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The Right to Health Care in the United States

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There are three basic points I would like to make in this paper. The first is the most straightforward: There is nothing that can be characterized—at least in any general sense—as a constitutional right to health care in the United States. The federal Constitution does not require any level of government to provide for or maintain the health of the population as a whole or any portion of it; there are a few circumstances under which an individual can make a constitutionally-based claim for a health or medical benefit, but these circumstances are rare and the use of the term "right to health care" in reference to them would be both misleading and inappropriate.

The second point is related to the first, somewhat more abstract, but equally important: Given the nature of constitutional rights in this country and the manner in which they are enforced, it is hard to imagine that there *could* be any general or broadly applicable constitutional right to health care. Even a court that would be inclined to do so would be faced with both theoretical and practical difficulties of insurmountable proportions in devising and enforcing such a governmental obligation.

My third point will sound in some ways contradictory to the first two, but is, ultimately, the most important: There are significant rights to health care in the United States, although they are more properly characterized as political rights or entitlements than constitutional rights. And it is the nature and extent of these rights which are of prime significance when comparing the United States to other jurisdictions or otherwise evaluating contemporary health policy.

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SECTION I

To begin with the most fundamental, the United States Constitution does not require the federal government, the state governments, or any other level of government to protect the health of its citizens collectively or individually.[1] This has less to do with the fact that the Constitution neither explicitly nor implicitly recognizes the value of health or health care, there is no textual reference to either term, and more to do with the overall structure of the Constitution. The constitutional provisions that protect individual interests, and that are generally referred to as constitutional rights, are almost exclusively negative. They prevent, rather than require, government action of one sort or another. The interstate commerce, spending, and other constitutional provisions that empower the federal government to act have been interpreted broadly and to include the power to create federal health programs of virtually any kind, but this authority is permissive not mandatory.[2] Similarly, the definition of the states' inherent "police powers," as implied by the enumeration of the federal government's powers and as preserved by the language of the Tenth Amendment, clearly includes broadly defined powers to act in matters relating to health, but, again, the states' authority is defined permissively and does not obligate the states to act to protect their citizens in any affirmative sense.[3] In fact, the Constitution does not require gov-

1. It should be emphasized at the outset that the analysis in this paper is focused exclusively on the requirements of the United States Constitution. It is possible—although rarely explored in either the case law or in legal commentary—that the constitution of an individual state could be interpreted differently and in such a way as to recognize that either the state itself or a state's local government has an affirmative obligation to provide for the health or welfare of its citizens. For example, in Deaconess Medical Center v. Department of Social & Rehabilitation Services, 720 P.2d 1165 (Mont. 1986), the Montana Supreme Court implied that the state had some minimal obligation to provide for the health needs of its citizens under a state constitutional provision which reads: "The legislature shall provide such economic assistance and social and rehabilitative services as may be necessary for those inhabitants who, by reason of age, infirmity, or misfortune may have need for the aid of society." MONT. CONST., art. XII, § 3(3).

Affirmative obligations have also have been imposed on county or local governments in some states by legislation (although not by constitutional mandate). *See, e.g.*, ARIZ. REV. STAT. ANN. § 11-251 (1992) (as interpreted by Hernandez v. County of Yuma, 369 P.2d 271 (Ariz. 1962)); CAL. WELF. & INST. CODE § 17000 (West 1992).

2. For a discussion of the enumerated powers of the federal government in matters relating to health and health care, see KENNETH R. WING, THE LAW AND THE PUBLIC'S HEALTH 17-18 (3d ed. 1990).

3. The federal Constitution does not explicitly define the state's powers; rather, it is structured in such a way as to define those powers ceded by the states to the federal government. All other governmental authority, subject to other constitutional restrictions, is assumed to belong to the individual states. As such, the Tenth Amendment is generally regarded as confirming the states' powers, rather than an independent or pri-

ernment to provide any domestic or social welfare benefit. Governing, at least in these areas if not in all matters, is essentially discretionary under the American constitutional structure.[4] The Supreme Court has repeatedly and consistently reaffirmed this "no affirmative right" principle as a fundamental and general precept of modern constitutional doctrine.[5]

The few relevant exceptions to this principle only highlight its breadth and implications. The Supreme Court has recognized that government has some affirmative responsibility to provide for the needs, including the medical needs, of mental patients, the institutionalized retarded, prisoners, and, presumably, other wards of the state or federal governments.[6] But in each of the cases in which it has done so, the Court has premised its reasoning on the fact that the protected individual was in the custody, in the most literal sense, of the government and has insisted that any mandatory government responsibility be strictly limited to those circumstances.[7] And even with regard to the individual who is in custody, the government's obligation to provide care has been so narrowly defined by the Court as to represent little more than a "freedom from abuse," and nothing that could be realistically regarded as a generalized right to health care or treatment, or as a right to treatment or services of any particular kind.[8]

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mary source of state authority. For a more detailed explanation of the states' powers in matters relating to health, see *id.* at 18-19, 25-35.

4. DeShaney v. Winnebago County Social Servs. Dep't, 489 U.S. 189, 196 (1989) (state social service programs had no constitutional obligation to prevent child abuse even where it had evidence that the father was physically abusing the child). *See also* Rust v. Sullivan, 111 S. Ct. 1759, 1776 (1991) (quoting *DeShaney* as applicable in defining the obligation of the federal government).

5. Virtually the only circumstances in which the Supreme Court has required the government to act are those where the government has already undertaken to provide some benefits and constitutional principles require others to be provided as well. *See infra* notes 13-21, 82-85. Otherwise, the government is not even required to provide basic policing or public health services.

6. In O'Connor v. Donaldson, 422 U.S. 563 (1975), the Supreme Court recognized that involuntarily confined mental patients have a "right to liberty"—although the Court explicitly declined to rule that that right might require the treatment of those who are involuntarily confined. In a complicated line of cases in the 1980s, the Court also recognized what could be loosely termed a constitutional right to "treatment" or "habilitation" for the mentally retarded. *See* Youngberg v. Romeo, 457 U.S. 307 (1982); Pennhurst State Sch. & Hosp. v. Halderman, 465 U.S. 89 (1984). The Court also has recognized that incarcerated prisoners have what could be characterized as a limited right to medical treatment. *See* Estelle v. Gamble, 429 U.S. 97 (1976); Wilson v. Seiter, 111 S. Ct. 2321 (1991); Hudson v. McMillian, 112 S. Ct. 995 (1992). *Cf. infra* note 8.

7. *DeShaney*, 489 U.S. at 198-201.

8. *See* discussion in WING, *supra* note 2, at 58-72. The Supreme Court's interpretation of the "right" to medical treatment of incarcerated prisoners is demonstrative. On

If the term right to health care has any relevance in describing constitutional doctrine in the United States, it is in reference to those constraints imposed on the government's discretion once it has exercised its broadly defined powers to provide or finance health or health-related benefits. In authorizing or implementing such programs as Medicaid, Medicare, or any of the other federal, state, or local health care financing or service activities,[9] the government must comply with important constitutionally-imposed constraints, particularly the nondiscrimination requirements of equal protection and the "fairness" requirements of due process as imposed by the Fifth and Fourteenth Amendments.[10] While still essentially negative in nature, these constitutional constraints could be characterized as creating rights to health care in that they allow, in essence, the argument that so long as some benefits are provided to some people they must be provided to others as well.

The extent and nature of the rights to health care created by these constitutional constraints has been rather definitively illustrated by a series of abortion funding cases decided in the last two decades. In the companion cases of *Maher v. Roe*[11] and *Beal v. Doe*,[12] the Supreme Court rejected the argument that a Medicaid program which allowed state funding for childbirth and therapeu-

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several occasions the Court has interpreted the Eighth Amendment's prohibition on cruel and unusual punishment to mean that the state cannot be deliberately indifferent to the medical needs of prisoners; however, the Court has specifically held that ordinary "malpractice" is not cruel or unusual. *See Estelle*, 429 U.S. at 97; Whitley v. Albers, 475 U.S. 312 (1986). In *Wilson v. Seiter*, Justice Scalia, writing for the Court, summarized these cases:

> Since we said, only the " 'unnecessary *and wanton* infliction of pain' " implicates the Eighth Amendment, . . . a prisoner advancing such a claim must, at a minimum, allege "deliberate indifference" to his "serious" medical needs. "It is *only* such indifference" that can violate the Eighth Amendment . . . . [A]llegations of "inadvertent failure to provide medical care" . . . or of a "negligent . . . diagnos[is]" . . . simply fail to establish the requisite culpable state of mind.

111 S. Ct. at 2323 (emphasis added) (citations omitted).

9. *See* description of these programs *infra* notes 87-90.

10. While most arguments are premised on the requirements of equal protection and substantive due process, it can also be argued—although rarely with much success—that other constitutional constraints impose similar obligations on the government. *See* Eighth Amendment cases, *supra* note 8; O'Bannon v. Town Court Nursing Ctr., 447 U.S. 773 (1980) (procedural due process does not require continuation of benefits to patients in decertified nursing home); Harris v. McRae, 448 U.S. 297 (1980) (limits on government funding of abortions do not violate the right to privacy or the establishment clause of the First Amendment; First Amendment free exercise claim not properly raised); *Rust*, 111 S. Ct. 1759 (First Amendment free speech not violated by limits on abortion counseling).

11. 432 U.S. 464 (1977).

12. 432 U.S. 438 (1977).

tic abortions, but denied reimbursement for nontherapeutic abortions, was a violation of equal protection. The Court held that the state's limitation on funding need only satisfy the requirements of "rationality," and that the state's interest in promoting childbirth was a sufficiently "rational" basis for refusing to fund some services while choosing to fund related services.[13] The Court followed similar reasoning in *Harris v. McRae*,[14] in upholding a congressional ban on all federally funded abortions except those involving rape or incest or those where the life of the mother was at stake. Even where the health (but not the life) of a woman may be in jeopardy, the government's decision to refuse to finance her medical care need only be rational to satisfy the requirements of equal protection and due process, and a legislative preference for childbirth over maternal health is sufficient to satisfy that constitutional standard.[15]

Virtually the same reasoning was applied to a state government decision to prohibit public institutions and public employees from performing abortions in *Webster v. Reproductive Health Services*[16] and to a federal prohibition on the counseling or discussion of abortions imposed on family clinics that receive federal funds in *Rust v. Sullivan*.[17] In both cases, the Court held that the government's decision to exclude abortion or related activities while continuing to finance or provide other services relating to childbirth or pregnancy need only be rational to meet constitutional requirements. And, again, it reaffirmed that the government's interest in discouraging or preventing abortions is by itself a sufficiently rational explanation for the limitations imposed on these governmental programs.[18]

The broader implications of these cases for defining the rights that may be claimed by those who are denied the benefits of government health programs may be obscured by the specific focus of each of these cases on the issue of abortion, as well as by the somewhat stilted rhetoric that characterizes constitutional analysis in this area of the law. Nonetheless, these decisions and their under-

13. *Maher*, 432 U.S. at 478.

14. 448 U.S. 297.

15. 448 U.S. at 326. Note that *Harris* also considered and rejected arguments based on the First Amendment and other provisions of the Constitution, in addition to equal protection and due process claims. *Id.* at 312-21.

16. 492 U.S. 490 (1989).

17. 111 S. Ct. 1759 (1991).

18. For a more detailed analysis of these cases, see Kenneth R. Wing, *Speech, Privacy, & the Power of the Purse: Lessons from the Abortion "Gag Rule" Case*, 17 J. HEALTH POL., POL'Y & L. 163 (1992).

lying reasoning deserve considerable attention because they define the outer limits and, as it turns out, decidedly narrow scope, of the rights to health care created by such constitutional requirements as those of equal protection and due process when applied to government discretionary decisions in health care and related programs.

At the time that each of these decisions was rendered, the Court's decision in *Roe v. Wade*[19] was still "good law."[20] That is to say, the Court analyzed the constitutionality of each of these abortion limitations as if a woman's choice concerning abortion was a constitutionally-protected "fundamental interest." In the rhetoric used by modern courts in equal protection or due process analysis, if a government decision adversely "affects" a "fundamental interest" or, alternatively, discriminates on the basis of a racial or other "suspect" classification, then a reviewing court is required to impose a rigorous "close scrutiny" analysis to that governmental determination.[21] Under "close scrutiny," the court must find that the government's interest is sufficiently "compelling" to justify the impact on the "affected" "fundamental interest" and that the legislation is "narrowly tailored" so as to minimize that impact. Legislative determinations subject to "strict scrutiny" can survive judicial review, but rarely do so. In functional terms, a judicial determination to extend the protections of "close scrutiny" to an individual interest or activity is a determination of that interest or activity's status as a "constitutional right."[22]

Conversely, if "close scrutiny" is not applied, as is generally the case with government decisions that do not affect First Amendment interests, citizenship, constitutionally-protected aspects of

19. 410 U.S. 113 (1973).

20. In Planned Parenthood of S.E. Pa. v. Casey, 112 S. Ct. 2791 (1992) the Supreme Court reformulated previous doctrine concerning the government's power to regulate abortions. In doing so, the Court somewhat diluted the constitutional status of abortion privacy, allowing the government to regulate abortions so long as there is no "undue burden" on the woman's privacy interest—as opposed to requiring, as had previous case law, a demanding "close scrutiny." As a consequence, the discretion of the government to finance or provide abortion services must be even more broadly defined than it was in those cases that assumed the *Roe v. Wade* definition of abortion privacy.

21. For a discussion of "suspect classifications," see *infra* text accompanying notes 48-52.

22. Whether an activity or interest is considered a "fundamental interest" for purposes of equal protection or due process analysis, or considered a constitutional right per se, e.g., the interests protected by the First Amendment, there is no absolute prohibition on government action with respect to that activity or that interest. Such constitutional recognition only secures for that activity or interest the protection of judicial "close scrutiny" or some equivalently enhanced level of judicial review of the underlying justification for its denial or abridgement.

privacy, or other recognized "fundamental interests,"[23] then the reviewing court need only find that the legislation or executive action is rational. Under a standard of rationality, a court is required to make only a cursory review of the government's purpose and its relation to the means chosen to achieve that purpose, and to engage in a minimal and decidedly deferential evaluation of the actual impact of the decision on affected individuals.

Prior to the abortion funding cases, the Supreme Court had in previous cases held that most government decisions to provide or fund social welfare benefits—cash payments, other social services, even public education—do not involve a "fundamental interest" and therefore are generally subject to no more than a rationality review.[24] Under the view adopted by the Court, an interest or activity must be both fundamental in the sense that it is very important *and* "fundamental" in the sense that it is somehow recognized as such by the Constitution to be regarded as "fundamental" for purposes of "close scrutiny" analysis.[25] In fact, the Court has carefully and purposefully adopted this rigid definition of "fundamental interests" in order to limit those circumstances under which heightened judicial scrutiny is required.[26] Similarly, the Court has carefully limited the circumstances under which judicial "close scrutiny" is triggered by the finding that the governmental classification is "suspect."[27]

The critical significance of the abortion funding decisions in clarifying these principles was threefold: First, these cases confirmed what had already been strongly implied by previous decisions: An individual's interest in health or health-related benefits, even where the health status of the individual is in serious jeopardy, is not within the limited class of interests that are "fundamental" in the constitutional sense of the term and, therefore, is not deserving of enhanced judicial protection. Health or health benefits may be fundamental, meaning that they are very important, but they are not, as noted earlier, recognized or protected, even by implication,

23. *See* discussion *infra* notes 28-31, 77-81.

24. *See* discussion *infra* notes 39-44, 71-73.

25. *See, e.g.*, San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 29-38 (1973). *See also* Lindsey v. Normet, 405 U.S. 56 (1972). For a broader discussion, see WING, *supra* note 2, at 117-21.

26. *See* WING, *supra* note 2, at 128-33. Note, however, that at least some *state* courts have adopted a different judicial posture and a somewhat broader reading of the antidiscrimination requirements of their state constitutions. *See, e.g.*, Olsen v. State, 554 P.2d 139 (Or. 1976).

27. *See infra* text accompanying notes 72-76.

in the federal Constitution.[28]

Second, these cases raised—and rejected—the possibility that at least some limits or exclusions from government health or health-related programs are subject to more rigorous judicial review, even if most are not, where such interests as privacy, speech, or perhaps other "fundamental interests" are "affected" by a limit or exclusion. In *Maher*, *Beal*, and again in *Harris*, the Court insisted that a government decision to finance some medical services related to pregnancy but not abortions does not "affect"—in the constitutional sense of the term—an individual seeking an abortion, even if abortion is an aspect of privacy deserving enhanced constitutional protection when "affected" in other ways.[29] According to the Court's analysis in these cases, unlike a government decision that makes an abortion a crime or otherwise affirmatively prevents an abortion, a decision by the government to deny abortion funding leaves the individual "no worse off" than if the government had not acted at all; as a consequence, no "fundamental interest" is "affected" by that decision.[30]

The decision in *Webster* took the same premise a step further. The government does not "affect" the privacy of a woman seeking an abortion when it denies her access to public facilities or to the services of public employees.[31] According to *Webster,* the woman is still "no worse off" than she would be if the government had provided no facilities or employees at all.[32] The underlying analysis in *Rust* was somewhat more complicated but essentially the same. At least in the eyes of the majority of the Supreme Court, a woman seeking family planning counseling is "no worse off" receiving counseling for some matters but not for others that the government chooses to prevent or discourage; consequently, her "fundamental interest" in abortion is not constitutionally "affected" when she receives family planning advice and counseling within the strict limits imposed by the "gag rules."[33] Similarly, the Court found that the First Amendment interests of the counselors who under those federal regulations are prohibited, in the most lit-

28. Indeed, in light of the Court's earlier decisions discussed *supra* note 25, the argument that health or health care is a "fundamental interest" was not even raised in these cases. *Cf.* Memorial Hosp. v. Maricopa County, 415 U.S. 250, 259 (1974).

29. Harris, 448 U.S. 297, 314-17, 322-23; Maher, 432 U.S. 464, 473-78.

30. *See* DeShaney v. Winnebago County Social Servs. Dep't, 489 U.S. 189, 196 (1989).

31. 492 U.S. 490, 507-11.

32. *Id.* at 509.

33. 111 S. Ct. 1759 (1991).

eral sense of the term, from any use of the word "abortion" are not "affected" by this prohibition:

> Individuals who are voluntarily employed for a Title X project must perform their duties in accordance with the regulation's restrictions on abortion counseling and referral. The employees remain free, however, to pursue abortion-related activities when they are not acting under the auspices of the Title X project. The regulations . . . do not in any way restrict the activities of those persons acting as private individuals. The employees' freedom of expression is limited during the time that they actually work for the project; but this limitation is a consequence of their decision to accept employment in a project, the scope of which is permissibly restricted by the funding authority.[34]

Taken together, these cases have practically foreclosed the possibility that exclusions from or limitations on government health programs will be subject to enhanced judicial scrutiny, whether those programs involve the direct delivery of services or the financing of services delivered by private providers.[35] If health or health care cannot be fashioned as "fundamental" in any general sense, and, in any event, if a refusal to fund or even to provide services related to a "fundamental interest" generally does not "affect" that interest, then in almost all circumstances the constitutional limits on the government's discretion in fashioning such programs are reduced to those provided by the minimal protections of rationality.

The factual context of *Harris* raised the question in the most dramatic fashion: The Court clearly acknowledged that the denial of abortion funding would place the health of some women in serious jeopardy *and*, since many of these women were poor, it also acknowledged that at least some of them would not find alternative private sources.[36] Nonetheless, the *Harris* Court's answer to the question was equally clear: The exclusion did not "affect" their "fundamental interest" in privacy and, consequently, it need only be rational.[37] In fact, the Court in *Harris* made it fairly clear that

34. *Id.* at 1775. This is perhaps the most controversial extension of the "no worse off" argument. It assumes that a pregnant woman with limited information—and who is unaware that some information has been omitted—is "no worse off" than someone with no information at all, an assumption which has been heavily criticized. It also ignores altogether the primary thrust of the argument by abortion counselors: They are required to provide "some but not all" information, something many regard as a form of malpractice. *See* Wing, *supra* note 18, at 165-66. *See also infra* note 79.

35. *Cf.* "penalty" cases discussed *infra* text accompanying notes 54-62.

36. 448 U.S. 297, 316-18 (1980).

37. *Id.* at 323.

the constitutional result would have been no different if the ban on abortion financing reviewed in that case (the so-called Hyde Amendment) had included a prohibition on life-saving abortions as well:

> [A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls into the latter category. . . . [T]he Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.[38]

Presumably this means what it stops just short of saying: A woman who will die unless she gets a life-saving abortion cannot demand assistance from the government if it rationally chooses not to provide that service, even if the government is providing health or health-related benefits of other kinds. She is no worse off than if there were no government program at all. Therefore neither her "fundamental interest" in privacy or anything else recognized as constitutionally "fundamental" is "affected."

The broader implications of this reasoning in *Harris* and that in the other cases are just as clear. If the impact of a government exclusion or limitation on a woman's privacy—at a time when abortion privacy was still afforded the highest level of constitutional protection—or even on her life does not elevate the constitutional analysis beyond the level of rationality review, then an individual subject to most any other exclusion or limitation obviously will be afforded no greater judicial protection. Thus there may be constitutional constraints that create rights to health care to those who are denied the benefits of government programs, but in virtually all circumstances those rights can be reduced to a single, minimal principle: The courts must find only that a government limit or exclusion is rational.

Even reduced to such terms, the rights created by these constitutional constraints must also be read in light of the other significant aspect of the abortion financing cases. Some earlier cases had suggested that even under the more limited review of rationality, an exclusion from or limitation on a government health program would have to have a legitimate government purpose and that purpose would have to be related, however minimally, to the underlying purposes of the program itself. In other words, rationality would require some judicial validation of the government's claimed

38. *Id.* at 316-17.

purpose in excluding or limiting the benefit and some evaluation of the linkage between that purpose and the broader objectives of the particular program to which the limit or exclusion is attached. For example, in 1972 the Supreme Court held that a state could properly give a lower level of welfare benefits to poor families with dependent children than to comparably-sized families comprised of poor blind, aged, or disabled welfare recipients.[39] But in doing so, the Court noted that the state could rationally make the legislative judgement that dependent children were more adaptable to the increased hardships of reduced benefits.[40] In 1982, the Court upheld as rational the use of different financial eligibility standards for different categories of Medicaid recipients, even where the net result would be the denial of benefits to some people with higher needs than those of some people who receive Medicaid's assistance.[41] Again, while decidedly deferential, there was at least some minimal judicial review of the legislative judgement and a finding that the use of differing eligibility standards was at least a rational attempt to measure the relative need of various recipients.[42]

The abortion financing cases further tested the limits of rationality review because the state or Congress did not justify the exclusion of abortion from various government programs on the basis of the relative value of various services or on some distinction between the needs of various recipients, or even as an attempt to allocate scarce program resources more effectively. Rather, in each case, the exclusion or limit was justified solely as an attempt to further a political or moral judgement to "encourage childbirth" or, to be more blunt, to discourage or prevent abortions.[43] These cases raised the question whether such a political or moral judgement is by itself a legitimate justification for a limitation or exclusion from a government program. Again the answer provided was

39. Jefferson v. Hackney, 406 U.S. 535 (1972).

40. *Id.* at 549.

41. Schweiker v. Hogan, 457 U.S. 569, 591 (1982). Hogan lost Medicaid eligibility when he received a Social Security "cost of living" increase. To regain eligibility he had to "spend down" income and resources far in excess of the "cost of living" increase. As a result, many people with higher available income were eligible for Medicaid while he was not.

42. *See also* Bowen v. Gilliard, 483 U.S. 587 (1987); Lyng v. United Auto., Aerospace & Agric. Workers of Am., 485 U.S. 360 (1988); *cf.* United States Dep't of Agric. v. Moreno, 413 U.S. 528 (1973).

43. From a policy point of view, the other significant difference between the abortion financing limits at issue in these cases and the governmental objectives sought in other cases lies in the fact that any government health program that funds pregnancy but not abortion is more expensive than a program which funds both. Nonetheless, it is apparently "rational" even if it is more expensive. *See* Maher, 432 U.S. 464, 478-80.

clear and definitive; again the broader implications for those who are denied the benefits of government health programs are best illustrated by the *Harris* decision: Even where the decision to exclude abortion financing from federal health care financing programs would seriously jeopardize the health of many of the programs' beneficiaries, a legislative decision to "encourage childbirth" is by itself a sufficiently legitimate basis for doing so.[44]

To state all this more broadly, there are in form and in theory constitutional constraints on the government's discretion when it undertakes to provide or finance health programs, most notably the requirements of due process and equal protection.[45] But in virtually all circumstances, such constraints are quickly reduced to no more than a requirement that the government be rational. And under traditional constitutional principles, a finding of rationality requires little more than the judicial acknowledgement that the government has advanced some legitimate objective to justify a limit on or exclusion from a health program—even where that objective is arguably unrelated to the purposes for which the program was established or where that same objective would be constitutionally unacceptable if pursued by other means. Indeed, given both the manner in which the rationality principle is applied and the underlying constitutional philosophy from which it derives, it is likely that even a truly irrational limit or exclusion would satisfy

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44. 448 U.S. 297, 324. The Court's justification for this position was best articulated in *Bowen*:

> The District Court was undoubtedly correct in its perception that a number of needy families have suffered, and will suffer, as a result of the implementation of [this amendment to the food stamp program]. Such suffering is frequently the tragic byproduct of a decision to reduce or to modify benefits to a class of needy recipients. Under our structure of Government, however, it is the function of Congress—not the courts—to determine whether the savings realized, and presumably used for other critical government functions, are significant enough to justify the costs to the individuals affected by such reductions. The [Constitution] "gives the federal courts no power to impose upon [Congress] their views of what constitutes wise economic or social policy," by telling it how "to reconcile the demands of . . . needy citizens with the finite resources available to meet those demands."
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> " ' "The discretion belongs to Congress unless the choice is clearly wrong, a display of arbitrary power, not an exercise of judgment." ' . . ." This standard of review is premised on Congress' "plenary power to define the scope and the duration of the entitlement to . . . benefits, and to increase, to decrease, or to terminate those benefits based on its appraisal of the relative importance of the recipients' needs and the resources available to fund the program."

483 U.S. at 596-98 (citations omitted).

45. *See supra* note 10.

the constitutional requirement of rationality.[46] In practical terms, virtually all government decisions in these matters are per se constitutional and the constitutional constraints that exist in theory and in form are, in fact and in substance, illusory.[47]

As with the "no affirmative right" principle, the few exceptions to the principle of rationality are so narrow that they primarily serve as a confirmation of the breadth of the general rule. As noted earlier, heightened judicial review of a government exclusion or limitation can be triggered if there is a finding that the result is discrimination on the basis of a "suspect class." This primarily arises under circumstances where there is an overtly expressed intent to discriminate on the basis of race or national origin or, at least where such intent can be inferred from sufficiently persuasive statistical evidence.[48] If such review is triggered, there is virtually no constitutionally acceptable justification for discrimination based on a "suspect class."[49] As noted earlier, however, the applications of this doctrine have been extremely narrowly drawn. Among other things, the Supreme Court has rejected any argument that discrimination based on age, condition of disability, or economic status would be considered sufficiently "suspect" for constitutional purposes, even where the intent to discriminate on such bases is

46. A possible example would be a statute that randomly excluded services or benefits from a program; or a health care program that intentionally covered expensive treatment options, but excluded coverage of less expensive comparable treatment.

47. United States Department of Agriculture v. Moreno, 413 U.S. 528 (1973), is the only case in the last twenty-five years in which the Court has applied the rationality standard to a government social welfare program and engaged in any realistic examination of either the government's objectives or the means by which the government claims it is achieving those objectives. In *Moreno*, the Court invalidated an exclusion of households of unrelated persons from the federal food stamp program. *Moreno* is so aberrational that it cannot be regarded as having any precedential value. Virtually the only other time the Court has ruled a government action unconstitutional under the rationality standard was in Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432 (1985) (zoning ordinance which excluded home for the disabled was a violation of equal protection).

48. For a good discussion of the limits of "suspect class" analysis as applied to social welfare programs, see San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 17-28 (1973), and *Cleburne*, 473 U.S. at 439-470.

49. According to the view adopted by the Supreme Court (at least in modern times), virtually the only acceptable government purpose that can be achieved by a means that incorporates an overt racial classification is some form of "benign" discrimination or "affirmative action." Even then some members of the Court would invalidate the classification and demand that all government actions be "colorblind." *See, e.g.*, City of Richmond v. J.A. Croson, Co., 488 U.S. 469 (1989). *Cf.* Metro Broadcasting, Inc. v. Federal Communications Comm'n, 497 U.S. 547 (1990).

clearly expressed.[50] The only notable exception is sex or gender discrimination. In a somewhat inconsistent line of cases, the Court has attempted to treat government decisions involving sex or gender discrimination as "quasi-suspect," applying something more than rationality review, but something less than "close scrutiny," to such decisions.[51] Again, however, such review is only triggered where there is intentional or overt discrimination.[52] Thus there is virtually an absolute prohibition on any government health program that discriminates on the basis of a "suspect class," and some limitations on discrimination based on sex or gender; but these are limits which create "rights" to health care in only a very limited sense.

Another possible but equally narrow exception to the general rule of rationality in determining the constitutionality of limits on or exclusions from government health programs arises where the limit or exclusion imposes a "penalty" on a "fundamental interest." In *Shapiro v. Thompson*,[53] the Supreme Court held that a state's durational residency requirement imposed as a precondition to eligibility for welfare benefits effectively "penalized" otherwise eligible recipients who had recently exercised their constitutionally protected "right to travel" (more aptly described as a "right to become a state resident.")[54] As such, the Court was required to "closely scrutinize" the legislation. Significantly, the Court rejected the state's interests in conserving resources or preventing fraud—i.e., saving government funds—as sufficiently "compelling" to justify the impact on the "fundamental interest" or the "right to travel."[55]

50. *See Cleburne*, 473 U.S. at 439-47 (1985); Kadrmas v. Dickinson Pub. Sch., 487 U.S. 450, 458-61 (1988).

51. *See* Califano v. Goldfarb, 430 U.S. 199 (1977) (differential treatment of widows and widowers in determining eligibility for benefits under the Social Security program unconstitutional); Califano v. Webster, 430 U.S. 313 (1977) (differential treatment of female and male wage earners' income under the Social Security program is constitutional).

52. For example, the Supreme Court had held that a state law that gives preference in public employment to veterans (who are predominately male) is not sex or gender discrimination despite the obvious impact on females. Personnel Adm'r of Mass. v. Feeney, 442 U.S. 256 (1979). Note that the various governmental limitations on abortions that have been considered by the Court have never been characterized as discrimination against females. *See* Geduldig v. Aiello, 417 U.S. 484 (1974).

53. 394 U.S. 618 (1969).

54. *See also* Memorial Hosp. v. Maricopa County, 415 U.S. 250 (1974). Note that both this case and *Shapiro v. Thompson* invalidated *durational* residency requirements; the Court has never suggested that the states could not give different social welfare benefits to residents and nonresidents, even if doing so were to impose a "penalty" on nonresidents.

55. 394 U.S. at 627-31.

As the cases summarized earlier reflect, the *Shapiro* "penalty" analysis has rarely been applied in subsequent decisions of the Court. Most limits or exclusions do not "affect" "fundamental interests"; they merely withhold funding or services for their exercise; they do not, as in *Shapiro*, deny financing or access to other benefits to those who have exercised their "fundamental interests" without government assistance. And like other exceptions, the Court has carefully and narrowly drawn the circumstances under which "penalty" analysis is appropriate. Thus, for example, in *Harris*, the Court distinguished the federal limits on abortion financing in that case from a *Shapiro*-type "penalty." In doing so, however, it acknowledged that:

> A substantial constitutional question would arise if Congress had attempted to withhold all Medicaid benefits from an otherwise eligible candidate simply because that candidate had exercised her constitutionally protected freedom to terminate her pregnancy by abortion.[56]

This acknowledgment of *Shapiro*, even to distinguish it, presumably reaffirms that the general rule of rationality may still be excepted where government efforts are characterized as "penalties" on "fundamental interests."[57] Nonetheless, it also reaffirms the narrow definition of the exception and, consequently, how few government actions could be properly characterized as "penalties" for this purpose.[58]

Using essentially the same reasoning, the Supreme Court has indicated that it also will except the general rule of rationality where a recipient of government financing or services is prohibited from engaging in a constitutionally-protected activity as a condition on the receipt of government services or funds for other activities. Paralleling the decision in *Shapiro*, the Court has in a few cases indicated that it is willing to distinguish between circumstances where a limit on a government program merely fails to subsidize or support an activity—under such circumstances the denied recipient is "no worse off" without the program's assistance—and circumstances where the limit is intended to inhibit or prevent other nonfunded activities or interests that are constitutionally pro-

56. Harris v. McRae, 448 U.S 297, 317 n.19.

57. *See infra* text accompanying notes 80-81.

58. From time to time and particularly in recent years there have been proposals, at both the state and federal levels, that would effectively deny Medicaid or other welfare benefits to recipients who obtain abortions (with their own funds) or to those who engage in other unpopular activities. To the extent that these activities are regarded as "fundamental," such limits on government benefits are entitled to *Shapiro*-type protections.

tected.[59] The *Rust* decision, discussed above, considered whether this exception would apply to the "gag rule" regulations at issue in this case. The *Rust* Court reaffirmed that if a government program does inhibit or prevent a "fundamental interest" greater judicial scrutiny is appropriate.[60] Nonetheless, it limited the application of this exception to those circumstances where the "affected" interest is clearly distinguishable from the activity receiving government assistance. Otherwise, *Rust* argued, such a decision is merely another government choice to fund some things but not others.[61] Under this view, the First Amendment interests of family planning counselors who would counsel or otherwise discuss abortion are not "penalized" where the government is attempting to fund family planning counseling services other than abortion. Again, the Court's acknowledgment of the possible exception to the rule of rationality only served to reaffirm the narrowness of its application and the Court's reluctance to give anything other than cursory review to government discretion as generally exercised in these matters.[62]

Perhaps the best way to conclude this extended discussion of constitutional doctrine is to translate these principles into terms that more concretely reflect their implications for present and future health policy controversies in the United States. Again to begin with the most straightforward, there is absolutely no federal constitutional requirement that any level of government in the United States adopt any health care financing or delivery program or otherwise provide for the health of its citizens. Whatever the costs—economic or otherwise—of the current mix of private and

59. *See, e.g.*, Federal Communications Comm'n v. League of Women Voters of Cal., 468 U.S. 364 (1984); Rust v. Sullivan, 111 S. Ct. 1759 (1991).

60. 111 S. Ct. at 1774.

61. *Id.*

62. There have been several other recent cases in which the Court has considered—and then rejected—similar arguments and, in doing so, also indicated that it is reluctant to find a constitutionally significant effect inherent in a social welfare limit or condition. In Lyng v. Castillo, 477 U.S. 635 (1986), the Court held that a restriction on the definition of "household" for purposes of determining food stamp eligibility did not "affect" the "fundamental interest" in choice of family living arrangements. The Court apparently viewed the restriction as a government decision not to subsidize certain kinds of living arrangements, rather than a prohibition or "penalty" for doing so. Similarly, the Court in Lyng v. United Automobile Workers of America, 485 U.S. 360 (1988), viewed the exclusion from the food stamp program of any household in which one member is on strike as merely a choice not to subsidize striking workers and not an "effect" on the "fundamental interest" in family integrity or on the First Amendment interests of striking workers. *See also* Bowen v. Gilliard, 483 U.S. 587 (1987) (repeal of a statute that allowed for exclusion of child support payments from determination of a family's income did not "affect" or penalize the integrity of the family unit).

public programs available in the United States, however great the needs of the over 35 million people without insurance, whatever other failing can be attributed to present health care arrangements, the impetus for resolving any or all of these problems must come from something other than the federal Constitution. For that matter, any of the existing state, local, or federal health financing and delivery efforts, including Medicare and Medicaid, could be repealed at any time. Whatever else may have led to their establishment and may prevent their repeal, there is no federal constitutional right to this sort of government assistance or to its continuation once it has been undertaken.[63]

Just as clearly, there is no constitutional right to any level of benefits or to eligibility for the benefits that are made available by the government. Income and resource limits for means-tested programs or categorical or other determinants of eligibility can be defined or limited or reduced rather arbitrarily. Similarly, the scope of service covered can be limited, conditioned, or "rationed" in any number of ways, and the results are unlikely to cross constitutional limits.[64] In this regard it should be explicitly noted that these statements delimit the constitutional rights of *both* those who are denied government assistance and those who could be regarded as the secondary beneficiaries of that assistance: the providers of health care. As hospitals, physicians, and other providers have already been informed on numerous occasions, limits on reimbursement, utilization controls, and other cost-containing efforts which affect the provision of government-financed health care are no different than limits or conditions on program eligibility or service coverage. With very few exceptions, such restrictions need only be rational to be constitutional and could be accurately described, therefore, as constitutional per se.[65] For that matter, as noted earlier, even truly irrational limits or exclusions from government health programs are likely to be regarded as rational in constitutional terms. If government can constitutionally exclude medically necessary or even life-saving health care or financing from programs that may well provide the only realistic opportunity for an individual to receive that care, then certainly the government can exclude or limit virtually any service or anyone from the health

63. *See infra* text accompanying notes 87-90.

64. There are several pending proposals to "ration" health care, most notably the scheme recently developed by the State of Oregon. For a general description, see Symposium, *The Law & Policy of Health Care Rationing: Models & Accountability*, 140 U. PA. L. REV. 1505 (1992).

65. *See* discussion in WING, *supra* note 2, at 157-69.

programs that it chooses to offer. There are a few limited but noteworthy constitutional barriers to the government's discretion: The Constitution does prohibit overt racial discrimination, some forms of sex or gender discrimination, and, perhaps, programs which impose "penalties" on "fundamental interests." But beyond these constraints, the federal Constitution, as currently interpreted, has little influence over the nature and extent of governmental efforts in matters relating to health and health care in the United States. There is not, in any realistic sense of the term, a constitutional right to health care.

SECTION II

The analysis of constitutional doctrine in the previous section is purposefully focused on what the Supreme Court, particularly as it is currently composed, views as the scope and meaning of the federal Constitution in matters relating to health and health care. The obvious next question is whether there are possible alternative views. The Supreme Court has clearly refused to recognize anything that could be realistically regarded as a constitutional right to health care. Could a future Court, perhaps one with an alternative philosophical or political inclination or one that regards the specific circumstances of some future health-related controversy as deserving a new or reconsidered application of constitutional principles, do so? Is it even possible to view the nature of the government created by the federal Constitution or the requirements of such principles as equal protection and due process so as to create constitutionally-mandated obligations beyond those very limited rights discussed in the section above?

I have staked out my response to these questions in the introduction to this paper. Simply put, I think the prospects for a recognition of a general constitutional right to health care are inconceivable for both theoretical and practical reasons. I can conceive of some future Court refining the principles described in the previous section in some limited ways and thereby extending the relevance of constitutional law in some specific health-related controversies. But I can only imagine the creation of anything that could be realistically regarded as a constitutional right to health care by constitutional amendment—an extremely unlikely event—and even then by one that is rather unusually written.[66]

Any judicial recognition that the state, local, or federal govern-

66. Again, the problem is one of creating an affirmative obligation or "right," rather than restricting government action of one sort or another. Nothing in the original Con-

ment has a general, constitutionally-mandated obligation to protect health or to provide health care would require much more than an expansive reading of the Constitution's text, the implications of that text, or the underlying principles that can be inferred from the structure of the Constitution—the usual interpretative tools available and not infrequently employed by courts seeking a more "liberal" reading of the Constitution's requirements.[67] The recognition of such a right would require a reading of the Constitution which restructures the general understanding of the Constitution itself. As noted in the previous section, the Supreme Court has throughout its history consistently and, literally, without dissent insisted that the governmental powers created by the federal Constitution are permissive, not mandatory. Only slightly overstated, the Constitution has never been read to require any level of the government—federal, state, or local—to do anything affirmative in the domestic policy area, let alone anything as specific as establishing a particular social program or extending an existing financing or delivery program in any significant way.[68] To adopt such a view of government or, conversely, such a view of health care, would be to redefine in the most fundamental sense the nature of the constitutional relationship between the government and its citizens. Just as importantly, to do so would require the reshaping of the role of the judicial branch of the government, both with respect to its responsibility for those citizens, but also with respect to its relative power within the government. It would be impossible in the present context to even catalogue all of the objections that could be raised to any attempt to reinterpret the nature of the Constitution in this manner.[69] These are matters that are so fundamental to American political and judicial thought that it is hard to imagine even a single judge willing to adopt and then apply such radically different views, let alone enough justices to comprise a working majority of the Supreme Court willing to do so. Or to put the matter in even more pragmatic terms, it is even harder to imagine that someone with the inclination to restructure constitutional doctrine in such a radical way could survive the various formal and

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stitution or any of its subsequent amendments is written in this manner. *See infra* note 81.

67. *See generally* GEOFFREY R. STONE ET AL., CONSTITUTIONAL LAW 1-71 (2d ed. 1991).

68. The only exceptions are discussed *infra* notes 82-85.

69. For general references, see STONE ET AL., *supra* note 67, at 759-1009. For a more textual explanation, see WING, *supra* note 2, at 17-39.

informal screens necessary to judicial appointment.[70]

What is imaginable—although still unlikely and certainly at odds with the philosophy of the current Supreme Court—is that some future Court may give a more expansive reading to the constitutional constraints on the government's discretion once the government undertakes to provide a health or health-related program. For example, there are a number of ways in which the Court could give more substantive meaning to the rationality standard in equal protection and substantive due process cases. The Court could require the government to more specifically or concretely define the purposes it claims are achieved by a limit on or exclusion from a health program, and then invalidate as "irrational" those that are only vaguely or inadequately defined.[71] Or the Court could require that the government's justification for a program limit or exclusion be more closely aligned with the overall purposes of the program, reversing the apparent dictates of the abortion funding cases.[72] The Court could also give more meaning to the rationality standard if it required that there be some minimal evidentiary or other basis for concluding that a limit or exclusion will actually achieve its claimed purpose, rather than deferring entirely to the government's judgement in these matters as the decisions of the Court almost always have in the past.[73] Any future modification of the rationality standard that gives the courts some meaningful role in reviewing or evaluating the underlying justification for a program limit or exclusion at least would provide some few, affected individuals with what current constitutional doctrine apparently denies

70. For a good, if somewhat biased account of the appointment process, see ROBERT BORK, THE TEMPTATION OF AMERICA (1989).

71. There are only two relevant precedents that arguably do so. In United States Department of Agriculture v. Moreno, 413 U.S. 528 (1973), the Supreme Court rejected the government's argument that the restriction of food stamps to households of related people was a rational attempt to eliminate fraud or to limit benefits to those who were "involuntarily" poor. Rather, in the Court's view, the statute was intended to prevent "hippies" from participating in the program, a purpose that furthered no "legitimate government interest." *Id.* at 535-38. A similar analysis was applied in Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432 (1985). In that case the Court held that a municipal decision to deny a zoning exception to a group home for the mentally retarded was a violation of equal protection. While claiming that it was applying a rationality standard, the Court rejected the government's argument that the zoning restriction was a "rational" attempt to protect the safety of the home's residents and concluded that the restriction was based instead on an "irrational prejudice" against the retarded. *Id.* at 450. Both of these cases are considered aberrational and have little precedential value. The weight of the case law holding to the contrary is overwhelming.

72. *See supra* notes 43-44. *See also* South Dakota v. Dole, 483 U.S. 203 (1987).

73. The *Moreno* and *Cleburne* decisions can be read as imposing such a requirement. As noted, however, these cases have little precedential value.

them: the opportunity to successfully argue that the government's denial of benefits to them is irrational and therefore beyond the limits of rationality.

A future Court also could provide additional constitutional protection to at least some individuals that are denied the benefits of government health programs if it chose to interpret its obligation to protect "suspect" classifications from discrimination more expansively. The Court could choose to expand the notion of a "suspect" classification, primarily limited under current doctrine to racial and ethnic minorities, to include discrimination based on age, disability, gender, or some other characteristic that the Court views as deserving the same sort of judicial scrutiny currently extended to overt discrimination based on race or ethnicity.[74] Alternatively, the Court could allow "close" or at least more heightened judicial scrutiny to be triggered where a government program has a disproportionate impact on a "suspect" class, rather than limiting the application of the doctrine to those cases where the Court finds intentional or "de jure" discrimination.[75] In fact, to do so would give constitutional status to some legislatively imposed requirements that already exist. Many existing federal and state statutory prohibitions on race, sex, and other forms of discrimination prohibit some kinds of "de facto" or disproportionate impact discrimination.[76]

Another possibility—again unlikely but at least conceivable—is that some future Court could expand those circumstances under which it will more closely examine limits or exclusions from government health programs that involve but do not, under current constitutional interpretation, "affect" important or "fundamental" interests. Unlike the doctrinal views demonstrated in the abortion financing decisions, a future Court might make a more realistic assessment of the actual impact of the government decision rather than rely so rigidly on "no worse off" analysis.[77] For example, the Court might reconsider whether an individual excluded from or denied the benefits of a government program is "no worse off" where the government is the primary provider of services in a geo-

74. *See supra* notes 48-52. See a discussion and rejection of these possibilities in *Cleburne*, 973 U.S. at 440-42.

75. Virtually the only argument for doing so was voiced by Justice Marshall, dissenting in the abortion financing cases. *See* Beal v. Doe, 432 U.S. 438, 454 (1977).

76. *See, e.g.*, Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (Supp. 1992); 45 C.F.R. § 80 (1992) (as interpreted by Guardians Ass'n v. Civil Serv., 463 U.S 582 (1983)).

77. *See supra* text accompanying notes 29-33.

graphic area and alternative private arrangements are not, in any realistic sense, available.[78] It is also possible—some might even argue likely—that the Court will be asked to directly reconsider the logic underlying its decision in *Rust*. The current Court's characterization of the "gag rules" reviewed in that case as merely a decision to fund some services but not others has been heavily criticized by both legal and medical experts.[79] Some future Court could question whether the *Rust* Court accurately understood the realities of family planning counseling or whether it was correct in concluding that women receiving the services subject to the "gag" limits were as a factual matter "no worse off."

Note, however, that none of these changes would have any significant effect on the analysis of most governmental decisions to deny services, condition eligibility, or otherwise limit the scope or coverage of government health service or financing programs. As described in the previous section, most government limits or exclusions do not involve—let alone "affect" in the constitutional sense—something considered "fundamental." Only if a future Court were to go one, dramatic step further, recognizing as "fundamental" an individual's life or health or some other interest related to the individual's health or medical needs, would the scope of judicial review of most government decisions regarding limits on or exclusions from health programs be radically changed. That is to say, if *both* the "no worse off" analysis demonstrated in the abortion financing decisions were abandoned *and* the Constitution were read as defining "life" or "health" as "fundamental," then existing government programs which exclude important and, arguably, all life-saving benefits would be subject to more rigorous judicial examination; and presumably, only those for which the government could present a sufficiently persuasive "compelling interest" would be upheld.[80] There still would be no constitutional

78. As the Supreme Court has demonstrated many times, if the services provided by the government are viewed as only one alternative available to consumers, then any refusal to provide abortion or any other service leaves the consumer "no worse off." *See, e.g.*, Webster v. Reproductive Health Serv., 492 U.S. 490, 508-510 (1989). What has *not* been addressed is whether the logic of these cases would apply if the government were the *only* provider of health care under some sort of socialized scheme. Surprisingly, even Justice Rehnquist has admitted that a "different analysis might apply." *Id.* at 510 n.8.

79. *See* WING, *supra* note 2, at 174. Note, however, that during the presidential campaign of 1992, Bill Clinton promised to repeal these regulations if he were elected. As a consequence, judicial reconsideration of these particular regulations may have been mooted by his subsequent victory.

80. Among other questions that would have to be answered is what was suggested but not completely answered in earlier decisions: Whether the government can claim an in-

basis for a claim that the government has an affirmative obligation to provide health or health-related programs in the first place.[81] Nonetheless, once the government undertook to provide any health service or financing program, as both the states and the federal government in the United States traditionally have, there would be substantial, judicially enforceable constraints on the government's discretion to limit eligibility or service coverage, to impose cost-containment measures, or to make any resource-limiting decision. The specific implications of "closely scrutinizing" these decisions are almost impossible to anticipate; to do so would be unprecedented, in both the popular and the technical sense of the term. The more general implications are, however, abundantly clear. The courts would be required to do exactly what the traditional interpretation of the constitutional constraints on government discretion and of the judicial role in their application has prevented: specifically define those purposes that the government can legitimately pursue in such matters and, more importantly, evaluate the wisdom and effectiveness of pursuing those purposes through means which "affect" the life or health or other "fundamental interest" of some individual. In essence, under such doctrinal revisions there would be a constitutional right to health care.

But to state the potential implications of such doctrinal changes in these terms only confirms how unlikely it is that they will be adopted and applied. Such substantive constraints on government discretion and such an enhanced and powerful judicial role are exactly what the Court and most constitutional authorities in the United States have been seeking to avoid. As the discussion earlier demonstrates, the Court repeatedly has resisted attempts to take even relatively modest steps towards the recognition of a right to health care. It has done so because of the particular way in which it has defined "fundamental interests," the rigidity with which it has adhered to "no worse off" analysis, and its specific applications of other important constitutional principles that, taken together, almost always result in a complete deference to government discre-

terest in saving resources or reducing costs as a sufficiently "compelling" justification for denying or adversely "affecting" a fundamental interest.

81. Again it must be emphasized that the recognition of health or health care as a "fundamental interest" or even as an explicitly enumerated constitutional right would still not obligate the government to provide health care benefits. As discussed in *supra* text accompanying notes 3-5, there are no affirmative obligations imposed on the government; constitutional rights primarily serve as limitations on discretionary actions. That is the primary reason that an amendment to the federal Constitution that is intended to obligate the government to provide health care of one form or another would have to be rather "peculiarly" written.

tion in determining the scope and nature of its health benefits programs. But that deference is not merely the net result of these specific applications of principle or, for that matter, of the Court's specific views concerning the importance of health or health care. Rather, the converse is true: The Court has interpreted and applied constitutional principles narrowly in health-related cases primarily because of its long-standing insistence that the judicial role be deferential in most if not all matters and, therefore, in these particular cases as well. To create a constitutional right to health care, the Court would have to abandon the traditional view of the Constitution and its division of authority among the branches of government in some very fundamental ways. Whatever the merits or appeal of doing so might be, the prospects for doing so are, literally, inconceivable.

Even if some future Supreme Court was willing to do just that, break with these constitutional traditions in an inconceivable manner, that Court would still find considerable difficulty in attempting to define and enforce a constitutional right to health care. In most of the circumstances under which the Court recognizes an individual right and consequently allows for its protection by judicial "close scrutiny" or some other heightened form of judicial review, the basic judicial decision is whether to invalidate or, in some cases, enjoin some specific governmental action. To make such a decision, the reviewing court may be required to weigh the social or economic impact of various alternatives available to the government, to evaluate competing public and individual interests, and to make other difficult, value-laden determinations—assessments for which judges and the judicial process are not particularly well-suited or prepared. But at least in most of these cases, a court need only address these issues to the extent necessary to decide whether a particular government action, an action which the legislative or executive branch has chosen to undertake, exceeds constitutional limits. In contrast, the recognition and enforcement of an affirmative government obligation to finance or provide health-related benefits would require the courts to examine similarly difficult questions in a much more abstract and protracted fashion. In addition to some general statement of the government's affirmative obligation, the courts would be required to adopt judicially-measurable standards to determine whether the government has met that obligation; where the government fails or refuses to comply, the courts would be required to devise and oversee a judicially-prescribed remedy. In doing so, the courts might be required to

prescribe changes in statutes and regulations, rather than simply invalidate those that are enacted, or restructure the manner programs are managed and delivered, rather than prohibit specific actions. Perhaps most critically, where the remedial measures ordered by the courts require additional resources—as the judicial recognition of a constitutional right to health care most certainly would—the courts must be prepared to order the reallocation of governmental resources from existing programs to health-related programs or to order the creation of new revenue sources. In short, the recognition of a right to health care would require the courts, within the confines of judicial proceedings, to tell the other branches of the government how to govern, rather than tell them what actions are beyond their reach. As discussed earlier, most courts are reluctant to do anything that even suggests that they are usurping the roles of their coordinate branches; just as importantly, courts are not structured or prepared to make the sorts of decisions that are required when they do so. Indeed, implicit in any argument that the courts should recognize and enforce a constitutional right to health care is the assumption that the judicial branch of the government could devise a distribution of government health benefits that is more equitable or comprehensive or, simply, better than that which had been previously provided by the legislative and executive branches. If who-should-get-what and how-it-will-be-paid-for decisions are made by judges and through judicial process, that assumption is at best unproven. The result may well be no better and could well be worse than that which exists now.

Moreover, whatever the extent of the courts' willingness and ability to define the government's obligation to provide health care, they still may be unable to mandate compliance with their pronouncements where the legislative or executive branches refuse or claim they are unable to comply. The enforcement options available to the courts, such as monetary penalties or imprisonment of government officials, the judicial takeover of government programs, and the like, are at their best crudely fashioned and are particularly inappropriate when used to coerce those officials to affirmatively govern. The few circumstances under which the courts have recognized an affirmative government obligation to provide health or related benefits have demonstrated these difficulties far too well. After two decades of attempting to enforce the much-publicized "right to treatment" for mental patients recognized in *Wyatt v. Aderholdt*, the federal courts officially terminated efforts

to do so, openly admitting their inability to enforce such an obligation absent legislative cooperation.[82] The other occasions on which there have been judicial efforts to enforce even modestly defined rights to health care for the mentally retarded, prisoners, and other confined individuals have fared little better.[83] The only circumstance in which the American judicial system has attempted to enforce an obligation on the government that could be regarded as comparable to that which would be required if a general constitutional right to health care were recognized involves the Supreme Court's decision in *Brown v. Board of Education of Topeka*, ordering the racial desegregation of public schools with "all deliberate speed."[84] Americans learned many lessons, both good and bad, about themselves and their government following the decision in *Brown*. Among those lessons was the clear demonstration of the inability of the judicial system to enforce any substantial affirmative government obligation so long as the other branches of government are unwilling or unable to comply.[85] A judicial recognition of a broadly-defined, constitutional right to health care, itself an inconceivable event, might well demonstrate that same lesson once again.

SECTION III

My primary objective in this paper is to demonstrate that the government in the United States has no constitutional obligation to provide health care. The federal Constitution established a government in which decisions regarding the distribution of benefits and services are almost exclusively discretionary. The judicial role within that government allows for the recognition and protection

82. Wyatt v. Aderholdt, 503 F.2d 1305 (5th Cir. 1974). *See* Edward H. Stevens, Wyatt v. Stickney *Concludes with a Whimper*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 139 (1987).

83. *See* cases cited *supra* note 6. *See also* WING, *supra* note 2, at 58-72.

84. 347 U.S. 483 (1954) (original declaration that separate but equal schools are inherently unequal); 349 U.S. 294 (1955) (enforcement order including the "all deliberate speed" language). Note that even in this case, the Court was not imposing an affirmative obligation on the government, rather it ordered local governments that choose to provide public schools to do so within the requirements of the Equal Protection Clause. In theory, local governments are not required to provide public education. *Cf.* Griffin v. County Sch. Bd., 377 U.S. 218 (1964) (local government not required to provide public education but could not close schools with the intent of avoiding a desegregation order).

85. In the opinion of most authorities, to the extent that American public schools were integrated following *Brown*—a dubious proposition—that success was a result of efforts taken by the legislative and executive branches of the federal government, not the judiciary, efforts that were fueled by political considerations and not judicially-ordered, constitutional considerations. *See* STONE, ET AL., *supra* note 67, at 524-33.

of individual rights, but that role has always been defined rather narrowly—and deliberately so; moreover, with few exceptions, such judicial power has been used only to limit or prohibit legislative or executive discretion, not to create affirmative governmental responsibilities. No court or, for that matter, any serious constitutional authority has ever persuasively argued that these principles should be or could be excepted in such a way as to require any level of government to provide health care or otherwise protect the health of its citizens.

This does not mean, however, that the term "right" has no relevance in describing health policy in the United States. As a constitutional matter, the government may have no obligation to provide for the health needs of its citizens, but in terms that reflect political realities, both the state and federal governments have very little choice but to act in such matters, and to act in accordance with what is perceived as the "right" of Americans to adequate health care—and what is, consequently, the responsibility of their government to provide for it. The meaning and limits of that "right," as with all political phenomena, are somewhat amorphous and, obviously, less immutable than a right that is based on constitutional principles or enforced by judicial decree. Nonetheless, it would be a mistake to describe current health policy in the United States or its likely future directions without an acknowledgement of the fundamental importance of health and health care in American politics and of the demands and expectations that Americans place on their government to provide for them. Perhaps most important in the present context, it would be equally inaccurate to assume that the lack of a constitutional right to health care in the United States is the primary difference between the health care available in this country and that available in others.

There is no doubt that for many Americans, health care delivery and financing are primarily private-sector transactions. They purchase services from physicians and other private providers with financing by some form of private insurance, insurance that they receive as an employment benefit.[86] The role played by the state and federal governments is supplemental to these arrangements. Nonetheless, the role of the government is extensive and significant. At least since the enactment of the Medicare program in 1965, the federal government has provided financing for the pri-

86. For a basic description, see GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW 121-64 (1990). For a more detailed description, see EMPLOYEE BENEFIT RESEARCH INSTITUTE, DATABOOK ON EMPLOYEE BENEFITS (2d ed. 1992).

mary health care needs of virtually everyone 65 years of age or older and, after 1972, many disabled people as well.[87] At the same time it established Medicare, the federal government also created the Medicaid program, providing federal funding for state programs of health benefits for some—though clearly not all—the nation's poor.[88] There are a variety of other state and federal efforts that finance and in some cases provide health services for other targeted populations.[89] In addition, a few states and many local governments maintain public hospitals, clinics, or other service delivery programs.[90]

The government also plays a less visible but equally important role in maintaining and, to a certain extent, regulating privately-purchased health insurance. Both the state and federal government have provided tax incentives for the purchase of employment-based health insurance.[91] Since 1986, employers have been required to provide continuing coverage to former employees for up to eighteen months.[92] Some state laws prohibit certain insurance practices, mandate coverage of certain services, and regulate the structure of health maintenance organizations and other alternative arrangements.[93] A variety of state and federal laws also provide some limits on the circumstances under which treatment can be denied, even to those without the ability to pay.[94]

87. For a basic description, see ANNAS ET AL., *supra* note 86, at 29-32, 187-98. For a more detailed description, see PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO CONGRESS (1992).

88. For a basic description of Medicaid and the contours of Medicaid eligibility, see ANNAS ET AL., *supra* note 86, at 29-32, 165-87. There is no single reference that adequately describes the details of the various states' Medicaid programs. The most useful resource is HEALTH CARE FINANCING ADMINISTRATION, HEALTH CARE FINANCING REVIEW (published four times a year and including articles summarizing various aspects of these programs).

89. For a basic overview, see ANNAS, ET AL., *supra* note 86, at 25-29, 159-64. For a description of recent state efforts, see U.S. GOVERNMENT ACCOUNTING OFFICE, ACCESS TO HEALTH CARE: STATES RESPOND TO GROWING CRISIS (1992). In addition to Medicaid and Medicare, there are a number of other health care programs that represent substantial fiscal commitments. *See, e.g.*, 42 U.S.C. § 701 (1991) (federal block grant funding to states for maternal and child health programs).

90. For a basic description, see ANNAS, ET AL., *supra* note 86, at 22-25, 64-71. *See also* NATIONAL HEALTH LAW PROGRAM, MANUAL OF STATE AND LOCAL GOVERNMENT RESPONSIBILITIES FOR INDIGENTS (National Clearinghouse for Legal Services 1985).

91. *See* ANNAS, ET AL., *supra* note 86, at 138.

92. 29 U.S.C. § 1161 (Supp. 1992).

93. For a general description, see ANNAS, ET AL., *supra* note 86, at 142-50.

94. There are a variety of state common law and legislative requirements concerning obligations to provide emergency care. For an overview, see ANNAS, ET AL., *supra* note

Obviously the aggregated result of these various governmental efforts is something less than a comprehensive national program or even a coordinated national policy. There are many shortcomings and inequities inherent in such a mix of private and public, and state and federal arrangements.[95] Perhaps most critically, as many as 35 million Americans, roughly 15% of the population, were unable to purchase private third party coverage in 1992, yet they were also ineligible for the various government financing programs.[96]

Notwithstanding, the magnitude of these government efforts should not be understated. In 1992 over 45% of the more than $800 billion spent on health services in the United States were paid directly by the state or federal governments.[97] In addition, a significant portion of the services that were privately financed were publicly subsidized by the tax treatment of employment-purchased health insurance—at an estimated cost of over $60 billion in government revenues.[98] Medicare alone cost nearly $140 billion in 1992,[99] representing the second largest—and fastest growing—item in the federal domestic budget.[100] The costs of the state Medicaid programs were comparable; indeed, in their efforts to maintain their Medicaid programs many states have been driven to the brink of bankruptcy.[101] Whatever these programs have failed to do should not overshadow what they do provide or the level of fiscal commitment that they represent.

Nor should their shortcomings overshadow the depth of the political commitment that underlies these efforts. Programs such as Medicare and Medicaid may be extraordinarily expensive, but

86, at 43-90. The most substantial obligation derives from the federal law adopted in 1986 which requires most hospitals to examine and treat all emergency patients and women in labor. 42 U.S.C. § 1395DD (Supp. 1992).

95. Obviously there are many shortcomings inherent in this peculiarly American system of health care—of which the number of people who do not have third party coverage is only the most prominent and, perhaps, critical. For a full discussion, see Kenneth R. Wing, *American Health Policy In The United States*, 36 CASE W. RES. L. REV. 608 (1986). For a more recent critique (and one with a slightly different tone), see CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, ECONOMIC IMPLICATIONS OF RISING HEALTH CARE COSTS (1992) [hereinafter ECONOMIC IMPLICATIONS].

96. For a good, recent analysis of the number of people who are uninsured and their characteristics, see EMPLOYEE BENEFITS RESEARCH INSTITUTE, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 1991 CURRENT POPULATION STUDY (Issue Brief No. 123, February 1992).

97. CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, PROJECTIONS OF NATIONAL HEALTH EXPENDITURES 38 (1992) [hereinafter NATIONAL HEALTH EXPENDITURES].

98. *Id.* at 56. *See also* ANNAS, ET AL., *supra* note 86, at 139.

99. *See* NATIONAL HEALTH EXPENDITURES, *supra* note 97, at 44.

100. *See* ECONOMIC IMPLICATIONS, *supra* note 95, at 49-52.

101. *Id.* at 54.

they are extraordinarily popular as well. Despite two presidential administrations expressly committed to reducing federal health spending, federal support for Medicare, Medicaid, and most other health programs survived the Reagan-Bush years remarkably intact.[102] Federal health spending not only continued to grow during these years, but there also was a surprising level of support for expanding the scope of federal health programs—and, consequently, the share of the federal budget committed to health care.[103]

The 1992 election year politics reaffirmed the strength of these political sentiments. Even at a time when the reduction of the federal deficit was a central concern of the election debates, no candidate "dared" suggest a reduction in government health programs as a solution. The costs of such programs must be "contained," many argued, but no one argued that the level of benefits should be "reduced"—a rhetorical distinction that carried an important message.[104] The campaign of 1992 also confirmed that many if not most Americans wanted the government to both contain health care costs *and* to provide some sort of public solution for the problems faced by the nation's uninsured. Indeed, the repeated pairing in campaign debates of the problems facing those who are uninsured with the problem of containing health care costs—when the latter represented the most convenient excuse for ignoring the former—was the best single indicator of the political status of health care. Even when the economy in the United States was suf-

102. For an overview and analysis of Medicare and Medicaid expenditures during the 1980s, see PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO CONGRESS 17-19 (1992), and Katharine R. Levit et al., *National Health Expenditures, 1990*, 13 HEALTH CARE FINANCING REV. 29, 39-42 (Fall 1991).

103. *See, e.g.*, UNITED STATES BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION, FINAL REPORT, 101st Cong., 2d Sess. 90 (1990). Of equal importance in documenting the prevailing politics of health care in the United States was the fate of various proposals to promote market-based systems of health care financing and delivery in the United States. Even the most ardent advocates of such "conservative" approaches have had to restructure their proposals to account for the political support for some government effort that will ensure universal access. For a good analysis, see STUART M. BUTLER & EDMUND F. HAISLMAIER, A NATIONAL HEALTH SYSTEM FOR AMERICA (rev. ed. 1989).

104. Documenting campaign rhetoric and translating it into specific policy positions are particularly difficult tasks. For creditable efforts to do so, see PRESIDENT BUSH PRESENTS HEALTH CARE REFORM PROPOSAL, SOCIAL INSURANCE UPDATE NO. 22 1-4 (National Academy of Social Insurance, March 1992); *Noninvasive Surgery: George Bush & Health Reform*, MED. & HEALTH, Oct. 12, 1992; *Covering the Bases: Clinton & Health Reform*, MED. & HEALTH, Oct. 5, 1992; *President Clinton: What Will It Mean?*, MED. & HEALTH, Nov. 9, 1992.

fering and the economics of health care were even worse, many Americans were nonetheless demanding that their government spend more resources to make health care more widely and adequately available.[105]

The political demands of 1992 were not aberrational nor will they be short lived. Some Americans may prefer the initiative to come from their state government rather than the federal government and many have a strong bias against "big government" programs and in favor of strategies that give a significant role to private institutions.[106] But in some way or form, "something must be done" and done rather quickly to reform health care or, at least, something must be done to give the appearance that the government is responding to these demands. The simple political reality is that many if not most people in the United States believe that an adequate level of health care should be available to everyone and that it is the responsibility of the government to take whatever steps are necessary to make it available. More importantly, many if not most people are considering those beliefs as significant factors in their voting behavior. It is in this regard that health care can be accurately described as a political entitlement or "right" in the United States. Government efforts to insure the adequacy or availability of health care may be constitutionally discretionary, but as a political matter such efforts are something that Americans demand and expect.

CONCLUSION

While the political support for a right to health care in the United States should not be overlooked, it should not be overstated either. There are obviously differences between a right to health care that is secured by the United States Constitution and one that is based only on the political will of the electorate, not the least of which is the increased ability of governmental institutions to resist or deflect even the strongest-held political belief. Students of history would be quick to point out that on several occasions in the past prevailing politics in the United States had apparently dictated

105. For a good summary of public opinion in the United States concerning health care and its reform, see EMPLOYEE BENEFITS RESEARCH INSTITUTE, PUBLIC OPINION ON HEALTH, RETIREMENT, AND OTHER EMPLOYEE BENEFITS (Issue Brief No. 132, December 1992).

106. Given the peculiar contours of these political sentiments, it was no political surprise to hear the eventual winner in the 1992 presidential campaign promising that he would immediately undertake dramatic health care reforms, but based on something called "managed competition." *See* discussion in sources cited *supra* note 104.

that the government soon would undertake major health care reforms; yet what followed was something far less than what was initially predicted.[107] For that matter, whatever the dictates of current politics for health care reform, there are a number of competing demands on the nation's governmental institutions. Even purely as a matter of good policy and stripped of politics altogether, there are some sound reasons why the American government may not attempt simultaneously to expand access *and* control costs *and* do all of the other things that would be necessary to secure access to health care for all its citizens.

Thus while it appears in the early 1990s that the United States is poised on the brink of some major health care reform, even the short-term future is difficult to predict with any specificity. The state or federal political leadership may be willing to expend the resources that will be necessary to provide for the needs of the nation's uninsured; they may be willing to spend the "political capital" that will be the necessary price of containing health care costs; they even may be willing to do both. On the other hand, they may respond to the call that "something must be done" as politicians more often do, with patchwork programs and temporary answers, more rhetorical handwringing and less that results in real change or reform. What they cannot do is ignore altogether the current political status of health care. The government must respond—one way or another—to the strong and undeniable demand that adequate health care be available for everyone in the United States. That is the nature of the right to health care in the United States, no more and no less.

Observers from other jurisdictions may find this to be a peculiar and peculiarly American scenario. Certainly the manner in which health care is financed and delivered in the United States is somewhat unique, as are the social and historical origins of that scheme. It should hardly be surprising that the legal and political status of such a scheme is equally unique. There is also the undeniable fact that health care expenditures in the United States have been increasing at extraordinary rates and that these expenditures have reached unparalleled levels. It should again come as no surprise that a country that is spending in excess of fourteen percent of its gross domestic product on health care—nearly twice what most other industrialized countries manage to spend on theirs—is facing unique and peculiar circumstances.

107. See, for example, a description of President Carter's proposals for health care reform in WING, *supra* note 2, at 154.

These same observers, however, should hesitate before concluding that the differences between the circumstances facing the United States and those facing other countries derive from the fact that the right to health care in the Untied States is no more and no less than what has been described above as a political and not a constitution right—and that this too is unique and peculiar to the United States. Are the demands and expectations for health care that are imposed on the governments of other jurisdictions based not only on political foundations but on constitutional mandates as well? In particular, when the legislative and executive branches of their governments fail to provide adequate health services, can the citizens of other jurisdictions seek—and receive—a judicial mandate that they be provided, a mandate that these other branches have no choice but to obey? Or is it the case that in other countries, as in the United States, that the government ultimately must respond to the demands of its electorate, no more and no less?

These questions outline a framework for what could be a rather interesting comparison among jurisdictions, albeit one that is somewhat more complicated than that which usually takes place in health policy debates. I ask these questions in this manner not because I claim to have the answer to each but rather to invite some response from my counterparts in other jurisdictions. My "hunch"—and it is little more than just that, a "hunch"—is that the answers to these questions will indicate that the nature of the rights to health care that exist in other countries is ultimately little different than that which exists in the United States: They are political and not constitutional rights. In fact, I have a hunch that in most other countries the distinction I have drawn in this article between a constitutional right and a political right is blurry at best if not wholly inapplicable. That is to say, what may be most unique in the United States is not the nature of the right to health care, but the particular and peculiar meaning we give to the concept of a constitutional right as we claim it exists in the United States—notwithstanding the gap between that concept in theory and that concept in practice.[108] Thus I am really raising two related sets of questions: Are there constitutional rights in other jurisdictions and, if so, is a right to health care among them? I have my hunches about the answers to both lines of inquiry, but, as noted above, I look forward to the responses from my counterparts in other jurisdictions.

108. *See* discussion *supra* notes 84-85.