); Copp, *supra* note 32 (same); Veatch, *supra* note 34 (advocating equal access).
39. See infra notes 43-45.
40. See, e.g., *supra* notes 10-13 & accompanying text.
41. Thus, even many devotees of the market may have great difficulty justifying the current distribution of health care. No one defends the market as an end itself. Many of its defenders — Richard Epstein, for example — view the market as the best real-world way of implementing utilitarianism.
42. Even Richard Epstein, who advocates a deregulated market for health care, acknowledges that, “Unfortunately, in the case of medical goods and services, it is easy to envision situations where wealth is a poor proxy for utility or need.” Richard A. Epstein, *Why is Health Care Special?*, 40 U. Kan. L. Rev. 307, 314 (1992).
Epstein nonetheless argues that the results of governmental intervention are worse than the imperfect workings of the market.

This position makes it difficult to explain why, with the exceptions of the United States and South Africa, the government of every affluent nation intervenes in the market to guarantee all citizens access to health care and such intervention apparently works tolerably well. Reagan, *supra* note 6, at 15-16. Indeed, in terms of access and cost, the health care systems of these other nations fare better than ours. *Id.* at 53-54, 86, 94-95, 148; Paul Starr, *The Logic of Health Care Reform* 18-19, 26-27 (1992); Dougherty, *supra* note 6, at 172. Life expectancy at birth is lower and infant mortality is higher in the United States than in Canada, Germany, Japan, and Great Britain, even though the United States spends more per capita on health care. Starr, at 26-27. In addition, “[a] study that compared public opinion about health care in 10 countries, conducted by Louis Harris and Associates in 1988 and 1990, found that the U.S., along with Italy, had the highest level of public dissatisfaction with its health-care system.” *Id.*
43. Aaron, *supra* note 24, at 75.
44. Reagan, *supra* note 6, at 6.
45. As the President’s Commission has noted:

[T]he cost of basic health insurance (which does not even guarantee financial access to adequate care in all cases) is high enough to place it beyond the reach of many families by any reasonable standard of affordability. Ironically, those who need the most care will find it most difficult to obtain it, both because their disease or disability impairs their opportunities for accumulating financial resources and because insurers will charge them higher rates.

1 President’s Comm’n, *supra* note 8, at 26-27 (footnote omitted) (emphasis in original). Since 1983, when this report was written, health care costs and medical insurance premiums have increased at a rate far in excess of the rate of general inflation.
46. As the President’s Commission concluded after surveying the evidence on who has health insurance, “[i]n short, health insurance coverage in the United States is to some extent a matter of ‘luck.’” 1 President’s Comm’n, *supra* note 8, at 100.
47. On what utilitarianism does support, see Daniel Wikler, *Philosophical Perspectives on Access to Health Care: An Introduction in 2 President’s Comm’n, supra* note 8, at 138-40.
49. See, e.g., Susan Sherwin, *No Longer Patient: Feminist Ethics & Health Care* 240 (1992) (“A health care system that reflects feminist ideals would ... be significantly more egalitarian in both organization and effect than anything that we are now accustomed to.”); Rita C. Mannon, *Speaking from the Heart: A Feminist Perspective of Ethics* 69-72 (1992) (under feminist “ethic of care,” one has an obligation to care for all other persons in need, even “starving children in Africa”).
51. For the view that this is not only immoral but also unconstitutional, see Richard A. Epstein, *Takings* (1985).
52. See, e.g., Nozick, *supra* note 50, at 182.
53. Because the government subsidizes the provision of insurance through the Medicare and Medicaid programs and through tax subsidies, see infra notes 66-74 & accompanying text, the current allocation overshadows the insured as well.
55. Beauchamp & Childress, *supra* note 38 at 276 (in contrast with “social” goods, “health care is largely a matter of the individual’s private good.”). Some kinds of public health measures can be characterized as public goods. Antibiotic treatment for tuberculo-
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sis, for example, benefits not only the patient, but also others to whom the disease might otherwise be transmitted. See Wendy E. Parmet, Health Care and the Constitution: Public Health and the Role of the State in the Framing Era, 20 HAST. CONST. L.Q. 267, 279-80 (1993).

56. Nozick, supra note 50.

57. Id. ch. 7.

58. Id. at 114-15.

59. First, the notion that, as a general matter, persons are morally entitled to property they acquire through consensual transactions is, at best, questionable. To some extent, the value of property is due to the natural world rather than man-made improvements. It is unclear why any single person should be morally entitled to this value. In addition, a person’s ability to acquire valuable property derives from factors for which the person has no responsibility: genetically determined or influenced intellectual and physical capacities; receipt of a better or worse education; family influences, etc. It is not clear why a person should be morally entitled, to exclusion of everyone else, to the value of property attributable to these factors. It is not clear why those who are, for reasons beyond their control, more fortunate have no moral obligation to assist those who are, for reasons beyond their control, unable to acquire valuable property.

Perhaps it would be good social policy to allow persons to own property they acquire through consensual transactions because such ownership creates incentives that increase productivity. But such a defense of property rights does not preclude involuntary taxation. Involuntary taxation need not destroy incentives and can produce other morally significant benefits. The conclusion that, wholly apart from incentive effects, persons have absolute property rights seems difficult, if not impossible, to defend.

Second, the opposition of coercive taxation to provide health care seems difficult to reconcile with libertarianism’s underlying concern for individual freedom. Such taxation to some degree diminishes the freedom of those who are taxed. But by increasing the availability of health care, such taxation increases the freedom of those whose ability to realize their life plans would otherwise be ended or limited by treatable disease or disability. No reason exists for attributing infinite weight to the freedom of those who are taxed and no weight to the freedom of those who would benefit from care tax revenues make possible.

It is difficult to see how, given an overriding concern for freedom, a libertarian could support involuntary taxation for a criminal justice system, but oppose it for a system to provide health care. As a threat to individual freedom, illness seems indistinguishable from criminal acts. For compelling criticisms of libertarianism of all stripes, see Will Kymlicka, Contemporary Political Philosophy 95-159 (1990). For compelling criticisms of libertarianism as applied to health care, see Dougherty, supra note 6, at 83-91.


65. Several commentators have argued that although the Constitution perhaps does create welfare rights, such rights are not judicially enforceable. See Cass R. Sunstein, The Partial Constitution 155 (1993)(“the right to welfare, if it exists at all, is a good candidate for membership in the class of judicially underenforced constitutional principles.”); Black, supra note 60. at 1107; Akhil Reed Amar, Forty Acres and a Mule: A Republican Theory of Minimal Entitlements, 13 HARV. J. L. & PUB. POL’Y. 37, 42 (1990).


67. “No personal income or payroll tax is levied on health insurance financed by employers.” The estimated value of government “expenditures” on this tax subsidy in 1991 is $36.3 billion. Aaron, supra note 24, at 66-67.

68. “In 1990 government accounted for $269 billion or 42% of the total national expenditures on health care.” Furrow, supra note 66, at 565.

69. Reagan, supra note 6, at 42. By contrast, in 1965 Medicaid covered 76% of those below the poverty line and 63% in 1975. Id. 70. The greater a person’s income, the higher one’s tax bracket and the greater the tax subsidy resulting from the exclusion of employer-financed health insurance from taxable income. Reagan, supra note 6, at 168. See also 1 President’s Comm’n, supra note 8, at 168. According to one study, the poor and near-poor receive an average of $2 per person in tax subsidies from government, those in the middle-income bracket receive $43 per person, and those in the high-income bracket receive $90. (citing Gail R.
71. Individuals also may deduct medical costs not reimbursed by insurance to the extent that these costs exceed 7.5% of adjusted gross income. Government "expenditures" on this tax subsidy totaled $3 billion for 1991. Aaron, supra note 24, at 67. Presumably, the uninsured received some portion of this subsidy, but the medical expense deduction "is available only to those who itemize deductions (a practice that is generally advantageous only to those with higher incomes), and the percentage subsidy is the taxpayer's marginal tax rate." 1 President's Commn, supra note 8, at 165.
72. Reagan, supra note 6, at 42. Medicaid covered 63% in 1975. Id.
73. See Wilensky, supra note 70, at 206.
74. 1 President's Commn, supra note 8, at 117.
75. A principal aim of the Fourteenth Amendment was to provide a constitutional basis for the Civil Rights Act of 1866, which gave African-Americans equal rights to property ownership and to judicial enforcement of those rights. Alfred H. Kelly et al., The American Constitution 338-44 (6th ed. 1983).
76. Sunstein, supra note 65, at 140.
77. Some commentators argue that the Fourteenth Amendment meaning must be limited by its objective of constitutionalizing the Civil Rights Act of 1866. On this view, the equal protection guarantee only prohibits race discrimination, not discrimination against other societal groups, and then only respecting the rights of property ownership set forth in the Civil Rights Act, not respecting other aspects of life such as social intercourse. Raoul Berger, Government by Judiciary: The Transformation of the Fourteenth Amendment, ch. 10 (1977). Such a cramped view of the equal protection guarantee defies both the generality of its language and the understanding of those who made it law that courts and future Congresses would have flexibility to define its dictates expansively. See, e.g., Bruce Ackerman, We the People 334-36 n.21 (1991); Alexander M. Bickel, The Original Understanding and the Segregation Decision, 69 Harv. L. Rev. 1, 58-59 (1955) (the framers deliberately chose language "capable of growth"); Eric Foner, Reconstruction 257-59 (1988).

Given this, the equal protection guarantee might plausibly be generalized in at least two ways. First, one might generalize the guarantee's concern for race discrimination so as to condemn all governmental race discrimination, whether or not it obstructs equal access to basic opportunity shaping institutions. Second, one might generalize the equal protection guarantee's concern with equal opportunity so as to condemn obstructions to basic opportunity shaping institutions, whether or not those obstructions involve race discrimination. Existing law generalizes the equal protection guarantee in both of these ways. See infra notes 78-83 and accompanying text.

79. Personnel Adm'r v. Feeny, 442 U.S. 256 (1979); Washington v. Davis, 426 U.S. 229 (1976). Governmental acts not designed to discriminate against a suspect societal group are presumptively valid, even if they have the effect of disadvantaging such a group.
84. See supra note 64.
87. See, e.g., Brown v. Board of Educ., 347 U.S. at 493-94 (describing link between education and opportunity); Daniels, supra note 30, at 46-47.
89. Tennessee Small Schs. Sys. v. McWherter, 851 S.W.2d at 156. 90. In other "institutional reform" settings, courts typically have sought to define a role that gives the legislative and executive branches great flexibility in remedying unlawful insensitivity to constitutional values. This role may range from a simple, "hands-off" declaration that a violation exists to extensive supervision of the institution. See generally Special Project, The Remedial Process in Institutional Reform Litigation, 78 Colum. L. Rev. 784 (1978).
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91. SUNSTEIN, supra note 65, at 147-49.
92. Id. at 145-46.
95. Vanderbilt Note, supra note 86, at 155 (noting that “frustration with continual legislative inaction is implicit in virtually every [successful school finance challenge] . . . . Only when a court is convinced that the legislature is unwilling or unable to effectuate financing reform will the court take on the responsibility.”)(footnote omitted).
96. ROSENBERG, supra note 93, at 22-23.
97. Id. at 23-24.
98. As Paul Starr has written:

American society provided insurance against medical expenses primarily to the well off and the well organized. The people who lost out were those without membership in groups, like the veterans and unions, that had political influence or economic power. The poor, for whom health insurance was originally conceived, were precisely the ones who did not receive its protection.

99. STARR, supra note 98, at 280-89 (describing the American Medical Association’s role in securing the defeat of President Truman’s effort to establish national health insurance); RASHI FEIN, MEDICAL CARE, MEDICAL COSTS 47-51 (1986) (same). STARR, at 404-05 (describing President Nixon’s unsuccessful effort to establish national health insurance); FEIN, at 145-50 (same).
100. ROSENBERG, supra note 93, at 31 (“when political, social, and economic conditions have become supportive of change, courts can effectively produce significant social reform.”).
104. SUNSTEIN, supra note 65, at 69-71.
105. Cf. Id. at 119 (“The text is properly treated as binding”).
106. The Continental Congress charged what is now called the Constitutional Convention with the task of recommending amendments to the Articles of Confederation. The Constitutional Convention violated this charge by drafting a new scheme of governance. Furthermore, the Constitution became law in violation of the Articles of Confederation. The Articles of Confederation provided that amendments receive the unanimous consent of all thirteen state legislatures. According to its own terms, the Constitution became law after approval of special ratifying conventions in only nine states. State legislatures played no role in the ratification process. See ACKERMAN, supra note 77, at 41.
107. SUNSTEIN, supra note 65, at 100.
109. See generally A. JOHN SIMMONS, MORAL PRINCIPLES AND POLITICAL OBLIGATIONS (1979). For a skeptical discussion of the notion that morally deficient laws may nonetheless be binding, see DAVID LYONS, MORAL ASPECTS OF LEGAL THEORY 208-12 (1993).
110. This does not mean that courts may routinely ignore the text of statutes and use statutes as a free-wheeling charter to do justice. One fundamental principle of any acceptable moral-political theory, which is and should be a part of our Constitution, is that representative decisions normally deserve to be respected by the citizenry and by the courts. As a way of indirectly assuring fair and morally defensible results, representative decision-making is generally better than the alternatives. The Constitution exists both to establish fair representative processes and legitimize generally the results of those processes and to rule out fundamentally unjust results.
112. See, e.g., JOHN HART ELY, DEMOCRACY AND DISTRUST (1980). This theory holds that courts should fill in ambiguities in the Constitution’s text so as to cure imperfections in representative processes.
113. See RONALD DWORKIN, LAW’S EMPIRE (1986). This approach holds, roughly, that the Constitution’s text and precedent interpreting it should be interpreted by reference to moral principles that provide their best justification. See LYONS, supra note 109, at 207.
114. ACKERMAN, supra note 77. Ackerman’s “dualist” theory of the Constitution asks courts to identify, constitutionalize, and reconcile the “considered judgments” made by mobilized political majorities.
118. It makes good sense to give the federal judiciary final authority, vis-a-vis the other branches of government, to elaborate fundamental requirements. Because the very purpose of this task is the identification of outcomes that representative institutions must avoid or achieve, the task should be entrusted to an institution relatively insulated from direct electoral accountability. Federal judges, who have life tenure and a guarantee against diminution of salary, are so insulated. Furthermore, unlike other branches of government, courts must articulate reasons for their decisions and are under an obligation to strive to make their decisions and reasons coherent. Rationality and coherence are essential qualities in the elaboration of the fundamental requirements of justice. *Id.* at 86-105.