Egalitarian Provision of Necessary Medical Treatment

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I. Introduction

Many have argued that the state should ensure that all citizens have access to some range of health care services regardless of their ability to pay (Buchanan 1984; Courtland 2017; Daniels 1985; Daniels 2008; DeGrazia 1991; Dworkin 2000; Kelleher 2014; Menzel 2011; Sachs 2008). There has been less philosophical discussion about whether the state should allow some people to purchase access to a higher level of care than the minimum level it guarantees to all. If the state provides public insurance, should it allow some to opt out, to purchase supplementary insurance, or to pay for additional services out of pocket? If the state provides universal access to health care by subsidizing the purchase of private insurance, should it allow insurance companies to offer different tiers of coverage? Many countries, such as Australia and the United Kingdom, provide public insurance but allow people to purchase supplementary insurance.[1] By contrast, several Canadian provinces largely prohibit supplementary private insurance.[2]

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[1] About ten percent of U.K. citizens and over forty percent of Australian citizens purchase such plans. Some other nations, such as Sweden, allow such private insurance plans but do not have a significant market for them. Dhalla (2007).

[2] Specifically, they prohibit private insurance from covering medically necessary physician and hospital services that are covered by public health insurance (Palley et al. 2011). In a recent case (*Chaoulli v. Quebec* [Attorney General] 2005), the Supreme Court of Canada found that Quebec's restriction on

The choice between a single-tier health care system and a tiered health care system matters most in economic circumstances that make it impossible for everyone in a country to receive all the treatments they genuinely need. Genuinely necessary medical treatments include those that are have significant prospects of significantly extending people's lives, curing or mitigating disabilities, or relieving serious forms of suffering, and for which no comparably effective, less expensive alternatives are available.[3] Many less well-off countries currently cannot ensure that all their citizens get the medical treatments they genuinely need. It is debatable whether some wealthy countries are currently able to provide all necessary medical treatments to their citizens.[4] Even if they are, they may become unable to do so. Scientific advances could make inherently expensive treatments substantially more effective than less costly treatments for some common, serious conditions. Or aging populations could make it economically infeasible to maintain the same per capita level of support for health care. Should it become impossible to provide all necessary treatments, the difference between Canada's egalitarian approach to health care and the tiered approach pursued in most other developed countries will be stark.

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private insurance violated the Quebec Charter of Rights and Freedoms. The government of Quebec responded by authorizing private health insurance to cover a narrow range of elective procedures, initially including only knee replacements, hip replacements, and cataract operations (Dhalla 2007).

[3] This definition of genuine medical necessity is admittedly vague. There are, however, clear cases of genuinely necessary treatment. If a certain radiation treatment for certain cancer patients extends life by an average of three more years than the next best alternative, with comparable side effects, it is genuinely necessary, regardless of its price.

[4] Fleck (2009) argues that rich countries already face such conditions of scarcity: "Health care needs (not wants) far exceed our capacity to provide the financial resources needed to meet those needs—this is essentially why health care rationing is inescapable, and why it must be seen as a moral problem."

This article offers a new argument for egalitarian provision of genuinely necessary medical treatment. Under economic circumstances in which a government cannot guarantee necessary medical treatment to all citizens, it should prevent citizens' finances from affecting their access to treatments they genuinely need. To do this, government must place restrictions both on the private insurance market (as some Canadian provinces do now) and on out-of-pocket payments for medical services. Government must do this even if doing so would involve leveling down and even if it is unclear whether this policy would lead to better health care to the poor than would a tiered system that allowed people's finances to affect their access to necessary treatment. The grounds for egalitarianism about access to necessary medical treatment include considerations of autonomy and independence. If people's finances affect their access to necessary medical care, they will be subject to objectionable forms of private domination.

My argument will build on premises that many liberal non-consequentialists will find attractive. I will not attempt to persuade utilitarians or right-wing libertarians.[5] My aim is to show that some moral premises that have been used to defend basic public support of the poor, including provision of "basic" health care, have more demanding implications.[6] The core of the

[5] Left-libertarians may accept the argument, as may consequentialists who believe that individual autonomy or independence has non-instrumental value.

[6] The premises I use are close to the premises of Kant's argument for public support of the poor, as recently interpreted by Gilabert (2010), Ripstein (2009, 25-26 and 267-286), and Weinrib (2003). Ripstein and Gilabert both note that Kant's argument supports a requirement to provide health care to all, but they do not claim that it requires equality in access to necessary treatment. My premises are in an important respect weaker than Kant's: I do not assume—as Kant does, on Ripstein's reading—that the only permissible end of government action is to protect citizens' independence, i.e., to prevent some citizens' continued effective exercise of rational agency from depending on others' discretionary good will. I defend the weaker claim that law must not itself empower some citizens to decide, entirely at their discretion, whether other citizens shall be sick or healthy.

argument is an observation about the relationship between the opportunity to purchase access to health care and the possibility of dependence on charity. If private money can be used to buy access to medical treatment, some citizens' ability to get treatments they genuinely need without lawbreaking (without, e.g., stealing money or medicine) will depend on other citizens' legally discretionary choices to give or to withhold charity. Health law and property law will thus interact in a way that gives some private citizens discretionary power over other citizens' health. This power, I argue, is objectionable. It is objectionable for the same reason it is objectionable for discretionary private charity to be some citizens' only source of food. To avoid establishing objectionable relationships of private power between and among citizens, government must prevent decisions to give or to withhold charity from determining whose biological needs are satisfied. It must thus prevent citizens' finances from affecting their access to necessary medical treatment.

Readers may find my argument uncomfortable. It may be personally troubling to anyone who currently has good private health insurance and whose access to high-quality medical care could be reduced by the institution of a single-tier health care system. Moreover, the argument implies that *to protect people's autonomy*, government should stop people from spending private money on health care. This claim may seem counterintuitive. Nevertheless, my argument cannot be dismissed as a *reductio ad absurdum* or as a pie-in-the-sky proposal. Unlike many of the proposals political philosophers have defended, single-tier health care is being pursued by actual, democratic governments. If my defense of single-tier health care is sound, it is an important contribution to debates on health care policy, since it relies less on contestable empirical claims

than the existing arguments for single-tier health care.[7] Absent conclusive evidence whether single-tier health care results in the best health care for the least well-off, it would be helpful to have an argument for single-tier care that does not rely on speculation about this empirical question.

Section II argues that if citizens' finances affect their access to necessary medical treatment, the property system will demand that citizens allow their lives and health to depend on other citizens' discretionary decisions to give or to withhold charity. Conversely, the property system will not demand this sort of dependence on discretionary charity if the health care system provides medically necessary treatment on a strictly egalitarian basis and if there is public support for people who cannot meet their other (less expensive) basic needs. Section III argues that it is objectionable for law to demand that citizens let their lives or central aspects of their health depend on others' private whims. Government should thus institute an egalitarian health care system to prevent private dependence. Section IV draws out the implications of the argument and attempts to show that they are less troubling than they may at first appear.

II. Dependence on discretionary charity and passive self-harm

In some economic systems, less well-off citizens are sometimes unable to get things they truly need except by receiving charity or by stealing. When citizens face this situation, the law of property demands that they be prepared to engage in a form of passive self-harm. Citizens are

[7] For instance, one defense of single-tier health care predicts that the rich and upper middle class will use their political influence to improve the health care system if they must get the same quality of care as the less well-off. This may be true, but there are also possible mechanisms by which unequal access to some treatments (e.g. patented medicines) could improve health care for the poor in the long run. For critical discussion of this argument and other existing arguments against tiered systems of health care, see Krohmal and Emanuel (2007).

legally required to refrain from taking what they need if charity from other citizens is not forthcoming. The law thereby demands that these citizens let their lives or their health depend on the decisions of other citizens, decisions that are discretionary in the following sense: the decision-makers face neither a legal requirement nor strong social pressure to justify their decisions to the people who are affected.[8] Private resource owners may have good reasons for giving or withholding charity, but they are legally and socially free to make decisions about giving on whim.[9]

To see how a society's resource-allocating laws can require citizens to subject their health to others' discretionary choices, consider first an example that does not involve health care. Suppose a society has wealth inequality and lacks public provision for those who cannot support themselves through work. Suppose that a citizen has no money and no food and that she either cannot find work or is unable to work. She can eat without stealing only if she receives charity from others—charity that others may legally give or withhold, at their discretion. If the legal system prohibits theft even in cases of necessity, it demands that impoverished citizens refrain from taking the food or the money that they need to live. Even if this food or this money is physically available to a person in need, and even if the person could take the food or the money without violence against persons, home invasion, or deception, the law demands that the person in need refrain from taking the food or the money. The law thereby orders impoverished citizens to engage in passive self-harm if charity is not forthcoming.

Set aside for the moment the question whether it is objectionable for an economic system to make people dependent on charity and for the law to demand that the needy risk their lives or

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[8] Not all decisions that involve judgment calls are discretionary in the sense used here.

[9] A decision may be discretionary in this sense even if some specific reasons for decision, e.g. ethnic discrimination, are legally prohibited.

their health if charity is not forthcoming. Is this sort of dependence inevitable in a society that has private property and wealth inequality? If the costs of providing for people's basic needs are relatively modest, there are two ways to avoid this form of dependence. First, government could provide public support for those who cannot support themselves through work or through their own resources. Second, government could grant citizens an extensive right of necessity, one that authorizes people who cannot meet their needs through work or through their own resources simply to take what they need.[10] This would prevent citizens in need from facing a choice between lawbreaking and seriously endangering their lives or their health if charity is not forthcoming. An extensive right of necessity would have the unhappy consequence of allowing the burden of supporting the needy to be distributed unpredictably and in a morally arbitrary way.[11] Public support for the poor does not have this disadvantage, as the burden of taxation is predictable and subject to public deliberation.

In the health care context, public support can prevent people from depending on charity for medical needs if the state can pay for all the medical treatment that people genuinely need. In the face of resource limitations, however, public support for the health care needs of the poor cannot stop people from being dependent on discretionary charity. In some economic and

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[10] A more modest right of necessity would allow non-consensual borrowing of property when needed to prevent loss of life or other serious losses, provided that the borrower compensate the owner after the fact. Consider Joel Feinberg's (1978, 102) example of a stranded hiker who is caught in an unexpected snowstorm and needs to break into an unoccupied cabin to survive the night. Whether the stranded hiker has a moral duty to compensate the owner of the cabin is disputed (Oberdiek 2008), but it is uncontroversial that the hiker is morally justified in breaking in—and that the justification for breaking in does not rest on the likelihood of being able to provide compensation later.

[11] Even if the right of necessity included an obligation to repay when possible, many people who exercised the right would never be able to repay.

technological environments, the government cannot provide all the medical treatment people genuinely need (Fleck 2009; Sreenivasan 2012; see also Krohmal and Emmanuel 2007).[12] Sometimes the problem is a shortage of medicine, devices, or trained medical personnel. These problems may or may not be remediable in the long run. The deeper potential problem is cost. If many serious, common illnesses can be effectively treated only by means of inherently expensive treatments (such as resource-intensive surgeries, dialysis, and exotic forms of radiation), it may be economically impossible for the government to ensure that everyone who has these illnesses gets effective treatment. The same problem can arise if many common illnesses can be treated somewhat effectively by treatments that can be affordably provided, but inherently more expensive treatments are much more effective. If a cancer patient would have a 40% chance of five-year survival after a $10,000 radiation treatment, and this patient would have an 80% chance of five-year survival after a $100,000 radiation treatment, the patient genuinely needs the more expensive treatment. It is not a luxury. The state cannot provide all the treatments citizens' health requires if doing so would cost a very large percentage of the nation's gross domestic product.

Suppose that because of resource limitations, a government cannot and does not provide all the treatments citizens' health genuinely requires. Instead, it only guarantees all citizens access to some package of health services it (misleadingly) labels "basic health care." It allows people to purchase access to necessary treatments that others cannot afford, either by paying out of pocket or by purchasing supplemental insurance. If wealthy individuals can choose to purchase access to expensive, medically necessary treatments, they can choose to provide these

[12] The boundary between necessary and non-necessary treatment is vague, but there are clear cases. This section discusses scenarios in which providing all *indisputably* necessary treatment is economic scenarios. Section IV will discuss scenarios in which government can guarantee access to all indisputably necessary treatment but cannot provide access to all the treatments that are arguably necessary.

treatments to *some* people who need them and are financially less well-off. They can do this by paying other people's medical bills directly, by paying for their supplementary private insurance, or simply by giving them money. Wealthy individuals may or may not be likely to engage in this sort of charity. The crucial point is that law empowers them to make this choice. They legally may choose to give or not, as they wish. If a less financially well-off person genuinely needs a treatment that is not covered by the universal insurance system, and if she cannot pay for the treatment with her own resources, she can obtain the treatment she needs in only two ways. She can seek and receive charity from others, or she can steal something: either the money she needs to pay for treatment or insurance, or the treatment itself (if she can administer it herself). If law prohibits people in need of expensive treatment from stealing to obtain treatment, law thereby demands that people in need abide by private resource owners' discretionary decisions whether to share their resources.

Set aside for the moment whether this form of dependence on charity is objectionable. Can it be avoided? Since the state cannot provide the treatments in question to everyone who needs them, public provision cannot address the problem. Perhaps the state could grant citizens a *very* extensive right of necessity, allowing them legally to take private resources to obtain medically necessary treatments that the universal health care system cannot provide to all. Such an extensive right of necessity would clearly have bad consequences. Another strategy that will not work is limiting gifts. If government could prohibit gifts intended to help recipients get medical care, it could thereby prevent individuals in need of expensive treatment from being dependent on legally discretionary favors from private citizens. Citizens with money would be prohibited from providing these favors. To prohibit people from using their resources to help others get medical care, however, it would not be enough to prohibit people from paying for

others' medical care or insurance. It would be necessary to prohibit unconditional monetary gifts, as well as exchanges whose purpose is to transfer a large sum of money from one person to another (e.g. paying thousands of dollars for someone's willfully bad artwork). Government cannot regulate gifts and exchanges in these ways without radically changing the nature of money. Money would cease to be an all-purpose medium of exchange.

There is only one way to prevent citizens in need of expensive medical treatments from being dependent on legally discretionary charity for continued health. That is for the state to prevent citizens' finances from affecting their access to medical treatment. To do this, government would have to prohibit people from using money to buy access to necessary medical treatments that others cannot afford. Government would decide which medical treatments would be provided to whoever needs them, which treatments would be provided only to some patients (e.g. those with the best prognoses), and which treatments would be taken off the market despite their effectiveness because they are a relatively inefficient use of limited resources. If some drugs or devices would be provided to only some patients based on publicly articulated criteria, privately distributing these drugs or devices to patients on other criteria would be prohibited. Government would finance universal access to medical treatment either by providing public insurance to all or by subsidizing private insurance plans that would compete on cost, convenience, and perhaps on the range of medically *unnecessary* services covered, but not on the range of medically *necessary* services covered. Government would prohibit citizens from obtaining necessary treatment outside of the publicly supported system.

If people's ability to get necessary medical treatment depends entirely on public policy choices, not on their ability to pay, their ability to get medical treatment they genuinely need will never depend on private charity. Moreover, in a reasonably well-functioning representative

democracy, no one's access to needed medical treatment will depend on discretionary choices. Recall that a decision is discretionary if the decision-maker faces neither a legal requirement nor strong social pressure to present reasons for deciding one way rather than another. Executive branch officials will be constrained by law in choosing which treatments to include in the plan, and they will face public pressure to explain their decisions. Legislators, likewise, will face public pressure to explain their reasons for the criteria they set out in law for inclusion of treatments in the public program. All of this may be true even if the decision-making processes in both branches of government are quite flawed. Officials in flawed democracies might make *bad* decisions about what to cover, and they might make those decisions to some degree undemocratically, but they typically cannot make these decisions based purely on whim. Thus, in a representative democracy with egalitarian provision of health care, citizens may not be able to get health care they need without lawbreaking, and they may be able to get health care they need by lawbreaking. But they would not face a choice between breaking the law and complying with people's *discretionary* choices whether to let them have the resources they need.

To sum up, if government allows citizens' finances to affect their ability to get medical treatment they need, some citizens' ability to get the treatment they need without lawbreaking will depend on whether other citizens offer them legally discretionary charity. When charity is not forthcoming, the law instructs needy citizens to engage in a form of passive self-harm. Needy citizens cannot legally take the resources they need. They legally must yield to private resource owners' discretionary decisions about those resources, even if these decisions are based on whim. Government can avoid making citizens dependent on discretionary charity by ensuring that private money cannot buy access to things people need to live or to have at least a minimally acceptable level of health. In some economic circumstances, government can do this by ensuring

that all citizens can meet their basic needs, including their needs for health care. If government cannot provide all the medical treatment that citizens genuinely need, preventing private dependence is still possible. Government can prevent citizens from being dependent on charity by ensuring that criteria other than ability to pay determine who will get access to expensive, medically necessary treatments.

III. Why private dependence is objectionable

Is it objectionable for some citizens' ability to get medical treatment without lawbreaking to depend on their ability to obtain private charity? Does government therefore have a duty to prevent citizens' finances from affecting their access to needed medical treatment? This section argues that the answer to both questions is yes. The moral duty to respect property rights is limited if the rules of the property system allow private property owners to make legally discretionary life-and-death or sickness-and-health decisions for others. Government should aim to make property law morally binding on everyone, including people in need. Government should thus ensure that citizens' ability to fulfill basic needs, including health care needs, does not depend on their ability to obtain charity.

Before defending this claim, I want to acknowledge and to set aside two other reasons one might have for thinking private dependence on charity objectionable. First, one might think that dependence on charity is objectionable because charity is not always forthcoming and public provision is more reliable. This is an empirical claim. My argument does not rely on it. Second, one might worry that if some citizens depend on charity for their medical care, donors will have opportunities to exploit the people they help. As Garthoff (2004) points out, opportunities for exploitation may arise when someone depends on charity and is only likely to get it from one person. For example, if a cancer patient needs expensive radiation treatment that is not covered

by public insurance, and if the only likely donor is a wealthy relative, this relative will have power over the patient. The risk of exploitation is reduced if patients can attempt to pay for medical treatment via crowdfunding (soliciting many small donations) or from a private charitable organization whose procedures for distributing aid are public and transparent. My objection to allowing citizens to depend on charity applies equally to all forms of charity, including large donations by private individuals, crowdfunding, and aid from well-run non-profit organizations. The argument rests on three premises, which I will explain in turn.

The nature of property

The first premise is a claim about property: the legal obligations that prohibit people from taking what they need to survive (or to maintain at least a minimal level of good health) are government-created obligations. This is so because the property rights that account for differences in wealth in modern societies are creations of government.[13] Some political philosophers, notably including Locke (1998 [1689], II.27), have held that there are property rights that are not creations of government. Perhaps this is true to a limited extent. Perhaps, for instance, people who gather wild food are morally entitled to keep the food they gather, no matter what the law says about it or whether there is any law at all. But many important property rights, such as ownership of money and financial instruments, are necessarily legal creations because their objects are created by law. Rights to scarce natural resources with long-term value, such as land and mineral deposits, are necessarily social or legal creations because there are no *a priori* moral principles that fully specify how rights to these things could be acquired. Being the first to apply labor to a resource and to use it productively may give one some moral claim to be

[13] Kant took the stronger view that there are *no* conclusive property rights in the state of nature. See *Doctrine of Right* 6:255-257, 264-266.

able to continue using it, but it does not give one an unconditional right to control the resource's future use, since such a right would not leave 'enough and as good' for others (Otsuka 2003; Steiner 1997; Vallentyne 2000).

If it is possible to use private money to pay for necessary medical treatment, and some citizens need medical treatment they cannot afford, property law will tell these citizens they may not simply take the money or other resources they need to obtain treatment. The property rights at stake are creations of government, not natural rights. Thus, the legal obligation not to steal, even to save one's life or one's health, is a government-created obligation, not a natural duty.

Inalienable permissions and the moral duty to obey the law

Because property rights are creations of government, a system of property is acceptable only if the restrictions it imposes are consistent with general standards for good law. My second moral premise concerns these standards: government should prevent foreseeable conflicts between the legal requirements it creates and people's inalienable permissions.

Government should aim to avoid imposing legal requirements with which people could not be morally required to comply. Imposing legal requirements knowing that people will be morally justified in violating them is objectionable for at least two reasons. First, imposing such requirements is likely to undermine public respect for law. Second, imposing such requirements would make the law problematically coercive.[14] It would attempt to influence people's behavior purely threatening them and without giving them a reason to comply other than fear of governmental coercion. No doubt government is often justified in using coercion as an added inducement to get people to do things they should do. When fear is people's only reason to

[14] Coercive social pressure to comply with law may be relevant here, in addition to coercion in the legal system itself (e.g. the threat of fines or imprisonment, direct compulsion to comply).

comply with law, attempting to influence people's behavior by threatening them shows contempt for these people as rational agents. Government thus should avoid imposing legal requirements that people foreseeably will be morally permitted to ignore or to flout.[15] It may sometimes serve useful purposes to enact laws that could never become morally binding. But good effects rarely, if ever, justify imposing legal requirements that foreseeably will not be morally binding.[16] Enacting such laws violates regulated people's right to a legal system that treats their rational agency with respect.[17]

From this it follows that government has a duty (arguably an overriding duty) not to enact laws that foreseeably require people to refrain from doing things they have an inalienable permission to do. An inalienable permission is a moral permission one cannot give up by making a promise. Most moral permissions can be alienated. For instance, I can give up my moral permission to spend Sunday afternoon reading by promising to help a friend with a project. At least two sorts of moral permissions are inalienable. First, people have inalienable permissions to fulfill natural duties—moral or rational duties that were not created by human choice. These duties cannot be altered by promises. For example, there is a natural duty to refrain from intentional violence against innocents. If someone says he promises to participate in a robbery, it

[15] Of course, there will always be circumstances that lawmakers cannot foresee. It may be inevitable that citizens will be justified in lawbreaking in some circumstances the legislature could not have foreseen.

[16] I presuppose a deontological view of political morality here. On a strictly deontological view of political morality (which I endorse), good effects *never* justify enacting laws that will foreseeably not be binding. Threshold deontology would allow that good effects sometimes justify enacting laws that foreseeably will not be morally binding, but the good effects must be very good indeed.

[17] The right is violated and not merely infringed. For the distinction between infringing a right and violating a right, see Thomson (1990, 122).

remains wrong for him to participate in the robbery. Moreover, this promise (or purported promise) gives him no moral reason to participate in the robbery (Shiffrin 2011).

Second, there is an inalienable permission to maintain one's independent agency. Most contemporary liberals accept some form of this principle, as do Locke, Spinoza, Rousseau, and Kant (Kuflik 1984). One cannot make a morally valid promise to let someone else direct all of one's actions. Slave contracts are morally void. If people join religious orders in which all aspects of life are regulated by the religious hierarchy, they retain a moral entitlement to quit. People who volunteer for the military may not be morally permitted to quit, but their commitment has a time limit, and they retain the moral right to make some decisions for themselves (e.g., about marriage and religious affiliation). A commitment to let someone else direct all one's actions is an extreme form of voluntary subjugation. Later, I shall argue that the inalienable permission to maintain one's independent agency also prohibits certain less extensive commitments to comply with others' discretionary choices.

Inalienable permissions constrain the content of morally binding law because constraints on the possible content of a valid mutual promise are constraints on the possible content of any moral obligation created by human choice. Of all the ways members of a group could acquire a moral obligation, the method whose validity is least controversial is a mutual promise, made unanimously, explicitly, and voluntarily. The standards that the content of a proposed obligation must meet to be morally binding are perhaps higher, and certainly not lower, if the proposal lacks the explicit consent of everyone it will regulate. If the content of a proposed obligation would make it impossible for people to take on the obligation voluntarily, the proposed obligation cannot become a morally binding law. If laws impose requirements that sometimes conflict with

inalienable permissions, the law will be morally binding only when the law does not conflict with these inalienable permissions. If the conflict is foreseeable, the law is objectionable.

Since property rights are largely creations of positive law, the content of morally binding property rights is constrained by inalienable permissions. People are not morally required to comply with property law when the demands of property law conflict with an inalienable permission. It is probably inevitable that property law (and more generally resource allocation law) will impose requirements that conflict with inalienable permissions in some unforeseen circumstances. That said, foreseeable conflicts between property law and inalienable permissions should be avoided. A property system in which illegal takings are often morally permissible is seriously flawed. The law's demand that people refrain from theft should be based on moral right and not merely on force.

My second premise, then, is that the state should prevent foreseeable conflicts between the legal requirements it imposes and people's inalienable permissions. Given the first premise, this premise constrains the permissible content of property rights.

The inalienable permission to preserve oneself

The requirement that law be consistent with inalienable permissions will place substantive restrictions on property law given a third premise: there is an inalienable permission not to let one's life or one's health depend on other people's discretionary choices. In other words, people cannot make morally valid promises to let their lives or their health depend on other people's discretionary choices.

I shall defend the claim about permissible self-preservation in two ways. The first defense relies on the inalienable permission to preserve one's independent agency. Most liberal political philosophers hold that one person cannot make a valid promise giving complete discretionary

control over his actions to another person. Whatever justifies this principle also justifies a prohibition on three lesser forms of voluntary subjugation. First, one person cannot make a valid promise subjecting his permission to engage in a major category of human action to another person's discretionary control. For example, person A cannot make a valid promise never to walk anywhere without person B's permission. Second, voluntary subjection to several people is no more valid than voluntary subjection to an individual. If A promises not to walk anywhere without a permission slip from a member of a group, this promise is invalid. Finally, to the extent that people cannot give others discretionary control over their agency, people also cannot give others discretionary control over the necessary means of effective agency. A cannot promise to let B decide, at her discretion, whether A may see a doctor if A gets a broken leg and must see a doctor to be able to walk. Nor can A make a promise not to go to the doctor without discretionary permission from a member of a group.

The inalienability of permissible self-preservation has another defense based on the duty of self-preservation.[18] If there are any self-regarding duties, these duties include a duty not to destroy oneself or to injure oneself on a whim. The duty of self-preservation applies equally to active and to passive self-harm. One should not stop eating or leave an injury untended on a whim. It is equally wrong to choose to die in response to *other people's* whims. Since one cannot make a valid promise to violate a moral requirement, one cannot make a valid promise to let other people's mere whims determine whether one shall eat or whether one shall get medical

[18] Though the existence of self-regarding duties is controversial, there have recently been compelling defenses of them. See Schofield (2015); Timmerman (2006). For a contemporary Kantian defense of a strong prohibition on self-harm, see Velleman (1999). The duty of self-preservation I describe here is compatible with a moral permission to commit suicide for good reason, e.g. to avoid being tortured for state secrets. It is also compatible with a moral permission for the terminally ill to decline aggressive treatment.

treatment necessary to live. Likewise, one cannot make a valid promise to let other people's discretionary choices determine whether one may pursue treatment for a disabling injury or illness.

The inalienable permission to preserve oneself has three limitations. First, the permission is limited to actions that have a significant chance of significantly extending life, curing or mitigating disabilities, or relieving serious forms of suffering. A permission to do something that would only slightly reduce a health risk is alienable. There is no moral duty to maximize one's health prospects; there is no such thing as maximizing one's health prospects, since there are unavoidable trade-offs between different components of health. A promise to allow others' discretionary choices to determine one's access to an intervention that slightly alters one's health risks would not give others undue control. Second, the inalienable permission to preserve oneself is consistent with making promises to allow one's health or survival to depend on a justified policy decision. For example, one could make a valid promise that if food becomes scarce, one will abide by rules allocating food to those who need least food to survive. Finally, the inalienable permission to preserve oneself is consistent with natural rights that make some people's survival depend on other's discretionary choices. The right to bodily integrity gives prospective live organ donors the right to decide whether to donate. Some people's survival thus depends on discretionary choices, but this dependence is unobjectionable, since it results from a natural right. The inalienable permission to preserve one's health only limits the creation of individually or socially chosen obligations, such as promises and law, including property law.

Dependence on charity and the moral duty to respect property

Together, the three moral premises I have defended entail that there will be at most a qualified duty to obey property law if the rules of the property system enable some citizens to make

discretionary life-and-death or sickness-and-health decisions for others. Government ought to design the legal system so that everyone whose behavior the law regulates morally ought to follow the law even when they can get away with lawbreaking. A legal system is defective if people often have no reason to follow the law other than fear of sanctions. Since the property rights that account for differences in wealth are creations of law, people will have no reason other than fear of sanctions to respect property rights when those rights conflict with citizens' inalienable permissions. The inalienable permission to preserve oneself limits the rules of property citizens can make a valid promise to obey. A promise never to take others' resources, even when one is in dire need and cannot get what one needs legally, is a conditional promise to engage in passive self-harm. It is a promise to let others' discretionary decisions about whether to give charity determine whether one lives or dies or whether one will be sick or healthy. Since citizens cannot make each other a morally valid promise to comply with a property system that makes some citizens dependent on private charity, the moral duty to respect property rights in such a system is limited. Citizens who cannot meet their basic needs without stealing are morally permitted to steal, if they can do so without violating natural duties (such as the natural duty to refrain from violence against persons.

This is not a radical claim. It does not assert that one morally may always steal to save oneself. It is wrong to steal for the sake of self-preservation if stealing would violate a *natural* duty. For instance, it would be wrong to save one's health by stealing if the person from whom one steals needs the stolen resource to live. It is arguably also wrong to steal through violence against persons or through deception, since there are natural duties to refrain from battery and deception. When, if ever, self-preservation justifies violating these duties is a difficult question I will not address. I claim only that there is nothing wrong with stealing as such when the purpose

of the theft is to preserve one's life or central aspects of one's health, stealing is the only way to do this, and the resource's owner does not have an equal or greater need for the resource. This claim is consistent with conventional ethical views. Many believe that a poor person unable to obtain sustenance without lawbreaking is morally permitted to steal bread nonviolently. Even Hobbes, the great defender of state authority, thought this.[19] It is even more widely held that the rules of property cannot justly give people the power of life and death over others. Even Locke, the great defender of natural property rights, thought this.[20] To be sure, the claim that people sometimes may steal to preserve their *health* goes beyond Hobbes' and Locke's claims about self-preservation. But it is difficult to see what rationale would support a permission to preserve one's life that would not extend to a permission to address serious compromises of one's health.

To avoid imposing legal requirements that citizens could not be morally required to follow, the state must ensure that citizens do not face a choice between stealing and complying with other citizens' legally discretionary decisions to share or to withhold private resources they need to survive or to be at least minimally healthy. As the previous section argued, the only way to establish a private property system that never forces citizens to face this choice is to ensure that citizens' finances do not affect their access to resources they need to sustain their lives or their health, including medical treatment. Whether citizens will be foreseeably morally justified in breaking property law thus depends on other parts of the legal system. To establish morally robust property rights, the legal system must include public support for those who cannot meet

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[19] In the Latin *Leviathan*, Hobbes wrote, "The right of nature permits those who are in extreme necessity to steal, or even to take by force, the goods of others." II.xxx.18. I do not endorse Hobbes' claim that the involuntarily poor have a right to use violence against persons to obtain what they need.

[20] "We know God hath not left one Man so to the Mercy of another, that he may starve him if he please…No Man could ever have a just Power over the Life of another, by Right of property in Land or Possessions." (Locke 1998 [1689], I.42).

their basic needs (including medical needs) through work and their own resources. When resources to meet medical needs are limited, the state must prevent private wealth from purchasing access to medical treatments that have a significant chance of extending life, addressing disabilities, or preventing serious forms of suffering. Those with medical needs they cannot pay for with their own resources have a moral duty to respect property rights despite their unmet needs only if the health system provides medically necessary treatment on an egalitarian basis.

The argument can be summarized thus:

A) If, and only if, government allows citizens' finances to affect their ability to get medical treatment they genuinely need, some citizens' ability to get the treatment they need without violating property law will foreseeably depend on whether other citizens offer them legally discretionary charity (conclusion of section II).[21]

B) Legal obligations that prohibit people from taking what they need to survive, or to maintain at least a minimal level of good health, are government-created obligations (first moral premise).

C) Government should prevent foreseeable conflicts between the legal requirements it creates and people's inalienable permissions (second moral premise).

D) There is an inalienable permission not to let one's life or one's health depend on other people's discretionary choices (third moral premise).

E) If, and only if, government allows citizens' finances to affect their ability to get medical treatment they genuinely need, some citizens' ability to get treatment they need without

[21] This summary of section II presupposes that the government rejects the (clearly inferior) option of giving citizens an extensive right of necessity.

violating government-created legal obligations will foreseeably depend on whether others offer them legally discretionary charity (from A and B).

F) If, and only if, government allows citizens' finances to affect their ability to get medical treatment they genuinely need, there will be a foreseeable conflict between government-created legal requirements and some citizens' inalienable permissions (from D and E).

G) Therefore, government should not allow citizens' finances to affect their ability to get medical treatment they genuinely need (from C and F).

IV. Implications

This section draws out some of the implications of the argument for egalitarian access to medical treatments people genuinely need. I shall try to show that the implications are more palatable than they may at first appear. That said, I remind readers that mere discomfort with the implications of an argument does not constitute an objection to it. A fully developed objection to an argument would explain either why the argument is invalid or why one of its premises is in doubt.

The wealthy have no complaint.

One might worry that egalitarian provision of necessary medical treatment would interfere objectionably with the liberty of wealthy people. There are two distinct worries here. First, one might think it odd to single out inequality in access to medical treatment as a target for government intervention. My argument does not imply that there is anything objectionable about private wealth as such, nor does it imply that there is typically anything wrong with wealthy people being allowed to spend their money as they please. Why would there be an objection to wealthy people being able to spend money on medical treatment but not on yachts or on

expensive forms of extended higher education? One might think that if wealthy people have an autonomy interest in the latter sorts of spending, they also have an autonomy interest in the former.

The objection is misplaced. The wealthy have control over greater economic resources than others have only because of the rules set out in the legally established property system. The wealthy are morally entitled to insist that the needy respect their property rights only if these rights do not empower the wealthy to make discretionary life-and-death or health-and-sickness decisions for others. Inequality in access to true necessities, such as necessary medical care, gives rise to forms of private dependence to which people cannot give morally valid consent. One cannot make a valid promise to obey rules of property that enable others to make purely discretionary decisions about whether one may get the medical care one needs. By contrast, one can make a valid promise to obey rules of property that enable others' discretionary decisions to determine whether one gets to have a yacht. One can also make a valid promise to obey rules of property that enable private discretionary choices to determine whether one gets access to forms of extended higher education that are desirable but not necessary to function as a member of society.[22] Thus, moral duty to respect private property rights is compromised unless the state restricts the use of private wealth to pay for medical treatment. The state need not restrict the use of private wealth to pay for yachts or for higher education.[23]

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[22] Though there may be a general moral duty to develop one's talents, one does not typically violate a self-regarding duty by forgoing a *particular* opportunity for extended higher education. By contrast, one typically does violate a self-regarding duty by forgoing a *particular* medical treatment that one's life or health clearly requires.

[23] There may be unrelated reasons of distributive justice to secure fair equality of opportunity and thus to prevent wealth from determining access to forms of higher education that are relevant to people's

A second worry is that restricting the range of treatments available on the private market would violate wealthy people's inalienable permission to preserve themselves. An egalitarian health care system operating under resource constraints would deny some wealthy people access to medical treatments that they could have purchased in the absence of regulation. The wealthy might protest that they cannot make a valid promise to comply with legal restrictions on access to care; the duty of self-preservation would require them to buy expensive treatments they need on the black market. But these duties do not prohibit one from complying with publicly justified policy decisions about what treatments should be made available, given resource limitations. They only prohibit one from complying with laws that make one's access to care subject to others' unconstrained discretion. Again, a choice is discretionary (in the relevant sense) if there is neither a legal requirement nor strong social pressure for the decision-maker to explain the reasons for deciding one way rather than another. A private individual's decision whether to donate money for someone else's medical treatment is discretionary in this sense. A public agency's decision what medical treatments to cover is not discretionary in this sense, since even in flawed democracies, agencies and legislatures face public pressure to explain their decisions. So restricting the private market for medical treatment based on publicly-defended criteria would be compatible with wealthy people's duty of self-preservation.

The vagueness of the necessity standard

Earlier, I characterized genuinely necessary medical treatments as those that have a significant chance of significantly prolonging life, curing or mitigating significant disabilities, or relieving serious forms of suffering. This characterization of medical necessity is vague. A treatment that

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career prospects. My argument for health care equality will not provide the grounds for such a policy, however.

is near-certain to extend life by five years is medically necessary. A treatment that is near-certain to extend life by five minutes is not, nor is a treatment that has a miniscule chance of succeeding. There is no sharp boundary between necessary and unnecessary treatments. The earlier argument avoided addressing this vagueness by stipulating that it concerned economic situations in which the government could not guarantee access to all *indisputably* necessary treatments. One might think that the economic situation of rich countries makes it possible to provide all indisputably necessary treatments to all citizens who need them. If this is so, the debate between tiered health care and egalitarian health care in these countries is a debate about the provision of treatments whose necessity is disputable, given their modest (but real) benefits. Thus far it is unclear what my argument implies for these scenarios.

It is important to distinguish the question what treatments are medically necessary from the question what treatments the government should include in a universal health care plan. Determining that a treatment is medically necessary does not entail that the treatment should be provided to those who need it. It entails that the treatment should be provided on the basis of non-financial criteria: perhaps everyone who needs the treatment will get it, perhaps no one will get it, or perhaps it will be provided to those with the best prognosis or those with the greatest need. It will not be sold on the private market unless the government subsidizes purchases of it by the less well-off. Though there is no sharp boundary between necessary and unnecessary medical treatments, there is a sharp boundary between the treatments that are provided on an egalitarian basis and those that are not. Governments must thus adopt criteria for medical necessity that are sharper than the vague standards of necessity that ethics and science can provide.

To be legitimate, a government's adoption of criteria for medical necessity must be publicly defended and subject to public pressure and debate. Earlier, I argued that people can make valid promises to accept public decisions about what treatments are to be provided. Such public decisions are not discretionary, even though they involve judgment calls, since there is public pressure and sometimes also a legal requirement to present reasons for deciding one way rather than another. If one can promise to accept a publicly justified decision about which medically necessary treatments one can receive, one can also promise to accept a publicly justified decision about the criteria for medical necessity. Inevitably, the public explanation of these criteria will be less precise than the criteria themselves. The government can explain why it deems N weeks of life extension significant, for instance, but it cannot be expected to say why it deems an N week life extension significant but not an N-1 week extension. The arbitrariness of some details of the public criteria for medical necessity does not render the government's choice of criteria discretionary. A choice is discretionary, in the relevant sense, only if there is no socially recognized obligation to explain it.

The government's procedure for selecting criteria for medical necessity must make those criteria stable over time. This does not mean that the criteria can never be revised. It does mean that revisions should be based on new science or rethinking of value judgments, not on fluctuations in the availability of economic resources. Changing economic constraints could make it impossible for a public health insurance program to continue to provide a treatment it had covered in the past.[24] It would be at best politically problematic and at worst incoherent for a government to assert that a treatment it used to classify as medically necessary has become

[24] This might happen as a result of an economic depression, a decrease in the percentage of the population that is working, or Baumol's cost disease (the tendency for labor-intensive services to become more expensive as productivity in other sectors increases).

medically unnecessary as a result of increased cost or reduced resources. In a society that can provide all indisputably necessary treatments universally, there may be political pressure to interpret the vague boundary of the category "medically necessary" in a way that enables the government to tell voters that the universal health plan covers everything necessary. It is more honest, however, to acknowledge that government may not always be able to cover everything medically necessary. Thus, resource constraints should not be considered in deciding what treatments are medically necessary, though they must be considered in deciding what treatments will be provided.

One other way of determining medical necessity suggests itself—not as a strict requirement, but as a rule of thumb. If many well-informed people care a great deal about having access to a certain medical treatment, that fact is (defeasible) evidence that the treatment is medically necessary. Thus, if many well-informed people advocate for the inclusion of a treatment in the list of publicly funded treatments, there is (defeasible) reason to classify it as medically necessary. Whether it should be provided is a further question that inevitably depends on resource constraints. If many well-informed, wealthy people vigorously advocate for the *exclusion* of a treatment from the list of medically necessary treatments, their motive may be to ensure its availability on the private market. There are other possible motives, e.g., a belief that the treatment is ineffective. But if informed, wealthy people care a great deal about the availability of a treatment on the private market, their concern is (defeasible) evidence that the treatment is medically necessary.

How much equality is required?

One might worry that my argument entails that a society with advanced and costly medical technology must make health care its overriding priority. Citizens cannot make valid promises

not to use resources needed for their health unless others need those resources more. Therefore, if not all health care needs can be met, government must raise taxes until all resources are devoted to health care and other basic needs.

Contrary to this line of reasoning, my argument does not require health care needs to be prioritized at the cost of every other good. On any plausible account of the duty of self-preservation, one need not value health above all else. Thus, one could legitimately choose not to use a resource to preserve one's health because one judges that others could better use the resource for another purpose not related to health. Citizens could thus promise to obey a property system that does not devote all available economic resources to meeting people's biological needs. What citizens cannot do is promise to let their access to resources they need depend on others' entirely discretionary choices. The decisions that deny some people access to medical treatments they need must be made on principled grounds and publicly defended. They must not be left to the unconstrained discretion of private property owners.

A related worry is that my argument could imply, implausibly, that there is a moral duty to respect property rights only if there is a perfectly equal distribution of economic resources. Access to health care is not the only social determinant of health. The environment in which people live influences their health in many ways. Does my argument imply that government must ensure that citizens' finances must not affect their access to healthy neighborhoods? There is some evidence that income itself is among the social determinants of health (Sreenivasan 2014). If this is the case, must government arrange for all citizens' income to be equal?

My argument calls for equality of social determinants of health other than medical treatment only when two questions both have an affirmative answer. First, is there a resource that citizens could acquire by gift or by taking that would improve their ability to achieve good health

outcomes? If one town has better health outcomes than others because it has prettier parks, which encourage exercise, enabling people to move to this town does not enable them to achieve better health outcomes. They can get adequate exercise where they are, even if they are not motivated to do so. Second, would the transfer of a resource provide a potential health benefit great enough that people who had this resource and failed to use it would thereby irrationally neglect their health? People are not rationally required to do everything that would reduce a health risk. For example, minimizing car travel reduces one's risk of death or injury in a car accident, but traveling by car does not constitute irrational neglect of one's health, even if safer alternatives are available. One can make a valid promise to drive a friend or a taxi customer somewhere, even though by driving one takes a health risk. Government is not required to enable citizens to move from a city in which driving is the primary means of transportation to a city in which safer transportation is available. More generally, government may be required to prevent citizens from being exposed to major health risks because of poverty, but government is not required to make all the social determinants of health perfectly equal.

Medical tourism

To prevent private wealth from affecting citizens' access to medical treatment, it is not enough to regulate the provision of health care and health insurance domestically. If wealthy citizens can go abroad to obtain necessary treatment that is not available domestically, wealthy citizens can also choose, at their discretion, to give or to withhold charitable donations that would enable some fellow citizens to travel abroad for medical care. Private citizens would thus have the same kind of power over each other that they would have if citizens' finances affected their access to medical treatment domestically. It appears restrictions on medical tourism are necessary to prevent the property system from giving rise to objectionable relationships of private

dependence. One might worry that these restrictions would have to involve violations of citizens' right to freedom of movement or draconian invasions of financial and medical privacy. But these sorts of draconian regulations would not be necessary. An egalitarian health care system could be achieved without any restriction on citizens' travel. Rather, government must regulate its citizens' activities abroad.

Citizens must be prohibited from obtaining medically necessary elective treatment while abroad unless they have reasons other than medical care to be abroad for an extended time. Enforcing this restriction fully would require invasions of privacy, but the restriction need not be enforced fully to achieve its purpose.[25] Indeed, it need not be enforced at all, provided that the restrictions are widely regarded as valid and morally binding (even if they are sometimes broken, as most laws are).[26] The purpose of the restriction would not be to change citizens' behavior. The purpose of the restriction would to ensure that citizens' ability to get treatment *legally* does not depend on their financial status. If medical tourism is prohibited, wealthy citizens' ability to give or to withhold financial gifts would not affect less well-off citizens' ability to obtain health care legally. A less well-off citizen who obtained treatment abroad either with money from a gift or with stolen money would be breaking the law in either case. That would be true even if the government did not actively investigate violations of the medical tourism regulations for fear of intruding unduly on privacy or of discouraging its citizens from traveling for reasons other than medical tourism.

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[25] For discussion of the enforcement of legal restrictions on medical tourism, see Cohen (2014).

[26] A legal requirement does not need an enforcement mechanism to count as a genuine legal requirement. As Hart writes, "In the case of rules of the criminal law, it is logically possible and might be desirable that there should be such rules even though no punishment or other evil were threatened" (1994, 34).

Leveling down and welfare considerations

My argument for egalitarianism in the provision of medically necessary treatment calls for strict equality in access to life-saving and health-preserving medical treatment even if this policy would involve leveling down. Prohibiting the rich from purchasing access to treatments that others cannot afford *might* indirectly result in an improvement of the quality of care for the poor. The policy will give the rich an incentive to use their political influence to increase the range of services available to all. But the argument does not assume that strictly egalitarian provision of necessary treatment will have this effect. It implies that necessary medical treatment must be available on a strictly egalitarian basis even if this policy makes the rich worse off without improving health care for the poor.

The argument is not subject to the so-called 'leveling down objection', however. The leveling down objection is a powerful objection to forms of egalitarianism, including health care egalitarianism, that value equality for its own sake (Parfit 1997). It charges that the value of equality could not justify reducing some people's welfare, or their access to important resources, without doing anything to make other people better off.[27] But my argument does not claim that equality is good for its own sake. Rather, it claims that inequality in access to health care has an unacceptable legal and relational consequence. It makes people who are sick and financially less well-off dependent on the discretionary choices of private resource owners in a way that compromises their moral obligation to respect the property system.

There is, however, a potentially serious objection that resembles the leveling down objection. Compared with the quality of care available under some inegalitarian health care

[27] For arguments that the value of equality sometimes provides a reason for leveling down, see Eyal (2013); Wolff (2001).

systems, equality in access to necessary health care might reduce the quality of available health care for *everyone*, the poor included.[28] Suppose that the care publicly *guaranteed* to the poor under an inegalitarian health care system would be no better under an egalitarian system. Under the inegalitarian system, people who need expensive treatments not covered by insurance could attempt to obtain treatment via charitable appeal. The egalitarian system would deny them this opportunity. So the inegalitarian system would give the poor better health care prospects. There could also be economic mechanisms that lead an inegalitarian system to provide better care for the poor in the long run. Suppose, for instance, that the opportunity to develop patented drugs and to sell them to the affluent at high prices gave pharmaceutical companies an incentive to pursue research that they would not pursue under a more egalitarian system. Since new drugs would become available to the less well-off after their patents expire, unequal access to care could improve the quality of care available to the poor over time.[29]

My argument implies that if citizens' finances affect their access to necessary medical treatment, the moral duty to respect property rights is qualified in a problematic way. If an expensive treatment is available on the market, citizens who need it and cannot pay for it (even after seeking charity) must choose whether to go without needed treatment or to steal the money

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[28] This empirical claim is speculative, but it is more plausible than the claim that *any* public health insurance program would reduce the quality of health care by reducing the rate of innovation. For a skeptical assessment of the latter claim, see Rajczi (2007).

[29] One might raise the further worry that an egalitarian health care policy would be incompatible with any form of medical research that does not make experimental drugs available to all interested potential subjects. This worry is misplaced. On a widely held view of research ethics, experimental trials can be ethically done only when the medical community is uncertain whether a new drug or other intervention is superior to an existing alternative, be it an established intervention or no treatment (Friedman 1987). Under these circumstances, it is unreasonable for patients to believe that their inclusion in a clinical trial is medically necessary.

they need to pay for it. Since the permission to use physically available resources to sustain one's health is inalienable, people cannot make a morally valid promise to refrain from stealing in such cases. But why would the moral permission to preserve one's life and health using physically available resources be inalienable if alienating this permission would improve one's health prospects? A promise to obey property law in an inegalitarian health care system is a conditional promise that, in some circumstances, one will refrain from taking the resources one needs to sustain one's health. Suppose that if everyone made each other such a promise, we would all increase our prospects of health in the long run. Why would such a promise be morally invalid?

The answer is that there are some promises one cannot make even if they are to one's advantage. For example, suppose that A wishes to have an extremely reliable helper on a future project—a project that does not merit risks to life or limb. A asks B to promise to show up and help with the project *no matter what.* Even if B is sick or injured and in urgent need of medical attention, B is to show up and help with the project rather than going to the doctor. (The work is not strenuous, so a sick person's help could still be useful.) In exchange, A will provide B high-quality exercise instruction. This deal might be *ex ante* beneficial to B's health. The reduction in health risks resulting from improvements in B's exercise program might outweigh the increased health risks resulting from a period with no access to medical care. Nonetheless, B cannot make a fully valid commitment to this arrangement. People are not morally required to maximize their health prospects. It is not wrong to go for a drive, for instance, and it is not wrong to promise someone a ride, even though driving involves risks. People are always morally permitted, and arguably required, to address grave threats to their health (unless doing so imposes equally grave threats on others). So A should not make B this offer, B should not agree, and if B does express agreement, the 'no matter what' clause of the agreement will be invalid if B gets sick or injured.

Likewise, people are not rationally or morally required to accept inegalitarian health care systems, along with the associated property rules, if doing so modestly improves their health prospects. The inalienable permission to address major illnesses and injuries with physically available resources compromises the moral obligation to comply with the rules of the property system if access to needed medical treatment is unequal.

Thus, my argument shows that a robust moral obligation to respect property law requires egalitarian provision of necessary health care, even if a tiered system for the provision of necessary health care would be better for people's welfare. If the state's first duty is to make law with which people could be morally required to comply, the state must institute an egalitarian health care system regardless of the welfare consequences. That said, the state need not pursue health care equality before it has addressed other threats to the moral obligation to obey the law. Some societies can provide for all citizens' basic non-medical needs but have not done so. In such societies, the lack of any public support for the involuntarily poor is a more urgent threat to the obligation to obey the law than is unequal access to medical treatment. Government should address this more urgent threat before making the health care system egalitarian.

Some readers may doubt that welfare considerations must always or almost always give way to the state's duty to legislate compatibly with a moral duty to obey the law. Though I believe this claim, my argument has some bite even if this priority claim is weakened. Consider the weaker claim that citizens' independence from others' discretionary choices has value, and that the state has *pro tanto* reason to try to secure citizens' independence. Suppose that instituting an egalitarian health policy would decrease the health prospects of the wealthy and the upper-middle class only modestly. Suppose further that we do not know how an egalitarian health care policy would affect the health prospects of the poor and the lower-middle class. There are

mechanisms by which an egalitarian policy could harm these classes' health prospects, there are mechanisms by which an egalitarian policy could help these classes' health prospects, and we do not have enough evidence to determine which mechanisms are stronger. Then the state should institute an egalitarian health care policy for the sake of citizens' independence. If this scenario obtains now in Canada and other high-income countries, then Canadian provinces that limit the ability of the wealthy to 'top up' with supplementary insurance should maintain these policies. High-income countries that have universal health care with supplemental private insurance should move toward single-tier systems. In better-off nations that are still trying to achieve universal health care, such as the United States, it is important not to make institutional commitments that would preclude a move to a single-tier system in the future.[30]

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