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A Property Right to Medical Care

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INTRODUCTION

Should American law recognize a positive, individual right to health care? Jurists,[1] ethicists,[2] economists,[3] lawmakers,[4] and others have agonized over this question for decades. Yet, despite the protracted, cyclical debate over this question, the most concrete and colorable legal ground that compels a right to health care in this country has received little attention.[5] This article attempts to correct this omission. Here, we outline a firm basis for recognizing a legal right to health care that has been overlooked. We assert that all Americans have a property right to receive medical care and that this property right should be legally protected.

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[1] *See, e.g.*, Kenneth R. Wing, *The Right to Health Care in the United States*, 2 Annals Health L. 161, 163 (1993) (stating the United States recognizes no constitutional right to health care); *see also* Wendy E. Parmet, *Terri and Katrina: A Population-Based Perspective on the Constitutional Right to Reject Treatment*, 15 Temp. Pol. & Civ. Rts. L. Rev. 395, 403 (2006).

[2] *See, e.g.*, Kristen Hessler & Allen Buchanan, *Specifying the Content of the Human Right to Health Care, in* Medicine and Social Justice: Essays on the Distribution of Health Care 84 (Rosamond Rhodes et al. eds., 2002); *see also* John C. Moskop, *Rawlsian Justice and a Human Right to Health Care*, 8 J. Med. & Phil. 329 (1983).

[3] *See generally* Richard A. Epstein, Mortal Peril: Our Inalienable Right to Health Care (1997) (making the economic argument that an individual right to health care would fail).

[4] *See generally* Mark A. Ison, Note, *Two Wrongs Don't Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care*, 56 Vand. L. Rev. 1497 (2003).

[5] *See, e.g.*, Lori Andrews, *My Body, My Property*, Hastings Cen. Rep., Oct. 1986, at 28 (arguing for recognition of property rights in organs, body parts, and tissue in connection with transplantation forms of health care, but falling far short of the overall property rights argument presented in this article); *see also* Thomas J. Bole, III, Rights to Health Care 28 (1991) (providing a sample of arguments, including one that posits recognizing a right to health care will limit the property rights of others).

Historically, arguments for a right to health care have been advanced on moral grounds ("Fairness requires this as our duty"[6]) or comparative grounds (the United States is the only developed nation that does not recognize such a right).[7] Arguments opposing such a right are wide ranging. The American Medical Association's position has been that recognizing a right to medical care would replace the professional obligation of beneficence with a legal duty and thus undermine physician autonomy and professional traditions that are the anchors to access and quality in medical care.[8] Others have argued that a healthy therapeutic relationship requires a direct economic relationship between patient and physician[9] that would be undermined by such a right, or that as a matter of economic prudence this nation cannot afford the cost of recognizing a right to health care for all. Libertarian philosophical argument holds that such a right inserts the state into an otherwise free economic exchange, replacing free choice with governmental coercion.[10]

We propose that recognizing a right to medical care should emanate from the massive public investment in medical training, research, infrastructure, and delivery. This investment creates a public property interest in medicine as a socially funded public good.

Legal rights arise from five sources of law: rights expressed in the United States Constitution or state constitutions; statutory laws enacted by a legislative branch of government; common or judge-made law, where judicial rulings set future precedent; administrative laws arising from the interpretation and promulgation of rules established by regulatory agencies; and, when applicable, international law contained in treaties or agreements to which the United States is a party. These five sources of American law share a firm commitment to protect the property rights of individuals in our society. From the broad prescriptions and proscriptions of the United States Constitution to complex and specific provisions, our laws from all sources reflect a heightened respect for individuals' rights to own, control, sell, convey, and defend against the deprivation of any interest we call a "property right."

Broadly defined, property rights are the legal interests that the law protects when one purchases or becomes the lawful recipient of a thing of value. Property rights exist most clearly whenever the law protects a person's

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[6] *See* Meredith Rosenthal & Norman Daniels, *Beyond Competition: The Normative Implications of Consumer Driven Health Care*, 31 J. HEALTH POL. POL'Y & L. 671, 677 (2006) (arguing a right to health care requires fair financing and distribution).

[7] *See, e.g.*, Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457 (2001); *see also* The Universal Declaration of Human Rights, G.A. Res. 217, art. 25, U.N. Doc. A/810 (Dec. 10, 1948) (declaring health care a human right).

[8] E.A. Pont, *The Culture of Physician Autonomy: 1900 to Present*, 9 CAMBRIDGE Q. HEALTHCARE ETH. 98 (2000).

[9] R.S. EPSTEIN, KEEPING BOUNDARIES: MAINTAINING SAFETY AND INTEGRITY IN THE PSYCHOTHERAPEUTIC PROCESS 129 (1994).

[10] Robert Sade, *Medical Care as a Right: A Refutation*, 285 NEW ENG. J. MED. 1288 (1971).

expectation of being able to draw an advantage from what that person has labored to create[11] or contracted to own. Moreover, property rights are not limited to tangible goods. United States law protects property rights held in intangible goods such as clear airspace, future income, electronically transferred funds, and promised employment. American law provides a qualified, limited right to health care for select populations;[12] however, no law recognizes a general property right to health care.

We argue here that the right to health care is, in fact, a property right, subject to the same protections and privileges as all other forms of property under the law. This individual property right to health care arises from the enormous investment each member of society makes to create health care. This investment by individuals into the public fisc creates an obligation owed by the state to exercise its spending power to provide access to basic medical care for all Americans. The property interest we claim is held by individuals, enforceable against the state.

It is a unique form of property, called a "public good." Although not all health care can be described as a public good in economic terms, the most basic forms of medical goods and services certainly can be. The simple claim is that, although American law has not directly created a right to health care, Americans' public investment in the medical industry has.

I. LIMITATIONS OF CURRENT LEGAL THEORIES

The Supreme Court has held the United States Constitution defines a right to health care only for those under the custody and control of the state. Prisoners, for example, have a constitutionally protected right to receive

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[11] Lior Zemer, *The Making of a New Copyright Lockean*, 29 HARV. J. L. & PUB. POL'Y 891, 907-10 (2006).

> The famous and influential Lockean labor theory of property derives from John Locke's Second Treatise of Government, in which the philosopher argues: Though the Earth, and all inferior Creatures be common to all Men, yet every Man has a Property in his own Person. This no Body has any Right to but him. The Labour of his Body and the Work of his Hands, we may say, are properly his. Whatsoever, then, he removes from out of the State that Nature hath provided, and left it in, he hath mixed his Labour with, and joined to it something that is his own, and thereby makes it his Property. It being by him removed from the common state Nature placed it in, it hath by this labour something annexed to it, that excludes the common right of other Men. For this Labour being the unquestionable Property of the Labourer, no Man but he can have a right to what that is once joyned to, at least where there is enough, and as good left in common for others.

See also Adam Mossoff, *Locke's Labor Lost*, 9 U. CHICAGO L. SCHOOL ROUNDTABLE 155 (2002) (explaining the breadth of Locke's labor theory of property in modern property law).

[12] For example, the Eighth Amendment to the United States Constitution guarantees prisoners a right to adequate medical care. *See* Estelle v. Gamble, 429 U.S. 97 (1976); *see also* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §§ 1395dd (2003) (entitling all in an emergency medical condition to appropriate medical screening in a hospital emergency department).

adequate medical care. Established by the Eighth Amendment, this right neither guarantees access to comprehensive health care nor defines precisely what medical care is constitutionally protected.[13] However, the Constitution's prohibition against cruel and unusual punishment has been read to require the provision of reasonable and adequate medical care to a prisoner. As currently interpreted, the Constitution also protects a woman's right to access medical procedures to terminate a pregnancy and protect her privacy and liberty interests.

Federal statutes define a number of qualified rights to health care. For example, anti-discrimination laws prohibit the denial of health care to patients based solely on their race or economic or disability status.[14] The Emergency Treatment and Active Labor Act (EMTALA) established the right to medical care for any person in an "emergency medical condition," including active labor, regardless of the patient's financial status; that right extends until the patient's condition is stabilized.[15]

The Social Security Act of 1965 created the Medicare and Medicaid insurance programs.[16] Medicare established the right to government financing of health care for certain elderly and disabled individuals.[17] Subsequently, that right was extended to individuals with amyotrophic lateral sclerosis and dialysis-dependent renal failure when those diseases became Medicare-qualifying conditions.[18] Medicaid established a right to health insurance coverage for the categorically needy.[19] Coverage varies by state depending on income, age, citizenship, financial assets, disability, and status relative to pregnancy or parenthood. These entitlements were created by Congress and the states to protect rights that arise because of an individual's membership in a protected class of citizens.

The federal government can also use its spending power to issue regulations that impose the obligation to deliver health care more equitably. For example, in the 1960s and 1970s, a series of regulations issued by the forerunner of the Department of Health and Human Services (DHHS) expanded the right to health care. By refusing to pay for the cost of care delivered in segregated hospitals built or expanded with federal construction dollars,[20] the DHHS in essence established an equal right of access to hospitals for minority patients.

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[13] *See Estelle*, 429 U.S. at 97.

[14] Emergency Treatment and Active Labor Act, 42 U.S.C. § 1395(dd) (West 2003).

[15] *Id*.

[16] Social Security Act of 1965, Pub. L. No. 89-384, *codified at* 42 U.S.C. § 1395 *et seq*. and 1396 *et seq*. (West 2003).

[17] 42 U.S.C. § 1395 *et seq*.

[18] Social Security Act of 1965, Pub. L. No. 110-27, *codified at* 42 U.S.C. § 426 (West 2007).

[19] Social Security Act of 1965, 42 U.S.C. § 1396 *et seq*. (2003).

[20] Hospital Survey and Construction Act (Hill-Burton Act), 42 U.S.C. § 291 (West 2001); *see also* CMS Manual System, Pub. 100-1, ch. 1/20.2.

Common law has also been used to define certain rights relative to medical care. For example, *Stanturf v. Sipes*[21] held a provider liable for turning away a patient with gangrene because the patient was unable to pay a $25 fee. This case stands for the common-law proposition that a provider may not turn away a patient who has relied upon the provider's representation that it is available to treat all medical emergencies. *Stanturf* establishes the common-law basis for protection of a patient's reliance interests or rights.

Similarly, patients who have an established and continuing relationship with a provider have the right not to be abandoned. The right to health care from that particular provider ceases, however, once reasonable notice and an opportunity to obtain alternative care are provided, because this right is founded only upon a fiduciary or quasi-contractual relationship between physician and patient. The physician's obligations under the contract are satisfied when the provider gives the patient a reasonable chance to make alternate arrangements for care.

In *Simkins v. Moses H. Cone Memorial Hospital*,[22] the Fourth Circuit Court of Appeals led the nation in recognizing that minority patients and physicians have the right to equal access to health care and could not, under the United States Constitution, be excluded or relegated to "separate but equal" health care facilities. This landmark case recognized citizens' constitutional and statutory civil rights to health care regardless of race, color, or national origin.

In summary, courts and legislatures recognize an individual's right to receive health care in limited circumstances, based on civil rights, privacy, statutory, reliance, contractual, or fiduciary grounds. However, an unqualified, general right to health care has not been protected on any grounds. Thus, current law provides protections that are narrow and fall far short of a comprehensive, universal right to health care. The law has failed to create such a right because the law continues to regard the right to health care as one emanating from individuals' private relationships or status, rather than from their monetary investments. We offer here an entirely new model.

II. A NEW MODEL: A PROPERTY RIGHT TO HEALTH CARE AS A PUBLIC GOOD

Health care, viewed as the medical goods and services that hospitals, physicians, and other providers deliver, is the property of the American public. This conclusion is supported by at least three arguments.

First, health care is fundamentally the product of the huge financial investment in research, education, financing, and delivery systems that each

[21] 447 S.W.2d 558 (Mo. 1969).
[22] 323 F.2d 959 (4th Cir. 1963).

American citizen makes. Second, the public's massive investment in health care results in an ownership interest in an institution that serves the public good, that is, the good of all citizens. Finally, because it shares substantial characteristics with other discrete property interests that economists readily recognize as public goods, medical care also must be recognized as a socially created public good. These three aspects of the public's property ownership of health care are discussed in turn.

A. The Public Investment in a Property Right Called "Health Care"

Medicine in the United States has slowly evolved away from delivering health care that is a product of private interactions, producing private goods and services, toward an activity that is the result of publicly funded investments that produce health care as a public good. This trend can be easily seen in the financing of training for physicians.

Prior to the 1919 Flexner report, most physicians funded their own education and training in proprietary schools. Within 10 years of the sentinel report, medical education was completely consolidated in universities with full-time faculties, laboratories, and libraries.[23] This development led to better quality and training, but it also increased the cost of training to the point that tuition could no longer cover the entire cost.

Medical education today is an enormously expensive enterprise and heavily dependent on public funding. Depending on the accounting model used, the total educational costs of pursuing an M.D. degree in 1997 ranged from $72,000 to $93,000 per student per year.[24] Graduate medical education is even more expensive, at an estimated $130,843 in direct costs per trainee in 1997 dollars.[25] Combining these estimates and adjusting for inflation, in 2003 the total cost of training an internist completing three years of residency fell between $792,000 and $883,000. The cost of a general surgeon completing five years of residency fell between $1,057,000 and $1,142,000. Depending on the school and assuming the trainee paid the full price of tuition without any grants or publicly subsidized loans, physicians entering practice would have paid only between 2.3% and 21% of the total direct costs of their own education.

Who pays the rest? All American medical schools have a specific budget for undergraduate medical education. These funds come from a variety

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[23] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 112-13 (1982).

[24] R.F. Jones & David Korn, *On the Cost of Educating a Medical Student*, 72 ACAD. MED. 200 (1997).

[25] Lynn Blewett et al., *Measuring the Direct Costs of Graduate Medical Education Training in Minnesota*, 76 ACAD. MED. 446, 449 (2001); *see, e.g.*, James R. Boex, *Factors Contributing to the Variability of Direct Costs for Graduate Medical Education in Teaching Hospitals*, 67 ACAD. MED. 80 (1992); COUNCIL ON GRADUATE MEDICAL EDUCATION, FIRST REPORT OF THE COUNCIL: PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, PHYSICIAN PAYMENT REVIEW COMMISSION (1988).

of sources earmarked for education, including state general funds, tuition, philanthropic contributions, and endowment income. The public contribution to these funds varies tremendously by school, yet uniformly these monies fall far short of the total costs of a medical degree. The remainder represents a cost shift away from other revenue-generating activities at the academic medical center. Those income sources vary by school as well. For the average American medical school, direct state and federal government appropriations and government-funded grants and contracts constitute 32.7% of total revenue. The profession of medicine is the largest contributor to undergraduate medical education through faculty practice plans, which contribute 34.2% of total revenue.[26] Private philanthropy and industry grants account for 11% of revenue. Each of these revenue streams contributes to the cost of training a physician.

For graduate medical education (GME), the accounting is simpler and the taxpayer funds a much greater share. In 2002, the last year for which national data are available, state taxpayers, through Medicaid, contributed $2.7 billion in direct and indirect payments for GME, or roughly $27,500 per medical resident.[27] In the same year, Medicare contributed $7.55 billion ($5.25 billion in indirect and $2.31 billion in direct payments), or roughly $76,530 per resident.[28] The exact contribution is elusive, but clearly the American taxpayer underwrites the largest share of the cost of training physicians.

The funding for clinical care has evolved as well. The first health insurance plans appeared in the 1920s through private, non-profit organizations with the strategy of collecting pennies a day from average families.[29] Prior to that, all health care payments were negotiated directly between physicians and their patients. Today, tax dollars underwrite the bulk of clinical care in the United States. Direct public funding, both federal and state, for programs such as Medicare, Medicaid, Veterans Affairs, and the Indian Health Service constitutes 45% of total national health expenditures (NHE). Including direct payment for the insurance costs of state and federal employees (5.4% of NHE), as well as subsidies for private insurance (9.1% of NHE), nearly 60% of all clinical care is in some way funded by tax dollars.[30]

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[26] American Association of Medical Colleges, *Revenues Supporting Programs and Activities at All US Medical Schools, 2000-2001 Fiscal Year, in* AAMC DATA BOOK, *available at* http://www.aamc.org/data/finance/2001tables/finance_table1.pdf (last accessed June 25, 2007).

[27] TIM M. HENDERSON, MEDICAID DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS: A SURVEY OF THE STATES 6 (2003).

[28] COUNCIL ON GRADUATE MEDICAL EDUCATION, STATE AND MANAGED CARE SUPPORT FOR GRADUATE MEDICAL EDUCATION: INNOVATIONS AND IMPLICATIONS FOR STATE POLICY 7 (United States Department of Health and Human Services 2004), *available at* http://www.cogme.gov/ManagedCare/ManagedCareReport.pdf (last accessed June 25, 2007).

[29] DAVID J. ROTHMAN, BEGINNINGS COUNT—THE TECHNOLOGICAL IMPERATIVE IN HEALTH CARE 18-29 (1997).

[30] Steffi Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, 21 HEALTH AFF. 88, 92 (2002).

Financial support for research and development has also evolved into a publicly funded model. One hundred years ago, most medical research occurred in universities—some private, some public—with little to no extramural funding.[31] By 1999, a survey of top research institutions indicated that 61% of their research was federally funded.[32] Although clinical trials designed to bring products to market and expand market share have steadily increased industry's contribution to biomedical research, the taxpayer (through the National Institutes of Health) still spends 25% more on the basic science research that fuels new breakthroughs than the industries that profit from those discoveries.[33]

The impact of public funding can also be seen in terms of research output. Fully 82.7% of biomedical research articles and 79.7% of clinical research articles come from government sources or academic institutions for which public monies pay the majority of research costs.[34]

Public investment has also heavily underwritten the infrastructure of American medicine. The largest single source of construction funds for health care facilities came from the Hospital Survey and Construction Act (the Hill-Burton Program)[35] that began in 1946. Between 1947 and 1970, this program disbursed $3.7 billion in federal funds, contributing to 30% of all hospital construction projects and accounting for 10% of the annual cost of hospital construction. The program also generated an additional $9.1 billion in federal matching of local and state funds.[36] By 2002, the public directly owned 23% of all hospitals through state and local governments. An additional 61% of hospitals were classified as not-for-profit and thus received a public subsidy through tax exemptions for operations and capital improvements. For-profit hospitals accounted for the remaining 16%.[37]

Even though American medicine is not wholly publicly funded, public funding is essential to its existence. Few physicians would be trained if they had to underwrite the full cost of their training. Few, if any, private entities could assume the risk of open-ended research that leads to most medical breakthroughs. Many hospitals could not exist without their tax-exempt status. Most medical services would be out of reach for most Americans without the current public funding for clinic care. At a minimum, the public's substantial

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[31] KENNETH M. LUDMERER, TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY 30-39 (1999).

[32] ASSOCIATION OF TECHNOLOGY MANAGERS, AUTM LICENSING SURVEY, FY 1999: A SURVEY SUMMARY OF TECHNOLOGY LICENSING (AND RELATED) PERFORMANCE FOR U.S. AND CANADIAN ACADEMIC AND NONPROFIT INSTITUTIONS AND PATENT MANAGEMENT FIRMS 9 (2000).

[33] H. Moses, *Financial Anatomy of Biomedical Research*, 294 J.A.M.A. 1333, 1333 (2005).

[34] Darren Zinner, *Medical R & D at the Turn of the Millennium*, 20 HEALTH AFF. 202, 204 (2001).

[35] Hospital Survey and Construction Act (Hill-Burton Act), *codified at* 42 U.S.C. § 291 (West 2001).

[36] STARR, *supra* note 23, at 348-51.

[37] *Tax Exempt Status*: *Hearing Before the House Committee on Ways and Means*, 109th Cong. (2005) (statement of the American Hospital Association).

financial investment in educating health care providers, financing health care delivery, funding health care research, and underwriting the construction of health care facilities purchases an ownership stake that must be viewed as a legally protected property interest. In both legal and economic terms, the public's ownership interest in health care is best understood as an interest in property that has the nature and characteristics of a "public good."

B. A Legally Cognizable Property Interest in Health Care as a Public Good

American courts have historically used the term "public good" both to express the scope of the benefit provided by certain property and to define the property itself. The term applies where the property is publicly necessary and therefore publicly financed for common use by the public. For example, in the following excerpt from *Ex Parte Selma & Gulf Railroad Co.*,[38] one court explains the long-established concept of public investment in property that serves a public purpose and is therefore deemed a public good under the law.

> Highways, including bridges, which are but roads over water, from time immemorial have been recognized by the law as the first of public necessities, and for their construction and repair the legislature has exercised the power of taxing the public at its discretion . . . as the means for accomplishing the object . . . .The railroad, in all important particulars, is promotive of the public good to a degree not rivaled, or proposed to be, by any other kind of road, ancient or modern. It is equally open to the whole people upon the same terms. . . . Railroads are public improvements from which the public derives a benefit. . . . The public has an interest in the use of the road, . . . Railroads are not private affairs; they are public improvements, and it is the right and duty of the State to advance the commerce and promote the welfare of the people, by making, or cause them to be made at the public expense. . . . In this country, beginning with Marshall and Kent, nearly every name distinguished among the judiciary of America is found with those who have affirmed the character of railroads as public institutions, and the validity of acts of the legislatures authorizing taxation in aid of their construction. . . . This is in effect declaring that works of internal improvement are a "public good," which the State should aid by pledging its credit for that end, though it is not best that such works should be carried on by the state as such.[39]

In several cases, the courts have recognized both the physical health and mental health of our nation's citizens are public goods "of transcendent importance."[40] However, these decisions have fallen short of expressly recognizing that the medical goods and services required to deliver good health

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[38] 45 Ala. 696 (Ala. 1871).

[39] *Id.* at 700; *see also* Pikes Peak Power Co. v. City of Colorado Springs, 105 F. 1, 44 C.C.A. 333 (8th Cir. 1900) (holding waterworks system to produce electrical power is a public good).

[40] *See* Jaffe v. Redmond, 518 U.S. 1, 2 (1996) (equating the importance of mental health with the public good of physical health).

also constitute a public good. Nonetheless, American law has implied a property right to the benefits of health care as a public good in cases involving conversions of non-profit health care organizations to for-profit entities.

Since 1996, numerous transactions involving the conversion of hospitals, managed care organizations, and insurers from non-profit to for-profit status have been challenged under state laws designed to protect the public's interest in the community benefit provided by non-profit health care entities. Over 30 states have enacted conversion statutes to recover the investment their citizens have made in charitable institutions;[41] these laws may best be understood as statutes enacted to protect a public good. These statutes rest on the understanding that a non-profit health care organization holds public assets, purchased by the community, as long as the community invests its expected tax revenues in the charitable organization. In other words, the community purchases a public good—the benefit of charitable health care—and pays for that public good with foregone tax revenues. This is why states have exerted significant government oversight and receive a return on their financial investment whenever health organizations seek to change from non-profit status to become for-profit entities, or whenever the entity seeks to employ the public's assets outside the original charter state.

In conversion cases, the government's proper role is to obtain payment for the public's asset, purchased by taxpayers who forgave past tax revenues. In Kentucky, for example, the state attorney general successfully argued the law, under the doctrine of *cy pres*,[42] required Blue Cross to fund a conversion trust when it merged with the for-profit insurer Anthem, Inc. of Indiana. In Colorado, the General Assembly enacted a statute requiring valuation of public assets held by non-profit organizations upon conversion.[43] The states of North Dakota and South Dakota challenged Banner Health's sale to for-profit companies.[44] All of these states acted to protect property rights in benefits provided by charitable health care.

However, even beyond the law's implied recognition that the benefits of charitable health care constitute a public good, our model suggests the law must go further to recognize a more general concept of health care itself as a public good. Not only is health care predominately publicly funded, but it also is created to confer both individual and societal benefits that cannot be delivered efficiently without some level of government intervention.

The most obvious case in point includes the most basic forms of health care—care that is preventative and that protects the public health overall (for

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[41] *See, e.g.*, Nonprofit Hospital Sale Act, NEB. STAT. § 71-20, 102 (2006); AZ. REV. STAT. § 48-1907 (2006).

[42] M.R. Fremont-Smith, *The Challenge of For-Profit Healthcare Conversions*, 31 J. L. MED. & ETH. 49 (2003).

[43] COLO. REV. STAT. §§ 6-19 & 401-407 (2002).

[44] *See* Banner Health Sys. v. Stenehjem, 2003 WL 501821 (D.N.D. 2003).

example, vaccinations or tuberculosis treatment). These forms of care are properly defined as public goods because they produce benefits that extend beyond the individual patient and are shared by society as a whole. Although basic health care is like other acknowledged public goods, such as fire protection, safe roadways, clean air and water, and national defense, the public good analogies are most readily seen in comparing health care to public education.

C. An Analogy to Public Education

Like public education, access for all to health care provides both individual and collective benefits.[45] Providing broad access to both health care and public education elevates a society to a status of well-being, improving its capacity to function and to prosper. Individuals with access to health care, like those with access to education, form a citizenry equipped to contribute to society's resources as laborers, consumers, creators, and managers, thereby benefiting the entire community. When public education produces an educated labor force, or results in well-trained scientists, journalists, and artists, the entire society benefits from the investment.

Similarly, benefits from publicly funded medical research accrue to all without depleting any single person's ability to benefit from these advances. The measles immunity one person receives via vaccination is shared by the entire population in the form of increased population immunity. The benefit received by one patient from enforcing hygiene and other like standards in a hospital are shared by all patients, regardless of their payment status. Even the public benefit that comes from providing health care for the indigent or uninsured confers a social good on all, whether or not anyone pays for that social good. These broad benefits are positive externalities and warrant the full investment and protection of society.[46]

Although it must be admitted the state constitutional provisions that give rise to a right to public education are not those that support the investment we argue gives rise to a right to receive medical care, the American legal system has recognized the government's role in providing or helping to finance and regulate public education as a public good. Similarly, the government must play a role in financing and regulating the right to access to basic health care so that this public good may be protected as an essentially non-excludable and non-rivalrous property right under the law.[47]

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[45] Brad Chandler, *State Law and Public Health*, 90 Kent. L. J. 815, 816 (2002).

[46] Teresa Gillen, *A Proposed Model of the Sovereign/Proprietary Distinction*, 133 U. Pa. L. Rev. 661, 663-64 (1985).

[47] *See* Thomas Jefferson, The Writings of Thomas Jefferson 316 (Richard Holland Johnston ed., 1904).

D. Recognizing Health Care as an Economic Public Good

Economists define property as a public good when several shared characteristics classically present in all public goods also occur in the good or service in question. These characteristics include, first, the essential reliance on public resources to maintain the scale and scope of an infrastructure necessary to deliver the goods to society. Second, public goods are characterized by the non-rivalrous nature of the property that is a public good. Third, the non-excludable nature of the public good is essential to define this category of property.

These three characteristics are present in the majority of health care services in much the same way that they exist in the cases of other classic public goods. Health care services, therefore, are public goods in much the same way and for many of the same reasons that national security, safe highways, and clean air are public goods.

1. The Volume of Public Use Sustains the Delivery of American Health Care

Developing and maintaining the capacity to provide modern medical services requires public participation. No private entity or initiative by itself could accomplish the same outcome. For example, developing the capacity to perform a single coronary artery bypass graft (CABG) procedure required decades of ongoing public funding. First, there were 50 years of collaborative, largely publicly funded, research culminating in the first procedure. Along the way, the public supported the training of a community of surgeons capable of mastering and refining the procedure. The public also facilitated the training of the nurses, perfusionists, and ancillary staff without whom surgeons could not provide the procedure. Additionally, all these professionals needed hospitals. They were, in part, created by public construction funds, public debt and, in the case of charitable institutions, the forgiveness of public taxes.

Ensuring a consistently safe, high quality, widely available procedure requires a high volume of patients; public funds ultimately provided the financing that reimbursed care provided to a significant number of these patients. The cost of a single procedure is so high that few individuals could pay for the procedure directly, and left to private insurance pools the number of procedures would drop dramatically. Without public investment, the volume of the procedure would be so low that few surgical teams could successfully and safely perform the procedure.

Therefore, once the public's investment has created a system of health care that provides coronary artery bypass operations, the public is needed to sustain that system so that the system itself is non-excludable. Since the procedure was first developed, this model of publicly funded research and

development has allowed the safety of the procedure to continually improve, such that today it is routinely and widely available across the United States.

2. The Non-Rivalrous, Non-Excludable Nature of Health Care

The underlying knowledge and capacity to provide health care are non-rivalrous. The example of a CABG surgery performed by a fully trained heart surgeon is instructive. Once the CABG procedure became reliable, reproducible, and safely available to one patient, the science and technology became available to all patients on a non-rivalrous and non-excludable basis. No matter how many patients avail themselves of the CABG operation, the capacity to provide this same service to additional patients is not depleted. The knowledge and technological capability are not depleted. Moreover, so long as there are a sufficient number of practitioners available to perform the CABG operation, one patient's use of the CABG technology and knowledge does not exclude future patients from using that same technology and knowledge simply because they did not pay for the original investment in research that led to the ability to perform a CABG today.

Economists recognize there are few examples of pure public goods that are wholly and unequivocally non-rivalrous and non-excludable. However, public goods, like health care services, possess these characteristics to a sufficient degree that markets alone prove insufficient to allocate these goods and services efficiently or fairly. In the case of recognized public goods such as clean water and air, police and fire protection, and public education, no single individual has the means of, or a sufficient stake in, generating public goods efficiently. Therefore, without collective, public intervention, the market alone will not produce clean air or water or fire protection. Thus, public goods are typically the product of collective societal investment.

Moreover, public goods benefit society as a whole in such a fundamental and essential way that the law has traditionally extended protections to ensure the government's ability to distribute the public good equitably and fairly. Health care is no different in these essential ways than other recognized public goods. It, too, must be produced collectively and distributed centrally because of its essential, economic characteristics.

E. Allocation and Distribution of Health Care as a Public Good

Whether or not any particular individual can pay, society invests in the provision of public goods like health and education, and we must be unwilling to withhold access to at least the most essential and basic goods and services despite any single person's inability to pay. In the United States, even the 46 million people who are unable to pay for health care get some medical treatment, because health care is a good that, in some senses, we do not wholly trust to market distribution.

As if in partial recognition of the public good aspects of health care, American society has adjudged that—at some fundamental level—health care may not be completely withheld from consumers who need it simply because they are unable to purchase care in a purely competitive market. United States law carves exceptions to the market control of health care, requiring, for example, that emergency medical care be available under EMTALA[48] regardless of an individual's ability to pay. However, unlike public education, society withholds many basic forms of medical treatment, limiting access to prenatal care, routine preventative care, and other non-emergency goods and services based solely on individuals' private purchasing power. In the same way that a basic basket of public education goods and services is available to all in kindergarten through high school, notwithstanding any individual's ability to pay, basic health care should be available to all Americans because they pay to create it and therefore own a property interest in this public good.

Health care and education share some characteristics with private goods. For one thing, some health care is excludable. When we use an hour of our physician's time, others are excluded from using that same hour of care. The medicine I take is unavailable to you. The hospital beds we occupy are unavailable for use simultaneously by others. Similarly, we may attend a class as the last enrolled students admitted and thus exclude others from the same learning experience. The knowledge we obtain in that class belongs exclusively to us in a way that is distinguishable even from others who enjoyed the same course. In these ways, both public education and health care are excludable as private goods and therefore are not pure public goods in an economic sense. However, these nuanced distinctions do not seriously weaken the public good analogy in either case.

Market allocation of medical goods and services without government intervention, as though these are merely ordinary private goods, has proven inefficient.[49] Socially beneficial aspects of health care such as preventative care are predictably under-produced, while privately beneficial care such as highly specialized elective care is over-produced at the expense of the common good. Moreover, market-based allocation excludes participation in the individual benefits of health care by the poor and under-privileged, and increasingly by the working middle class, as is commonly the case with other public goods unless government intervenes.

We should not exclude any American, rich or poor, from access to basic medical goods and services, any more than we withhold clean air and water, fire and police protection, safe roadways, national safety, or public education

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[48] 42 U.S.C. § 1395(dd).

[49] Kenneth J. Vandevelde, *Investment Liberalization and Economic Development*, 36 COLUM. J. TRANSNAT'L L. 501, 504-06 (1998).

from those unable to purchase it. In the same way that no single American can provide for the national defense or produce clean air or water, a network of public roadways, or a comprehensive K-12 education, no single individual or corporation can produce a cure for cancer, a network of trauma centers, a tertiary care hospital, or even train a neurosurgeon or family physician. The whole of society depends upon the availability of health care, as with other public goods.

American courts enforce the government's support of public education and challenge the constitutionality of wealth-skewed distribution of public school financing.[50] Although the same reasoning should apply to correct wealth-based disparities in the delivery of health care, lawmakers have generally rejected the entitlement-based rhetoric commonly associated with health care advocacy, precluding this result. This reticence may be traced, in part, to a misunderstanding of the policy implications of recognizing a property right to health care. Again, an analogy to public education is instructive.

Although the public's investment in education grants access to all Americans to basic services, private investment in education continues concurrently. This offers private education alternatives, under a market system, to those wishing to purchase education outside of the public system. Thus, the public's entitlement to publicly funded education does not preclude simultaneous market distribution of privately funded education to the extent the market will bear additional educational goods and services. Similarly, recognition of the public's property right to access health care as a public good, as we advocate, would not preclude the market from continuing to create and distribute private health care to those wishing to buy medical goods and services apart from the public health care system.

CONCLUSION

The policy implications of recognizing a property right in health care as a socially created public good are vast. First, members of the American public, through tax payments, collectively represent the largest investor in the United States health care system. This ownership of a property interest in health care should compel access to basic health care for all Americans. In any economic analogy, an investor who paid more than half of the investment costs would have a controlling interest and a powerful claim to assert control over the enterprise. Such is the universal claim of every American to a property interest in basic health care.

Second, recognition of medicine as a socially created public good will require equitable distribution of its basic benefits. Rather than relying wholly

[50] S.D. Cashin, *Federalism, Welfare Reform and the Minority Poor*, 99 COLUM. L. REV. 584, 587 (1999).

on distribution of health care as a privately purchased commodity, our nation will regard every American as owning an entitlement interest in the most fundamental products of her or his investment in the health care industry. Recognition of this ownership right would not limit anyone's ability to purchase more, but merely establish a basic level of access to which all are entitled.

Finally, the strongest argument favoring a government protected right to health care is a legal and ethical one: simple justice compels that health care must be provided equitably, because the public investment in the delivery of medical care is pervasive. Because we all pay for health care, we should all receive health care. It is that simple. Justice requires the conclusion that government must intervene to ensure the universal burden to pay for the creation and delivery of health care is rewarded by the universal and fair allocation of health care to the people who pay for it and without whose dollars health care would not exist at all.