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Robert M. Sade, M.D.

Dr. Sade is an associate professor and chief of pediatric heart surgery, division of thoracic surgery, Medical University of South Carolina.

When an academic surgeon who spends most of his professional life operating on children, worrying about their pre- and postoperative care, and lecturing and writing on cardiac diseases, stands before a distinguished group of professional people to talk about philosophy and politics, his first obligation is to say that he's neither a philosopher nor a politician. Although I am neither, I admit to a life-long interest in these disciplines. At one time, they were only of peripheral, avocational interest to physicians, but now they've taken on a more immediate importance. The previously sacrosanct relationship between physician and patient has been invaded by forces less interested in combating disease than in controlling the economics and the social utility of that relationship. The proper means of dealing with those forces will not be found in biology or medicine, but rather in philosophy. As physicians, we need philosophy to ask fundamental questions, to challenge unstated premises, to select appropriate professional goals, and to light a rational pathway to those goals.

Is the function of a physician basically to help individual men in distress who seek aid? Or is it to do everything necessary to lower the prevalent levels of disease in society at large? Do physicians function best as individual contractors for their services or as servants of the public good? Is a physician's primary professional goal the welfare of his patients or the welfare of society? Should medical care aim toward excellence in the treatment of individuals or toward quantitative distribution of care to society at large?

Social activists view physicians as public servants whose primary goal is the overall welfare of society. They are eager to use any means to lower prevalent levels of disease and believe that socially controlled redistribution of medical resources, despite the sacrifice in quality of care necessitated by such a system, is an appropriate goal for the health care industry.

In opposition to these social goals stand the ancient traditions of the medical profession. Does the nature of man support those traditions? The physician's main goal has always been to provide comfort

and aid to those who seek it. His highest professional obligation has been to the welfare of the individual patient. Should it continue to be so? Is the best interest of patients served by the physician's search for quality in providing care rather than quantity? The traditional system of values in medicine stands in direct opposition to the logic underlying all forms of government involvement in health care. We may wonder whether the traditional is not also the only rational value system for physicians.

The philosophic foundation of the current political drive to nationalize the health care industry rests on the concept that health care is a right. Consideration of that concept raises some fundamental questions concerning the relationship between the individual and society. Wherein lies the ultimate competence for solving problems relating to survival of men as rational beings: with individuals or with society? What is the proper code of behavior governing the relationships between men: voluntary choice or coercive force? Are men by nature independent and sovereign or are the conditions of their lives rightfully determined by the state?

The unstated premises of those who support the concept of medical care as a right are that the decisions of society have ultimate precedence over the judgment of individuals. Coercive force is a perfectly proper means for some men to deal with others; the conditions of survival and quality of life for human beings are rightfully determined not by themselves, but by society through its coercive arm — the state. Should we disagree with those premises and assert rather that men are sovereign, independent and rational? Should we conclude that medical care is not a right and resist the nationalization of medicine at that philosophic level?

I would like to direct my discussion toward consideration of the right to health care, what it means, and what its consequences are. I will show that the notion that health care is a right is a perversion of the concept of rights, and that the consequences of its implementation in society have been historically and will be in America the opposite of the desired effect.

Over the past several years, I have been told that arguing against this prevalent concept is shoveling sand against the tide. I think not. Other concepts, far more deeply imbedded in society than this one, have been reversed. One such notion is pertinent to this discussion. For thousands of years, power and authority to decide upon the affairs of man — sovereignty — resided in a small group of individuals, king or emperor, in almost every society. In the 17th Century of James I of England, the king alone was sovereign. During the political fermentation of the mid-17th Century when the crown lost much of its power, it was recognized that there must necessarily be an arbitrary power in every state somewhere. During the subsequent decades, the concept of sovereignty of Parliament became firmly entrenched, and

by the mid-18th Century this idea had become orthodox. Blackstone gave the classic formulation in 1765, the year of the Stamp Act: "There is and must be in all forms of government a supreme, irresistible, absolute, uncontrolled authority, in which the *jura summi imperii*, or the rights of sovereignty, reside." In England, this sovereignty was pledged in Parliament, whose actions "no power on earth can undo." It was this concept and the English insistence upon its applicability throughout the empire that led to the American Revolution, the major objective of which was to dislodge the site of sovereignty from Parliament, and place it where it properly belonged, in the individual: "We hold these truths to be self evident: that all men are created equal; that they are endowed by their creator with certain unalienable rights; and that among these are life, liberty and the pursuit of happiness."

Health Care as a Right

Let us look at the concept of health care as a right and see whether it's also an orthodoxy that deserves to be overthrown.

All philosophers since the ancient Greeks have believed that men possess certain rights, but differ widely as to the origin of those rights. They are divided into three basic groups based on three theories of rights: positive law, social good, and natural right. All agree that positive law (the laws of man) are necessary, that society is fundamental to the character of human life, and human beings possess rights. They differ in their placement of primacy upon one of the three.

The group of positive law philosophers, perhaps best represented by Thomas Hobbes, includes Spinoza, Hegel, and Oliver Wendell Holmes. This theory holds that the laws of man alone determine what is just, that is, that man's rights are whatever the law says they are.

The social good theory was espoused by Jeremy Bentham, David Hume, John Mill, Roscoe Pound, John Rawls, among many others, and perhaps is most associated with the utilitarian philosophers. They thought of a right as a possession of individuals which society, *for its own good*, ought to defend. Thus the social good for them is prior to any individual rights.

Exponents of the natural right theory are a very large group, including the ancients, Aristotle and Cicero and later, Augustine, Aquinas, John Burke, John Locke, Thomas Jefferson and in modern times, Robert Nozick and Ayn Rand. Their backgrounds and points of view vary widely, but all these philosophers have in common the view that man's nature is the source of his rights, and justice consists of rendering to each his due. They all believe that both society and positive law exist to serve the interests of individual men.

There are enormous variations in the details, but all philosophers fall into one of those three categories. I do not intend to expound

extensively upon the details of these three positions, but will comment briefly on them. At the root of both the positive law and social good theory of rights is the argument that *natural* rights do not exist because on a desert island there is no need for rights. In saying that, though, proponents of these two positions ignore the nature of man. The need to plan for his future, to marshal and protect his resources, are requirements for his life. It is *right* for him to think, *right* for him to plan *because* it is right for him to live. On a desert island, a man can ignore what is right, but to do so is to choose death.

All governments are based on one of the three philosophical interpretations of the origin of rights. With rare exceptions — notably the ancient Greeks — governments were philosophically based upon the positive law theory: that which is right is that which is legal, or might makes right. Later, in the 19th century, the social good theory became more prominent as socialism arose in Europe. The political implications of both of these theories become evident when one considers the Fascist governments of Europe in the 20th Century. If rights and justice are determined only by what is legal or what is socially good, with no other standard of reference, then the legally elected and popularly supported governments of Europe which saw certain races as inimical to the social good were perfectly justified in constructing their concentration camps and embarking upon systematic annihilation of Jews, Poles, and Russians. History has proven the positive law and social utility theories of right to be untenable for civilized, rational men.

The third alternative, the concept of natural rights, has provided a philosophic underpinning for a political structure that has led to the development and prosperity of mankind to an extent unparalleled in history.

A right defines a freedom of action. For example, the right to a material object, such as a loaf of bread, does not apply to the object itself, but to the freedom of the man who produced or earned it to dispose of it in whatever way he wishes, by consumption or trading. The right to free speech is the freedom to speak or write without coercion, not a guarantee that someone will supply a microphone or printing press.

Because man is above all else a living creature, his primary right is the right to life. This right is not a guarantee of life itself because accidents, diseases, or old age will eventually remove it. The right to life defines the freedom to act in support of one's own life. The goal of this life-sustaining action is the creation or acquisition of material values, such as food and clothing, and intellectual values, such as self-esteem and integrity. The standards by which man selects those values constitute his moral system.

Man must maintain a delicate homeostasis in a highly demanding and threatening environment, but has at his disposal a unique and

efficient mechanism for dealing with it: his mind. His mind is able to perceive, to identify precepts, to integrate them into concepts, and to use those concepts in choosing actions suitable to the maintenance of his life. It is the use of his mind that enables man to pursue a moral, that is, value-oriented life. However, the rational function of mind is volitional. A man must choose to think, to be aware, to evaluate, to make conscious decisions. Should he choose not to think, and be guided by instantaneous gratification or other irrational standards, his acts may work against his life: for example, excessive use of alcohol, tobacco, or drugs. If one's goals have been selected, the extent to which man is able to achieve them is directly proportional to his commitment to reason in seeking them.

Three Corollaries Implied

The right to life implies three corollaries: the right to select the values that one deems necessary to sustain one's own life; the right to exercise one's own judgment of the best course of action to achieve the chosen value; and the right to dispose of those values, once gained, in any way one chooses, without coercion by other men. The denial of any one of these corollaries severely compromises or destroys the right to life itself. The man who is not allowed to choose his own goals is prevented from setting his own course in achieving those goals, and is not free to dispose of the values he earned is no less than a slave to those who usurped those rights. His life is in their hands. Freedom of production and disposition, of course, means private property. The right to private property is indispensable to maintaining free men in a free society.

Rights have no meaning unless they can be protected, or enforced. In a social context, rights become a political issue. Governments are formed in order to protect man's right to support his own life. Indeed, the only proper function of government is to protect the rights of its citizens; that is, to provide for the defense of individuals against those who would take their life or property by force. The state is the only repository for retaliatory force in a just society, wherein the only actions prohibited to individuals are those of physical harm or the threat of physical harm to other men. The closest humanity has ever come to achieving this ideal of government was in America after the War of Independence. The Revolution, first and foremost, established the rights of the individual and the purely protective nature of government against Blackstone's "supreme, irresistible, absolute, uncontrolled authority." The principle of protection of the individual against the coercive force of government made the United States the first moral society in history.

Governments do not always act in a moral manner. In fact, they seldom do. In the United States, the perversion of the concept of

rights began long ago, but accelerated during the 1930's when Franklin Delano Roosevelt switched the meaning of rights from the field of action to the field of specific goods and services. The right to seek a useful and remunerative job became the right to a useful and remunerative job. The right of every farmer to ask a fair price for his products became the right of a farmer to get a fair price. The right of every family to compete in the marketplace for a decent home became the right of every family to own a decent home. The right to seek out or purchase adequate medical care became the right to medical care.

When a political body undermines the meaning of rights and ignores the progression of natural rights arising from the right to life, and agrees with a man, a group of men, or even a majority of its citizens that everyone has a right to a specific commodity or service, it must protect that right by passage of laws insuring everyone's share, in the process depriving the producer of the freedom to dispose of his own product. If the producer disobeys the law, asserting the priority of his right to support himself by his own rational disposition of the fruit of his mental and physical labor, he may be taken to court by force or threat of force where he will have more property forcibly taken away from him (by fine) or have his liberty taken away (by incarceration). Under those circumstances, the initiator of violence is the government itself. The degree to which a government exercises its monopoly on the retaliatory use of force by asserting a claim to the lives and property of its citizens is the degree to which it has eroded its own legitimacy. We frequently overlook the fact that that behind every law is a policeman's gun or soldier's bayonet. When that gun and bayonet are used to initiate violence, to take property or to restrict liberty by force, there are no longer any rights, for the lives of the citizens belong to the state. In a just society with a moral government, it's clear that the only right to a commodity or a service belongs to its producer, and that a claim by anyone else to that right is unjustified and can be enforced only by violence or by threat of violence.

If anyone doubts that health legislation involves the use of force, a dramatic demonstration of the practical political meaning of the right to health care was acted out in Quebec a few years ago with the passage of the infamous Bill 41. In that unprecedented threat of violence by a modern Western government against a group of its citizens, the physicians of Quebec were literally imprisoned in the province by what was possibly the most repressive piece of legislation ever enacted against the medical profession. Physicians objecting to a new Medicare law were forced to continue working under penalty of a jail sentence and fines of up to $500 per day away from their practices. Those who spoke out publicly against the bill were subject to jail sentences of up to a year and fines of up to $50,000 a day. The facts that the physicians did return to work and that no one was therefore jailed or fined do not mitigate the nature or implications of the passage of Bill 41.

Although the dispute between the Quebec physicians and their government was not one of principle but of the details of compensation, the reaction of the state to resistance against coercive professional regulation was a classic example of the naked force that lies behind every act of social legislation.

The concept of medical care as a social right is immoral because it denies the most fundamental of all rights: that of a man to his own life and the freedom of action to support it. Medical care is neither a right nor a privilege: it is a service which is provided by physicians and others to people who want to purchase it. It is the provision of this service that a physician depends upon for his livelihood, and is his means of supporting his own life. If the right to health care belongs to the patient, he starts out owning the services of a physician without the necessity of either earning them or receiving them as a gift from the only man who has the right to give them, the physician himself.

Care as 'Right' Violates Patient's Rights

The concept of medical care as a right also violates the patient's rights. It is the patient's right to select his own values, to dispose of his own property in pursuit of those values in whatever way he wishes. If he wants to buy a relatively inexpensive health insurance policy with a high deductible clause and use the excess to buy a season ticket for his local opera company or local baseball team, he should feel free to do so. If complete coverage of all possible health problems is more important to him, he can spend twice as much for a complete coverage insurance policy. It is his money and his values that are in question. Once medical care becomes a right, the choice is no longer his; he buys what the government is selling, or else.

While the question of rights is of fundamental importance to everyone, the question of medical care is of paramount importance to physicians. Any physician who is forced by law to join a group or hospital he does not choose, or is prevented by law from prescribing a drug he thinks is best for his patient, or is compelled by law to make any decision he would not otherwise have made, is being forced to act against his own mind, which means forced to act against his own life. He is also being forced to violate his most fundamental professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient.

I would like to change gears now and look at the other side of the coin. Many people in public life obviously don't agree with me. They claim that health care is a right. To protect that right, they have passed a variety of laws and have proposed numerous bills. Let us examine the justification for that legislation, and then its likely effect. As we look at the make-believe world of health care created for public consumption over the past several years, we can be forgiven if we feel

very much like Alice in the following exchange.

Alice went on: ". . . and I thought I would try and find my way to the top of that hill. . . ." "When you say 'hill'," the Queen interrupted, "I could show you hills in comparison with which you would call that a valley." "No, I shouldn't," said Alice, surprised at contradicting her at last: "A hill can't be a valley, you know. That would be nonsense. . . ." The Red Queen shook her head. "You may call it 'nonsense,' if you like," she said, "but I have heard nonsense, compared with which that would be as sensible as a dictionary!"

There is so much misinformation and misrepresentation in the public press that it has become nearly impossible to separate reality from the absurdities created by politicians and the press. It's such nonsense, in fact, that some surprising ideas become sensible as a dictionary by comparison.

Let us look at some of the myths that have become part of the public picture of American health care. *Health is primarily a community or social concern rather than an individual concern.* It is easy to disprove that notion with a few statistics, but I would rather make the point by quoting a recent statement by the liberal Sen. William Proxmire of Wisconsin. The senator said: "Advocates of comprehensive health insurance talk of the 'right' to health. The assumption is that if the government just did its duty and spent enough money on research and cures and doctors and nurses, we would have a far healthier country. That is just not the case. Health, for most of us, is a matter of personal responsibility. . . . The health problem with this nation is that too many people are too lazy, too fat, smoke too much, are tense, drink too much, and expect some kind of tranquilizing, stimulating, go-to-sleep drug to make them feel better. The Federal Government can triple its spending on health research, as it has done in the past few years. It can vastly increase the number of rewards for doctors and nurses. It can vastly increase the hospitals and medical technologies as we have done for years now, and we will still be taking millions of Americans to cemeteries before their time, and we will still be haunted by millions of Americans suffering painfully through their later years, sick and weak, because they ate too much, ate the wrong things, smoked and drank more than they should have."

The provision of health care lies outside the laws of supply and demand, and government-controlled health care would be free. TANSTAAFL! There ain't no such thing as a free lunch. I will enlarge upon this shortly, but the cost of government medical care to individual Americans will be enormous, far more than under a private system. In fact no service or commodity lies outside the economic laws. In the field of health care, market demand, individual wants and medical needs are entirely different things and have a very complex relation with the costs and total supply of available care. Somebody has to pay for health care, individually or collectively, at the expense of fore-

going the current or future consumption of other things. The question is whether the decision of how to allocate the consumer's dollar should belong to the consumer or to the state. As I said earlier, the choice of whether to buy a more or less expensive insurance policy rather than some other commodity or service belongs to the consumer as a logical consequence of his right to his own life. The government has the power to make these decisions for him, but not the right.

National Health Insurance

Next, I would like to talk about national health insurance. Before discussing the specifics of this issue in the United States, I would like to go back a few years to show that control of health care services by government is nothing new. The modern history of social health legislation really began in 1883 when Otto von Bismarck pushed through the German legislature his Sickness Insurance Law. Bismarck thought the passage of that law was necessary as a pre-emptive move against the growing political power of the new German Socialist movement. It was designed to mollify the working people with a paternalistic medical program. Soon after that, many other European countries developed social medical programs, and by the mid-1950's, almost all European countries had health care systems controlled by the state.

The purely political goal of medical legislation in most countries has usually been reached: consolidation of political power by giving away "free" goods or services. But the political goal has almost never been explicit. The reasons usually given by the government for taking control has been the improvement of the people's health; this was to be achieved by improvement of "quality" of health care, by making care available to more people, and by improvement of the overall health of the nation as measured by standard health indices. Historically, none of these nonpolitical goals has been consistently achieved by any nation merely by legislatively controlling its health care industry.

The myth is that *state medicine has worked better elsewhere than free enterprise has worked here.* The National Health System of England is a national disaster with waiting lists for most operations years long; with almost continuous contention between physicians and their employers, the government; with frequent strikes by hospital workers; and with an almost unbelievably top-heavy bureaucracy. Thirty years later, the brain-drain continues. One-third of the total output of British medical schools leaves every year, seeking a less oppressive environment elsewhere. Sweden, once a model for national health plans, is descending into the same abyss. The waiting list for plastic surgery exceeds seven years; for gall bladder operations, three years, varicose vein surgery five years. A man of average income pays over 50% of that income to direct national income tax; a large part of that

tax goes to provide medical care. And so on throughout the world. The most disturbing feature of almost all national health plans is that they depersonalize the physician-patient relationship by overloading the physician's time with worried-well and neurotic patients who perceive the doctor's time as their right and free of charge. In Sweden today, patients can never be sure that they will be treated by the same doctor twice, and when they do see one, he may be seeing as many as five times more patients than he did 20 years ago, leaving five-fold less time for each patient. Dr. Gunnar Biorck, a leading political physician in Sweden, has pointed out that these trends in Swedish medicine are the work of "the new masters, who are administration and information technicians, who are interested in the system, not in human beings." The stories are similar around the world.

Now let's look at the specific issue of national health insurance in the United States. Although the real goal of national health insurance is to consolidate the political power of those who pass it and will run it, it has three purported goals: control of costs, improvement of quality, and increase of availability of health care. None of these goals can be reached.

In order to control the staggering cost of health care, all we need do is put a cap on hospital charges and regulate the income of physicians, the two sources of rising costs. In fact, the major cause by far of inflation in health care costs is general inflation which is caused by government mismanagement. Other minor reasons for cost inflation have been high-cost technologies that are life-saving and illness-reducing, hardly an unjustified expense; extensive wage increases for hospital employees due largely to minimum wage laws and unionization; malpractice liability insurance premiums that have increased 10-20 times in the past few years; and the enormous costs of meeting the regulations of the 50 or more federal agencies overseeing health care. If Washington thinks it can control costs by taking over the health care industry, we point out to them that *nothing* they have done in the past, from running the post office to running Amtrak, has shown stable or declining costs. Quite the opposite.

GAO Study

Cost, efficiency and productivity of any government agency always compare unfavorably with those of private industry carrying out the same tasks. Thanks to the House Committee on Ways and Means, we now have the facts that demonstrate just how badly the government performs in the health care field, when contrasted against private institutions providing the same fiscal services. The General Accounting Office (GAO) carried out a study, in response to a request of the House Committee, comparing the performance of the Division of

Direct Reimbursement (DDR) of the Social Security Administration with that of private contract intermediaries which also deal directly with institutional providers of Medicare services. The GAO's report, "Performance of the Social Security Administration Compared with that of Private Fiscal Intermediaries in Dealing with Institutional Providers of Medical Services," dated Sept. 30, 1975, analyzed in great detail the intermediary functions, their costs, and the methods used to assure meaningful comparisons between institutions.

The average cost to the DDR of processing one bill was $15.83. The cost to private intermediaries for the same functions ranged from $4.94 to $12.33, all considerably under the government cost. When the data were weighted according to the type of bill processed, DDR's adjusted unit cost was $7.13 while the range for private providers was from $2.55 to $3.50.

The study compared annual compensation for certain personnel, including fringe benefits, vacation and sick leave benefits, and the like. Government accountants received $21,600 compared with private accountants' $15,900. Claims examiners for the government received $11,600; those for private intermediaries, $7,900. Compensations for nurses working for the government was $13,600, for those working for the private companies, $11,700.

Did differences in compensation reflect greater efficiency on the part of the more highly paid workers? The answer was suggested by analysis of the number of bills processed by the intermediaries per man-year. DDR processed 2500 while the private intermediaries processed from 3900 to 6600 bills per man-year. Higher personnel pay in the government apparently is not related to increased productivity. The report also noted that each of the private intermediaries had some type of production standards to measure performance, whereas the DDR had no such standards.

Efficiency can also be estimated by the length of time it takes to pay bills from the time of their receipt. DDR performed consistently less well than the private intermediaries. Inpatient hospital bills, for example, were paid by DDR within 15 days in 46% of cases, while private intermediaries paid from 79 to 89% of the inpatient hospital bills within 15 days.

Right now the government is responsible for all the medical care for veterans, Indians, and soldiers. While private medical care costs slightly over $600 per capita, the cost for the VA, Indian health service and military is over $2,000 per capita. The answer to controlling health care costs is not federal control; it is federal restraint in the rate at which the greenback printing presses are run, reducing deficit spending to zero — the only way to control general inflation. The regulatory bureaucracy that already exists should be removed: this alone could reduce health care costs by 20%. Cost control is best done by a free market, which means keeping the government out.

The quality of health care in the United States is not good. Our rate of infant mortality is disgraceful.

This statistic is meaningless as an index of health care. Infant mortality means different things in different countries; statistical methods vary from country to country, and even within countries, such as ours. There are no standard criteria for determining infant mortality; even if there were standard criteria, countries with people of small average stature would have infants of smaller size, therefore, an artificially lower infant mortality; reporting of births is the responsibility of parents in some countries, and reporting of deaths is not rigidly enforced in others; the extent to which legalized abortion in some countries lowers infant mortality is unknown; and there are racial differences not related to the socio-economic level in the rate of infant deaths. If the United States is to be compared with another country, it should be one of about equal population, spread out over an entire continent, and of multiethnic origin. Such a country is the Soviet Union, which has, since its start in 1917, emphasized specifically the types of public health that should lower infant mortality. Over the past 10 years, the infant mortality in the Soviet Union has consistently been 30-40% higher than than in the United States. The unreliability of infant mortality as a measure of national health is *so* well known, in fact, that anyone citing such statistics is either dishonest or malicious. We hear them cited often by American politicians.

Unnecessary Surgery Being Done

There are incredible amounts of unnecessary surgery being done in the United States. As much as 30% of all surgery is unnecessary. There has never been a shred of hard evidence produced to support that contention. When Dr. John Knowles made that statement and was invited by the Massachusetts Medical Society to produce evidence in support of his charge, he was unwilling or unable to do so and, for making this irresponsible statement, he became the first physician in 50 years to be officially censured by the Massachusetts Medical Society. If unnecessary surgery were being done for the profit of physicians, one would suspect that they would not subject themselves and their families to such risks for someone else's profit. In fact, the opposite is true: for certain operations which are considered largely unnecessary by critics, the operation rate is actually higher for physicians and their families than for the general population.

National health insurance will make health care available to those who do not now get it. To whom is health care not available? Federal legislation has already provided access to health care for those least able to afford it, the poor and the elderly. The fact of the matter is that these groups of people have always had good health care available

to them. One measure of quantity of medical care is the number of hospital admissions in a given population. A government survey during the years 1963-64 correlated age-adjusted hospital admission rates with income levels. The survey disclosed that families with incomes under $2,000 a year had 124 hospital admissions per 1,000 people. In families with a near poverty income of $2,000-$4,000 a year there were 142 admissions per 1,000. These figures contrast with hospital admissions in families with incomes of over $10,000: there were 120 admissions per 1,000 in this group. Length of stay in a hospital correlated negatively with income: the highest income group had fewer days in the hospital than the other groups.

Of course, it could be argued that the quality of care during those admissions was less than optimal. Not only is it impossible to find evidence of low quality, it seems likely that quite the opposite is true: large numbers of poor people live very close to major teaching institutions where the quality of medical care may be at its highest. It is likely that a disproportionate number of admissions of the poor was to such institutions. Furthermore, those who argue that poor people need significantly more hospitalization than others have yet to produce evidence that this is true.

Another fallacy that has gained public acceptance only by virtue of frequent repetition is that poor people cannot see a physician when they need one. Data to disprove that assumption were provided by the Department of Health, Education and Welfare through a survey that was carried out in 1970, investigating the quantity of medical care obtained by persons in the age range between 18 and 64 years, and correlating those data with economic level. During the year 1970, 68% of the low income group saw a physician; in the middle income group, 69% saw a physician; and in the high income group the figure was 70%. There was a significant difference in the quantity of medical care, however, since members of the low income group visited a physician an average of five times in 1970, those in the middle income group had four visits, and in the high income group the average number of visits to a physician was 3.7.

The popular belief that poor people in central cities cannot easily avail themselves of a physician's services is also fallacious. Seventy-one percent of persons between 18 and 64 years of age living in central cities saw a physician during 1970; in the middle and high income ranges 65% and 66%, respectively, saw a doctor.

Another way a national health program can make health care more available is to reduce the shortage and maldistribution of physicians. What shortage? In 1966 the shortage of physicians was estimated at 50,000. We still hear the same estimate, yet since that time there has been a net increase of over 75,000 physicans. The number of physicians is growing at three times the rate of the general population.

There is no shortage, many men are saying, but there is maldistribution. The most that can be said of this issue is that there is uneven distribution. Washington, D.C. has 410 physicians per 100,000 population, Florida 168, North Dakota only 96. But density of physicians in the population has nothing to do with the level of health in that population. Infant mortality, for example, in Washington in the early 1970's was 28.5, compared with Florida's 20.7, compared with North Dakota's 15.3. A last example: during World War II there was a sudden efflux of thousands of physicians from communities from all over the country. Many places suddenly found themselves with a quarter to a half of the previous number of physicians and some communities were without any. But, looking at any statistical measure of health, no significant differences can be demonstrated between the periods before, during, and after the war.

Catastrophic Illness Insurance Needed

Some of the smarter politicians in Washington realize that we simply cannot afford national health insurance. But at the very least, they say, *we must have national insurance against catastrophic illnesses.* First of all, catastrophic illness is uncommon. In a randomized sampling of 26,000 patients, it was found that only 4.2% of them had expenses over $5,000 and 0.3% had expenses over $10,000. Eighty percent of those with expenses over $5,000 were either medicare or psychiatric patients. Leaving out these two groups, only 0.16% of Americans will have catastrophic expense in any given year. For these reasons, private catastrophic health insurance is inexpensive, only $53 per year for a family of four. The expense for the same sort of coverage provided by the government has been projected at $370 for a family of four. The record of past government medical programs would predict expenses far in excess of that within a year or two after such a program would begin. Every national health insurance plan will make things worse rather than better.

We are told that *we as physicians must help design the legislation for a national health system, since we have to live with it.* To accept this concept is to concede to the opposition its philosophic premises and to lose the battle. Nonproducers throughout history have been able to expropriate material and intellectual values from producers only with the sanction of the victim. Historically, few people have lost their freedom and their rights without some degree of complicity. If the American medical profession accepts the concept of health care as the right of the patient, we will have earned national health insurance by default. The alternative is to withhold our sanction and to make clear to the politicians *who* is being victimized. Each of us must say to

those who would control our profession: I do not recognize your right to my life and my mind, which belong to me and me alone; I do not approve of any legislative solution to any health problem. In the face of the raw power that lies behind government programs, this type of rejection is the only way in which personal values can be maintained. It is with attainment of the highest of those values — integrity, honesty, and self-esteem — that the physician can achieve his most important professional value: the absolute priority of the welfare of his patients.

I would like to make a statement which is as pertinent today as it was on the day it was written: "Did you ever observe that there are two classes of patients in states, slaves and freemen; and the slave doctors run about and cure the slaves, or wait for them in the dispensaries — practitioners of this sort never talk to their patients individually, or let them talk about their individual complaints? The slave doctor prescribes what mere experience suggests, as if he had exact knowledge; and when he has given his orders, like a tyrant, he rushes off with equal assurance to some other servant who is ill, and so he relieves the master of the house of the care of his invalid slaves. But the other doctor, who is a freeman, attends and practices upon freemen; and he carries his enquiries far back, and goes into the nature of the disorder; he enters into discourse with the patient and his friends, and is at once getting information from the sick man, and also instructing him as far as he is able and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure. Now which is the better way of proceeding in a physician?"

That is how Plato put the same question now facing us. Our answers today to the philosophic question of whether health care is a right and to the political question of whether we will have National Health Insurance will determine tomorrow whether or not we will be free doctors treating free men.

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