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APPEAL TO JUSTICE IN ACCESS TO HEALTH SERVICES FOR VULNERABLE INDIVIDUALS AND GROUPS

Călin SĂPLĂCAN[1]

Abstract

The ethical approach of access to health services is motivated by the particularity of health services and the meaning of justice. Access to health services has become a priority of our societies, and inequalities in access to health services are perceived as inhuman, immoral, or unjust. Health policies mobilize solidarity networks as well as the health services offered. Fair access to health services depends both on individual demands (possibility of accessing services and actual access to health services) and supplies (availability and organization of the system). What are the choices to be made in accessing health services from the point of view of justice? What are the criteria that stand at the basis of justice? Is it the market? Or solidarity? Perhaps utilitarianism? These choices must be preceded by a serious debate.

Keywords: justice, theories of justice, access to health services, inequalities, distribution of medical services

Appeal to justice in access to health services of vulnerable individuals. Motivations

How is appeal to ethics justified from the perspective of justice in access to health services?

Firstly, by the fact that health services are especially important due to the special place they have in a good life, in the relationship with others and with the community. Illness, accident, or suffering can affect any individual, changing their lives (limitations in mobility, action), their relationships (limitations in relations with family and friends, they can be a burden for their family) and their community (in work relations, participation in community life, expenses for medical care).

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Health services can fit just as well to the field of the social than to the field of economics. On the one hand, they are strongly connected to individual vulnerability, aiming at the elimination of illness and relief of suffering or disabilities. The role of communities is important in this case through their power to influence health issues via relations of solidarity. The means through which communities mobilize and act are health systems: the totality of resources engaged in providing health services (doctors, structures, organizations, etc.). Their failure is perceived by members of the society as inhuman, immoral. On the other hand, medical services are subject to the logic of production and can be regarded as private enterprises. Their primary aim is not to improve the health condition of the population, but to increase their profit. Social justice rests in this case as a horizon of ethical interrogation.

Secondly, it is justified by the fact that equality or inequality in access to health services is a measure of justice. Although vulnerability cannot be restricted to illness, illness is part of it, for suffering is what "pushes" the patient to see a doctor. This brings about a pact of medical services between "two persons, one who is suffering and exposes his suffering, asking for the help of a master in health, and the other who knows, who knows what to do, who offers him treatment" (Ricœur, 2001, 246). Despite their willingness to help, doctors have to face in their activities an increasing number of social inequalities in health issues and access to health care. Although difficulties in access to health services are not a primary cause of social inequality, they are a part of it nonetheless. In the analysis of concepts of exclusion, fragility or vulnerability in access to health services, the issue of justice lies in the background of the ethical perspective as a critical interrogation regarding health system(s). Equal access to health services raises important ethical questions, since it does not also guarantee the fair distribution of health services. For example, the strictly equal allocation of access to health services can be unjust because it may not respond to personal needs, the proportion of contributions, or the distribution of goods in various fields of society (e.g., economy, education, culture, social services, etc.). The notion of justice is located at the intersection of the ethical and political. The problem of justice in access to health services questions the way of distribution of goods, made differently depending on the fields of activity. The distribution of goods in our society is differentiated: strictly egalitarian (e.g., access to voting); based on merits (public responsibility jobs); based on needs (social service aids); based on market economy (consumer goods) (Rameix, 2002, 21). How is distribution made on the level of access to health services?

Reference to justice in society, particularly in health systems, implies the instauration of an institutional system by political decision makers (democratic juridical and political structures), different for various political options. For instance, policies based on liberal market theories have different approaches than those based on egalitarian theories of solidarity. Before turning to the analysis of political perspectives relative to the distributions of medical services, it is important to map the inequalities in accessing health services.

Inequalities in access to health services

For Pierre Boitte and Jean-Philoppe Cobbaut (Boitte, Cobbaut, 2006, 9-40) access to health services has become one of the priorities of our society, as itself a determinant which creates inequalities and exclusions. Access to health services can be regarded from various perspectives, each of which creates inequalities.

Access to health services can be seen as a relationship between a user of medical services and medical services; the opportunity to get medical care for people with health issues, without any kind of constraint. In this case, access to health services depends both on vulnerable individuals and groups and on the distribution system of medical services; both on their demands and the system's capacity to answer these needs. From this point of view, the determinants of access to health services involve: (1) characteristics of vulnerable individuals (age, health condition, ethnicity, sex, income, behaviour towards health, etc.) and groups (homeless children, the Roma, the elderly, seropositive people, prisoners, etc.); (2) distribution system of health services, comprising multiple elements: availability (the lower the number of doctors, the harder the patients' needs to be met); organization of health system (health service networks, geography of health, geography of transportation, etc.) (Boitte, 1995, 174) In this case, inequalities are generally due to the health system and health policies (that is to say, the complication of health service networks, including various specializations which are not obviously interconnected), assisted by the altering ways of administrative report (medical insurances). Nevertheless, vulnerable individuals can hardly find their way in these complex networks. Met with this complexity, the ethical challenge of justice regarding access to health services is connected to the organization of a humanized system of medical care which offers quality care without excluding the vulnerable.

Access to health services can be regarded from the perspective of accessibility. The context of changes at a primary and secondary medical level (closing of hospitals, reducing medical staff in certain regions, overburdened medical staff) questions the inequalities regarding access to health services. In their turn, geographic aspects (transportation, disposition of health centres) also condition the access to health care, creating inequalities.

Enlarging the scope of the notion of access to health services, it can also be related to social (aging of the population, increase of chronic illnesses, more and more vulnerable populations) and economic aspects (low financial income). In these cases vulnerable individuals and groups are most exposed. The health system is organized more around biology and medicine, and leaves less space for the articulation of the relation between health and society. The consequences of social inequalities (for example the inability of vulnerable individuals to pay for their medical insurances or health care) reverberate on the access to health services.

This enlargement of the scope of access to health services interrogates health systems from the point of view of effective possibilities of vulnerable individuals and groups to receive medical care: "Cette effectivité comprend non seulement l'«arrivée» jusqu'aux soins, mais également la possibilité d'en retirer un bénéfice

réel, notamment par le fait que cette prise en charge médicale soit suffisamment en prise sur la réalité culturelle, sociale et économique des individus censés en bénéficier" (Boitte & Cobbaut, 2006, 13-14)[2].

The appeal to the notion of justice in confronting the inequalities in access to health services is justified by its pertinence both to the field of ethics and that of politics, mediating between them. On the level of justice, it is expressed by the principle of equality of opportunities[3]. *A good life with and for the others in reasonable institutions* (Ricoeur, 1991, 256) represents the ethical horizon in which we inscribe ourselves. The political may regulate the relations between the social and the economic by instating a reasonable institutional system that guarantees fair access to health services. On the one hand, political decisions imply social level interventions which manifest themselves through concrete decisions on an institutional level and forms of collective solidarity. This ethical perspective connects the individual to networks of solidarity and political action. On the other hand, political decisions imply an economic level intervention which ensures a reasonable distribution of resources. Economic aspects have a foremost role in health. While the demands in health care are practically endless, the resources are limited. Therefore the quantity of resources allocated to the health sector and especially their efficient use is a political concern. The perspective of choosing one type of policy or another on the level of health services is what lies at the basis of posing the question of justice.

Access to health services from the perspective of liberal market theories

From the perspective of liberal market theories, justice is seen as a formal equality of rights as respect for individual liberties. This means that all individuals have the same rights. As the state guarantees individual rights and liberties, it does not interfere with the distribution of goods. Goods are accumulated through the market. Liberal tradition considers that, due to its complexity, economic life escapes the knowledge of its actors; therefore it cannot transform this knowledge without risks. As each individual acts well when it comes to their interests, the balance can only get better. (Kymlicka, 2003, 109)[4] Therefore everyone knows what is more important for them, and is able to structure their own scale of values. Justice from the perspective of liberal market theories is not achieved through the

[2] This effectiveness means not only the 'arrival' to care but also to possibility to have a real benefice, especially by the fact that this medical care may be sufficiently well adapted to the cultural, social and economic reality of the individual who must benefit from it.

[3] We cannot speak about the principle of equality of chances without stating that it depends on the evaluation of medical needs.

[4] It must be said that not all adepts of liberalism share the idea that "the mechanisms of market are implicitly just" The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle" (Rawls, 1971, 302-303).

establishment of a distribution plan for goods by specific criteria, but it is self-regulated, starting from the observation of fundamental rights and liberties.

On this scale of values, health has the place which everyone is willing to afford to it. Therefore, in a liberal perspective, the state has no obligation towards the citizens to give them rights connected to health, such as health insurance. Each person may or may not buy any health insurance packages from private agencies in competition. Solidarity plays no important role here, as the responsibility towards health is everyone's own business. Noone may impose any sacrifice for a common good over someone else. Priority is given to procedural justice who supports individual liberties. Such a perspective may raise certain problems which will be discussed from the perspective of health service distribution.

Can we speak, from the perspective of liberal market theories, of health service distribution or the principles which lie at the basis of this distribution? Apparently, this is senseless as long as the positions of the advocates of these theories are concerned, which favour freedom and individual responsability towards health. So any collective intervention may seem problematic from this point of view since it would diminish individual freedom. If access to health services strictly pertains to each individual's freedom, what happens in case of inequalities within these societies? Biological inequalities (fragile health) can be remedied by the medical services offered (purchasing medical insurances). But what if these inequalities are doubled by social and economic ones (poverty)? This does not raise any problems on justice level, nor does it imply any responsibility of the others. The only chance for these vulnerable individuals to have access to health services are private charitable associations by their donations. This type of access remains indebted to donations and it is aleatory. The special character of health has motivated some positions which encourage charity actions in health services for individuals who have no access to these. But these charity actions do not regulate in any way the quality and quantity of health services. The problems raised by the position of the supporters of this theory appear not only in case the health of an individual is affected by the action of another, but also in case of diluted responsibility. While the responsibility of an individual regarding the alteration of another's health can easily be established through legal procedures, there is a real difficulty in establishing the responsibility in damaging the health of an individual due to issues connected to environment, labour, pollution, stress, poverty. Who is responsible for damage done to health in case of air pollution? Individuals? The society? The government?

Access to health services from the perspective of egalitarian theories of justice and solidarity towards individual needs

John Rawls is the best known representative of the theory of justice as equity, as a proposition for political philosophy to step out of the impasse of being caught between utilitarianism and intuitionism. While utilitarianism was based on the principle of maximizing utility, intuitionism was supported by a mixture of ideas

and principles. (Kymlicka, 2003, 61-64) Intuitionism claimed to be an answer given in opposition to utilitarianism, which failed to be convincing as it offered no guidelines when these principles got into value conflicts. Rawls's proposition has become an inarticulate place of political philosophy not because of the consensus it put forth, but because of its central idea: justice is the fundamental principle of human society and the central requirement of social and political institutions. This idea envisaged the egalitarian distribution of social goods, not trying to eliminate all inequalities but only those which defavoured certain individuals. As a result, Rawls rendered the different elements of the theory of justice in a hierarchy[5](Rawls, 1971, 302-303) The theory presumes the primacy of the equality of liberties over the equality of opportunities. Inequalities are acceptable for Rawls only if they favour those less privileged.

The application of Rawls's theory of justice on the level of distribution of medical care may be rooted in the principle of equal basic liberties, in the difference principle, or in the principle of equality of opportunity. (Boitte, 1995, 152-155). In the first case, health is considered an issue of primary social goods, justified by its vital importance. This perspective is questioned in multiple ways, such as: why is health an issue of primary social goods and feeding is not?; placing liberties and health services on the same level of social goods means to diminish the force of the first principle and the risk of a conflict between the two types of goods; assigning special importance to medical care would mean competition with the distribution of other goods such as education, culture, etc. In the second case, the difference principle should justify the distribution of health care. The failed attempt to establish an index of primary social goods placed health on the same level with other social-economic advantages regulated by the difference principle. This principle would assess life and health on unequal grounds, due to the difficulties to determine the way how inequalities must be favouring the less privileged. In the third case, access to health care is also inscribed in the perspective of equality of opportunity. This is justified by the importance of health in access to the opportunities of social life. Despite this significant openness, the question still remains: what does the equal distribution of health services really consist in?

[5] "*First Principle:* Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all. *Second Principle*: Social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity. *First Priority Rule* (The Priority of Liberty) The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty. *Second Priority Rule* (The Priority of Justice over Efficiency and Welfare). The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle." (Rawls, 1971, 302-303)

Access to health services from the perspective of utilitarian justice theories towards community needs

Whereas the egalitarian theories of justice were based on the criterion of individual needs, the perspective of egalitarian theories of the utilitarian type favour the collective good, the collective privileges related to one single value, "utility". From this perspective political decisions must be taken for the same reason, namely well-being, happiness or utility. In case of value conflicts due to various attitudes relative to happiness or well-being, the policies chosen are those which respect the principle of utility: a policy which produces maximum collective well-being and has positive consequences for the individual. This latter perspective tries to avoid policies which include irrational or erroneous positions of individuals. This kind of approach is attractive because of the neutrality of utilitarian laws. Moreover, the concern of assessing the consequences of political decisions is also an advantage. Criticisms are not lacking however, since such a principle has nothing to say about individual responsibility within the community, nor about the just or unjust nature of institutional practices.

How does such a theory work in health services? Let us note that the utilitarian perspective is not specific for Romania, but rather for the northern countries (Denmark, Finland, Sweden) and England. The utilitarian idea applied on the health system means a long and healthy life for the largest possible number of people. On the level of distribution of health services, utilitarianism seems like a theory which can face the problems raised, in contrast with other perspectives based on foundations difficult to describe such as the right of every individual to medical care, health as a common asset, personal responsibility towards health, or distributive equity of health services.

In the countries applying this system, medical doctors are paid depending on maximum community advantage. In health issues, global utility connects medical utility with economic and social utility, and thus medical care is prioritized for those who are able to work, who lead more active life than others. The QUALY factors, morbidity and mortality, are the support for calculating the relations between cost and benefice. The criterion of maximum utility in health definitely has its positive effects, if we think of the maximization of health in the population (reducing suffering, reintroduction of people with disabilities on the labour market). However, one must also emphasize the limits of this perspective, as social advantages impose the sacrifice of certain individuals, such as people with disabilities or serious chronic illnesses. The collective good comes before individual rights. At the same time, utilities quickly come in conflict with the distribution of goods, since the financial limitations of the health care system impose waiting lists and inevitably inequalities in access to health services. The privileged ones are those with higher financial resources, who can afford to either pay for supplementary medical services or access private health care.

Conclusions

The particularity of health services and problems of injustice due to inequalities in access to these services have raised the problem of distribution of health services from the point of view of health policies. The theories of justice underlying these policies have highlighted their positive sides, yet also their important limitations. Starting from these reflections, this paper proposes to make some inquiries as to the level of distribution of health services in Romania.

In Romania, access to health services based on free market coexists with access based on fair equality. Private medical services do exist, but there is no private medical insurance, citizens must purchase the services they need "one by one", which is very expensive. Not anyone can afford to buy these services, and this raises serious ethical problems regarding the distribution of goods, and inequalities in health issues. There are projects to revise health care laws in Romania, which also stipulate the introduction of private insurance. This would certainly lower the costs for the beneficiaries who can afford it, but the problems of injustice would persist. Even more, a further problem would also be raised, that insurance agencies filter patients depending on risk. Another problem is that in such a perspective the patient is at the doctor's discretion as regards his medical needs, which leads to the overestimation of medical actions and overconsumption on the patient's side. Finally, the discussion of access to health services from a market perspective also raises problems, since ill people find that their freedom to structure a scale of values which includes health is limited, because relation to health is vital in one's personal and professional development.

The most plausible position able to support the just distribution of health services is the approach from the perspective of equality of opportunities. This position allows individuals to share equal opportunities in life and inscribe their life plan into society. The criterion underlying this theory is the need for medical care: for equal needs equal health services. This implies strong solidarity. What is its mechanism? In Romania, employees and employers alike pay their regular and mandatory contributions to the National Health Insurance House. It must be stated that these contributions vary according to income and not according to risk. This kind of insurance also covers people living on unemployment benefits, men doing their military service, or pensioners. The government was determined to impose a health contribution for these people by the fact that unemployment has become structural and the average life expectancy is rising. The unemployed and pensioners also pay contributions to the National Health Insurance House depending on their income (unemployment benefits or pensions).

The egalitarian perspective based on solidarity depending on needs raises some problems. As life becomes longer, need for health care increases, and this poses questions regarding levels of efficiency and resources. Another issue is connected to the moral responsibility of the insured, who, knowing to be insured against risks, may take risks about his/her health. On the other hand, having unlimited access to doctors, the insured may abuse of it, causing overproduction in terms of demand for doctors and overconsumption in medication or

investigations. In order to limit these effects, the Romanian state considers the introduction of health tickets which would limit these excesses. While these tickets would moderate the abusive access of doctors, medicines and investigations, they would also be a factor of injustice for families living in poverty. To pay for the rest of the visits would mean for these families a delay in accessing health services and the aggravation of their health condition. In consequence, they would have to face much more serious medical care because they would only see a doctor in case of serious illness. If this perspective is the most plausible option, then the increasing needs in health care, the development of costly investigation and treatment technology, and the increasing number of chronic and disabled patients will force political decision makers to impose limitations in the distribution of health services.

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