HEALTH LAW, ETHICS, AND HUMAN RIGHTS

Mary Beth Hamel, M.D., M.P.H., *Editor*

The Elusive Right to Health Care under U.S. Law

Jennifer Prah Ruger, Ph.D., M.S.L., Theodore W. Ruger, J.D., and George J. Annas, J.D., M.P.H.

Is there a right to health care in the United States? No U.S. Supreme Court decision has ever interpreted the Constitution as guaranteeing a right to health care for all Americans. The Constitution does not contain the words "health," "health care," "medical care," or "medicine." But if we look deeper, a more nuanced picture emerges. The Court has found rights to privacy,[1] to bodily integrity,[2] and to refuse medical care[3] within the vague right to "due process" contained in the Constitution. The Court has also constructed a right to decide to terminate a pregnancy,[4,5] although it has also ruled that the government has no obligation to subsidize the exercise of this right[6,7] (Table 1). When this line of cases is considered together, it would appear that the U.S. Constitution provides scant affirmative obligation to provide health care.

Despite the absence of a universal right to health care in the Constitution, Congress and the Supreme Court have incrementally crafted an incomplete web of health care rights during the past 50 years. In prisons and emergency rooms across the country, physicians and medical institutions have for decades been required to provide medical care. In a 1976 landmark decision in *Estelle v. Gamble*, for example, the Supreme Court found a right to adequate medical care for prisoners grounded in the Eighth Amendment of the Constitution.[8]

To locate federal protection of a more universal right to health care, one must look past the judicial branch to the rights created by Congress. Through its core constitutional authorities to tax and spend and to regulate commerce, Congress may enact statutes that establish and define the rights of individuals to receive health care regardless of their ability to pay. In 1986 Congress did just that, passing the Emergency Medical Treatment and Active Labor Act (EMTALA), guaranteeing at least a modicum of medical attention for all who arrive at an emergency department in a hospital that accepts Medicare.[9] Congress similarly operationalized an incremental health care rights framework in establishing Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and most recently the Patient Protection and Affordable Care Act (ACA) (Table 2).

These statutes create an incomplete set of rights that reflect the inconsistency at the core of U.S. health care policymaking. Some programs, such as Medicare and EMTALA, are federal, and others, such as Medicaid, are federally subsidized and state-based, but all remain incomplete. Medicaid is rife with dramatic variation from state to state and from one needy group to another. For Medicare, there are geographic variations in payment levels, and Medicare does not include nursing home care or other long-term care. Courts have construed EMTALA, which includes only emergency care and care for women in active labor, to permit diverse levels of care in different hospitals. On the eve of the ACA's passage, the panoply of rights to health care in the United States could accurately be described as incomplete and incremental, with considerable gaps and shortfalls.

The ACA and the subsequent 2012 Supreme Court decision upholding most of its provisions represent substantial but incomplete steps toward operationalizing a more robust and complete right to health care. They also highlight our inconsistent framework of health care rights.

AMERICAN CONSTITUTIONAL LAW AND HEALTH CARE RIGHTS

American constitutionalism has championed negative liberties more than positive rights. The U.S. Supreme Court has recognized rights related to health care in ruling that the Constitution

Table 1. Major Supreme Court Decisions on Health Care Rights.

Case	Health Care Right
Griswold v. Connecticut (1965)	Right to privacy and right to use contraception
Roe v. Wade (1973)	Right to privacy, right to make reproductive decisions, and right to decide to have an abortion
Estelle v. Gamble (1976)	Right to adequate medical care for prisoners
Maher v. Roe (1977)	No right to government-funded abortion
Harris v. McRae (1980)	No right to funding for all constitutionally protected reproductive choices
Youngberg v. Romeo (1982)	No right to substantive services
Cruzan v. Director, Missouri Department of Health (1990)	Right to refuse treatment and right to privacy and bodily integrity
Planned Parenthood v. Casey (1992)	Right to liberty, right to make reproductive decisions, and right to decide to have an abortion

Table 2. Federal Laws Institutionalizing a Legal Right to Health Care.

Federal Program	Government Power from U.S. Constitution	Health Care Right
Medicare (1965)	Power to tax and spend for general welfare	Right to health care for persons 65 yr of age or older and for those younger than 65 yr of age with disabilities and those with end-stage renal disease
Medicaid (1965)	Power to tax and spend for general welfare	Right to health care for some individuals and families with low income
Emergency Medical Treatment and Active Labor Act (EMTALA) (1986)	Power to tax and spend for general welfare	Right to screening and stabilization on presentation at emergency department
Children's Health Insurance Program (CHIP) (1997)	Power to tax and spend for general welfare	Right to health care for uninsured children in low-income families who do not qualify for Medicaid
Patient Protection and Affordable Care Act (ACA) (2010)	Power to tax and spend for general welfare	Right to access health insurance

confers a right to privacy grounded in the Due Process Clause of the Fourteenth Amendment. According to the justices, laws implicating fundamental rights (including a right to privacy) are subject to a heightened standard of review referred to as "strict scrutiny." This means that the government must demonstrate a "compelling state interest" to interfere with the exercise of an individual's fundamental rights. Applying this standard, the Court in 1965 in *Griswold v. Connecticut*[1] invalidated a Connecticut law that prohibited the use of "any drug, medicinal article or instrument for the purpose of preventing conception."[10] The Court by a 7-to-2 decision ruled that the law violated the "right of marital privacy."[1] Justice William O. Douglas wrote in the majority opinion that the right to privacy is a right to be "protected from governmental intrusion."[1]

In 1973, in *Roe v. Wade*, the Court broadened the privacy right beyond contraception to recognize a fundamental right to decide about abortion under the Constitution, grounding it in the idea of personal liberty in the Fourteenth Amendment.[4] In 1992, in *Planned Parenthood v. Casey*, the Court upheld a woman's basic right to reproductive freedom as a liberty right, but it permitted the state to regulate the abortion decision in ways that did not impose an "undue burden" on the woman.[5] The Court recognized a different kind of long-standing health care right in its decision in *Cruzan*: bodily integrity encompassing the right to refuse lifesaving treatment.[3] Taken together, these cases reflect a transformation in judicial recognition of, and willingness to protect, claims of individual autonomy and bodily integrity in the health care area.

These cases demonstrate the well-defined limit to the Supreme Court's willingness to craft rights to health care; it has steadfastly refused to generate a positive entitlement to funding or access to effectuate these negative liberties as they relate to health and bodily autonomy. In a series of divided opinions on abortion, for example, the Court rejected the claim of a right to public funding to effectuate this right. In 1977, in *Maher v. Roe*, six justices held that "[t]he Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents,"[6] ruling that abortion rights were not a positive health entitlement. The government could refuse to provide funding for abortions even under a program providing public assistance for other medical expenses associated with pregnancy and childbirth, because the government could, consistent with the Constitution, favor childbirth over abortion. Justice Harry Blackmun, one of three dissenters, attacked what he regarded as the specious distinction by the majority between negative liberty in *Roe v. Wade* and positive entitlement argued for in *Maher v. Roe*, stating in *Beal v. Doe* that "[t]he Court concedes the existence of a constitutional right but denies the realization and enjoyment of that right on the ground that existence and realization are separate and distinct. For the individual woman concerned, indigent and financially helpless . . . the result is punitive and tragic."[11]

The Court majority extended this reasoning in 1980 in *Harris v. McRae*, when it decided, 6 to 3, that "[a]lthough the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom."[7] Indeed, the prohibition of using federal funds for abortion is routinely reinforced by Congress, and the ACA itself could not have passed without presidential guarantees of no ACA funding for abortions.[12] Similarly, in *Youngberg v. Romeo* (1982), the Court ruled that "a State is under no constitutional duty to provide substantive services for those within its border."[13] The result of these two lines of cases is a conceptual incongruity and a real-world shortfall in the judicialized constitution of health care rights — for many persons living in poverty, the libertarian rights to access reproductive health services are empty promises absent a requirement of government financial support.

EXCEPTIONS TO THE NEGATIVE-RIGHTS DOCTRINE

Doctrinal rules governing health care for prisoners and others under government control stand in stark contrast to this general distinction between protected negative liberties and unenforced positive guarantees. In *Brown v. Plata* in 2011, the Court ruled that "[p]risoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment. . . . A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."[14] Similarly, in *Youngberg v. Romeo*,[13] the Court found that the government must provide medical care to persons confined involuntarily in a mental health treatment setting. The government acquires the obligation to provide health care by making it impossible for the individuals it has deprived of their freedom to obtain it on their own.

Meanwhile, state courts, state legislatures, and Congress itself have incrementally constructed a near-universal right to one kind of health care: emergency treatment. In *Wilmington General Hospital v. Manlove* (1961), the Delaware Supreme Court established a duty for all hospitals with emergency departments to treat patients in cases of "unmistakable emergenc[ies]"[15] on the basis of the public's reasonable reliance on the hospital's "established custom" of rendering emergency aid. Fourteen years later, the Arizona Supreme Court in *Guerrero v. Copper Queen Hospital*[16] ruled that hospitals had a duty to treat emergency cases as an implicit condition of state licensure. These and other decisions, and pressure for a uniform nationwide rule, led Congress to pass EMTALA in 1986, which applies to any Medicare-participating hospital with an emergency department and covers both emergency conditions and active labor. EMTALA states that the hospital "must provide an appropriate medical screening examination within the capability of the hospital's emergency department, to determine whether or not an emergency medical condition exists."[17] If this initial screening reveals conditions representing

a risk to the patient on discharge, the treating hospital must "stabilize" the patient before discharge or transfer. EMTALA is very limited in scope, but the right it creates is widely available, even more so than Medicaid or the ACA because EMTALA rights extend to everyone arriving at an emergency department, including new and undocumented immigrants.

Beyond EMTALA's thin guarantee of initial emergency attention, Congress has over the past half-century incrementally created more robust statutory health care rights for certain populations. This statutory "constitution"[18] of positive rights to health care primarily includes Medicare, Medicaid, and CHIP. Amendments to the 1965 Social Security Act enacted Medicaid and Medicare. Federally administered, Medicare guarantees access to health insurance for those 65 years of age or older who have worked and paid into the system, and for those younger than 65 years of age with disabilities and those with end-stage renal disease. Medicaid, a means-tested health care program, is jointly funded by federal and state governments but primarily managed by states. Also state-administered under federal Department of Health and Human Services (HHS) oversight, CHIP provides matching funds to states to insure children in Medicaid-ineligible families. These programs collectively represent a political impulse toward a positive health care right, but their limited scope leaves tens of millions of Americans unprotected and vulnerable.

THE AMERICAN FRAMEWORK OF HEALTH CARE RIGHTS

The classical constitution of negative liberty and individual autonomy is an outdated conceptual framework, ill-suited for the 21st century. Contemporary health care involves interconnectedness and resource allocation. Individual health care spending and insurance choices affect other people. Disease pathways and public health realities also illustrate failures of the atomistic, individualized conception of health care rights. The emerging statutory framework of positive health care rights overlies an older judicial doctrine of negative rights to bodily integrity and autonomy, including physician autonomy.[19] These two influences can work at cross purposes, and opposition to the ACA arises in part from the negative-liberties doctrine of health care rights. ACA opposition focuses, among many things, on promoting individual autonomy in the health insurance sphere and keeping the government out of the physician–patient relationship. Although the ACA is an imperfect law, implementing fundamental rights embodied in its provisions regarding access to health insurance is a step toward enhancing equity.[20]

The new health care construct of positive entitlements properly results from statutory and administrative expansion rather than judicial fiat. The Supreme Court should not on its own initiative attempt to enact positive entitlements to health care or health insurance, but neither should it stand in the way of executive and legislative efforts to realize such rights. In the landmark *Hobby Lobby* case, the Supreme Court was forced to choose between two fundamental features of the American constitutional commitment, and we believe that the Court improperly inserted itself as an obstacle to health care access.[21] On one side is the long tradition of favoring religious prerogatives, the claim of the Hobby Lobby corporation under the Religious Freedom Restoration Act (RFRA). The religious-freedom claim resonates with the negative liberties of individual autonomy, freedom from government interference, and rights to privacy. On the other side is an emerging, but still incomplete, normative consensus that all Americans should share basic health care rights and that equity and social-justice principles of equal access and fair distribution support federal efforts to mandate health insurance that covers essential health benefits.[22]

In *Hobby Lobby*,[23] the five conservative justices of the Court came down squarely against the extension of equitable health care rights. The facts of the case offered multiple good rationales for the justices to rule in favor of the ACA's goal of broadening health care access while remaining faithful to the bedrock principles of religious accommodation embodied in the Constitution and in the RFRA. The Court might have ruled, as a lower court did and as many commentators still maintain, that for-profit corporations do not "practice" religion in a manner warranting the same level of judicial protection that religious organizations and individuals enjoy. Or it might have ruled that the attenuated causal chain by which covered employees might seek a prescription that would one day trigger insurance

coverage for contraceptives was simply too remote to be a burden on the religious beliefs of the corporation.

The Supreme Court will soon decide yet another critical challenge to the ACA's main goals that arises out of fundamental disagreement over the appropriate nature of universal health care rights in the United States. Challengers to the broad coverage of the ACA have latched onto a fragment of statutory text to attack the federal provision of subsidies to millions of individuals seeking health insurance from the Act's "exchanges" in those states that have chosen to have the HHS, rather than the state government, operate the exchange.[24] If the Court rules in favor of the challengers, it will transform the implementation of the Act in more than 30 states, pressuring states without their own exchanges to quickly create them and compounding the very incrementalism and incompleteness that the ACA was meant to address. As the American Hospital Association put it in their brief to the Court, a decision against the current subsidy practice of the ACA would be "a disaster for millions of lower- and middle-income Americans. . . . many more people will get sick, go bankrupt, or die."[25]

THE COURTS, THE CONGRESS, AND HEALTH CARE RIGHTS

It is notable that all three of these litigation efforts against the ACA — the 2012 ruling on the individual mandate, the 2014 ruling in *Hobby Lobby*, and the forthcoming ruling on subsidies for exchange participants — arise from the devolved structures of American health governance; none of the three issues would be valid constitutional or statutory objections to a taxpayer-financed single-payer system. As the Court ruled in *Hobby Lobby*, religious objections to general taxation used to finance national imperatives are not protected as strongly as the specific claim of Hobby Lobby against the regulatory mandate of the ACA. Perhaps paradoxically, under the Court framework, a completely single-payer system is more constitutionally sound than the ACA statutory design, which aims to preserve a private institutional role in the health care system.

The current health care system in the United States fits uneasily within the basic structures of American constitutional law. Current and future legal challenges to the ACA jeopardize its already insubstantial guarantee of a health care right. The powerful negative-liberty norm in American constitutional law suggests that, absent a major shift in American culture, perceptions about constitutional protections against government intrusion will continue to undermine ACA policy changes, even though the majority of the public, through its congressional representation, enacted this legislation.

This juxtaposition of statutory-rights fulfillment and constitutional libertarianism embodies a quintessentially American contradiction. Judicially crafted constitutional doctrine never aspired to and never could guarantee positive rights to health care, education, and other primary goods that all Americans need to flourish. Congress and other political institutions have recently stepped in to fill the void left by judicial doctrine in the area of positive rights to health care. Given the relative deficit that our unelected federal judiciary has in terms of democratic legitimacy, ongoing judicial interference with positive rights extended by the political branches is especially problematic. Our Supreme Court is not the solution to what ails our health care system, nor should it be. But if it gets in the way of the ongoing and gradual democratic process of arriving at solutions, it is a major part of the problem.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Perelman School of Medicine (J.P.R.), Leonard Davis Institute of Health Economics (J.P.R.), and the University of Pennsylvania School of Law (T.W.R.), University of Pennsylvania, Philadelphia; and the Department of Health Law, Bioethics, and Human Rights, Boston University School of Public Health, Boston (G.J.A.).

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