A Fundamental Constitutional Right of the Monied to “Buy Out Of” Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?

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A consensus has emerged among federal and state politicians, business and labor leaders, and the public that we should move toward universal health care coverage.² There is also a consensus that realizing this goal will require significant

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² In addition to the California plans referred to in the text infra at notes 61-70, Massachusetts is in the process of implementing a program that includes requirements that employers provide health care to their workers and that persons who do not have insurance through employment purchase it or suffer significant penalties. John Hechinger & David Armstrong, Massachusetts Seeks to Mandate Health Coverage; Bill Would Penalize Citizens Who Don’t Buy Insurance; Business Fears Higher Costs, WALL STREET JOURNAL, Apr. 5, 2006, at A1. As to some of the other states’ efforts, see Elaine Monaghan, Tennessee Passes Health Insurance Reform Package, AMERICAN MEDICAL NEWS, June 12, 2006, at 11; Doug Trapp, Oregon to Consider Universal Coverage Proposals Next Year, AMERICAN MEDICAL NEWS, December 4, 2006, at 9; Gov. Spitzer Says New York Should Move Toward System of Universal Health Coverage, BNA’S HEALTH CARE DAILY REPORT, Vol. 12, No. 18, Jan. 29, 2007; Washington ‘Blue Ribbon’ Panel Issues Plan for Building High-Quality Health System, BNA’S HEALTH CARE DAILY REPORT, Vol. 12, No. 10, Jan. 17, 2007; Pennsylvania Governor Outlines Plan to Expand Coverage to Uninsured Residents, BNA’S HEALTH CARE DAILY REPORT, Vol. 12, No. 13,
efforts to control the costs of the care that is delivered. At least the major Democratic candidates for president are not likely to dissent from this consensus. Senator Barack Obama, for example, has already announced that his goal is to achieve universal health care coverage, at reasonable cost, within six years. And, of course, Senator Hillary Clinton headed a task force that designed a reputedly cost-conscious universal health care plan that President Bill Clinton attempted to implement during his administration. President Bush's State of the Union address in January of 2007 proposed significant health care reforms designed to move toward efficient universal health care coverage, but at the same time he has called for tens of billions of dollars of cuts in spending on current government-funded health care programs. Some states have already passed or begun to implement reforms aimed toward universal health care, and most states are


3 The authorities in footnote 1 refer to the various plans' concern with efficiency, i.e., costs of care.


5 See infra text accompanying notes 63-65.

6 Steve Teske, Bush Proposes Grants to States, Tax Law Changes to Help Cover Uninsured, BNA'S HEALTH CARE POLICY REPORT, Vol 15, No. 4, Jan. 29, 2007; Acting CMS Administrator Defends Funding in Bush Budget; Lawmakers Voice Concerns, BNA'S MEDICARE REPORT, Vol. 18, No. 7, Feb. 16, 2007 ("trim Medicare and Medicaid funding by about $101 billion over five years").
considering significant health care reform.  

This is an historic moment when concerned citizens should be ready to pose important questions to their current and future political leaders. Some of these questions: (1) Political feasibility—How will you obtain the political backing needed to pass the plan you propose or support? Why will the plan find support when other programs such as the Clinton plan failed miserably? (2) Financial feasibility—How much will the plan cost? How will the plan control costs? How and by whom will the plan be paid for? Will the costs of the plan be such that they could hurt our economy? (3) Equity—Why is the plan fair? How much disparity does the plan allow between care that will be provided to the poorest persons and persons such as yourself? (4) Legal Feasibility—Are there any constitutional barriers to a politically, financially, and morally sound plan?

This article focuses on questions regarding financial and legal feasibility. Financial questions are central because we already spend a significantly greater percentage of our gross domestic product on health care than does any other nation. We have experienced, moreover, decades of unrelenting inflation in the health care sector exceeding that for other goods and services, while demographics and the prospects of expensive new technologies portend a continuation of this inflation. How, then, are we going to be able to afford extending coverage to the approximately 47 million uninsured?

It seems obvious that we will have to impose reasonable limits on the health care that is delivered to each recipient, restrictions more robust than those that exist in most current private and public health care plans.

Imposing limits might not be as severe as it first sounds because arguably we

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7 See supra note 1.
currently embrace beliefs, attitudes, and practices that lead to significant waste, if not extravagance. What is unquestionably daunting, however, is convincing a politically viable majority of voters to change their attitudes and beliefs so that they will accept the reasonable limits that are necessary to implement and maintain a universal health care program. We are at the potentially transformative moment of sensing the moral imperative that all persons should receive decent health care. This moral and emotional commitment must now be matched by the intellectual discipline necessary to realize and accept the changes that need to be made to do what we sense is right.

This article advocates a universal health care plan described only in its broadest structure. The purpose of the article is not to develop a full plan architecture, but to analyze root issues and concerns that will emerge in the consideration of any universal health care plan. The most basic of these concepts are that there must be restrictions both on the package of benefits made universally available and on the freedom of individuals to seek care outside the universal health care plan.

Restrictions on health care inevitably raise constitutional concerns. Restrictions on benefits that are made available through a government mandated universal package of benefits are not constitutionally problematic because it is well established that there is no affirmative constitutional right to receive health care from the government; any such right must be based on some governmental undertaking. Limits on what individuals can purchase outside a government mandated plan, however, readily suggest constitutional attacks involving the assertion of fundamental rights of access to health care. Nevertheless, this article contends that a viable universal health care program should and constitutionally can (1) at the least, limit its universal package of goods and services to efficacious, “cost effective” (there is no equally effective but less costly alternative), “cost beneficial” (marginal benefits exceed marginal costs) care, (2)

11 NATIONAL HEALTH CARE REFORM: THE POSITION OF THE NATIONAL BUSINESS GROUP ON

12 Kenneth R. Wing, The Right to Health Care in the United States, 2 ANNALS HEALTH L. 161, 162-78

13 See infra text accompanying note 56 regarding a basic definition of “cost beneficial care” The
disallow supplemental or “private” insurance for out-of-plan delivery of care covered by the plan’s universal package of benefits (as long as the plan delivers timely care),14 and (3) allow purchase of insurance covering items of care not within the plan’s universal menu of benefits, with the exception of limiting supplemental insurance to coverage of efficacious and cost-effective.15

As to (1), for example, if care “X” portends some slight improvement in quality use of this concept requires a mechanism to agree on what metric(s) will be used to judge benefits.

14 Private is in quotes because the universal plan might actually call for delivery of health care goods and services by private providers. Persons nevertheless often refer to care that is privately delivered pursuant to a government mandated or financed plan as “public” care, and care care offered outside the mandated universal package of benefits “private” care. A more precise terminology would be to label care within a universal benefits package basic care and care outside the package supplemental care. Consistent with common practice, however, I will use “private” and “supplemental” interchangeably. My plan does not call for a ban on direct purchase of supplemental care because I am not aware of any nation that attempts to bar direct purchase of supplemental care. Moreover, such a prohibition could require expensive and Draconian enforcement measures. It also appears unnecessary because most people need insurance to access care, and the relatively small number of persons who can directly purchase care do not pose a substantial threat of drawing resources from the goal of ensuring universal access to a basic package of benefits.

15 “Cost-effective” is not synonymous with “cost (risk)-benefit ratio.” It refers to “a project that is effective in terms of its cost ....” OXFORD ENGLISH DICT., at http://dictionary.oed.com/cgi/entry/00051199/00051199se29. Roughly, it's getting the most for your money. The OED also states that cost-benefit analysis concerns “assess[ing] the relationship of the actual cost of a project, etc., and the value of social and other benefits resulting from its completion ....” See generally Kelman, Cost-Benefit Analysis: An Ethical Critique, in FOUNDATIONS OF ENVIRONMENTAL LAW AND POLICY 93 (Revesz ed. 1997); and Lave, The Strategy of Social Regulation: Decision Frameworks for Policy, in id. at 84, 89 (“get[ting] the most bang for the buck”—quoting Charles Wilson, Pres. Eisenhower’s defense secretary). Cost-benefit analysis generally involves using the same explicit measuring system (usually money) for both costs and benefits, while cost-effectiveness analysis generally compares costs measured one way (e.g., money) against certain goals generally quantified differently—e.g., number of lives saved, QALYs obtained, and kinds and degrees of disabilities prevented. See INSTITUTE OF MEDICINE, THE ARTIFICIAL HEART: PROTOTYPES, POLICIES, AND PATIENTS 286 (1991) (glossary). Efficaciousness and cost-effectiveness can be judged concerning groups of patients or as to individual patients. The individual patient perspective will become more important as technologies are developed that are targeted toward one’s particular genetic makeup. Concerning the latter, see Eric Topol, All Medical Treatment All Your Own, LOS ANGELES TIMES, March 28, 2007, available at http://www.latimes.com/news/printedition/opinion/la-oe-topol28mar28,1,2495308.story?coll=la-news-comment. Of course, the universal health care plan I argue for would have to include an administrative mechanism to make determinations concerning interventions’ efficacy, cost-effectiveness, and cost-beneficial nature.
or quantity of life (say, an extra day of life or a week of slightly less pain) at a cost of hundreds of thousands of dollars, it should not be covered. X’s marginal benefits do not exceed its marginal costs on any plausible scheme for metricizing benefits and costs. For the purposes of this article, such care will be called “non-cost beneficial care.” Concerning (2), for example, if the plan covers aorto-coronary bypass operations, one should not be able to purchase insurance covering provision of such operations outside the plan if the procedure is timely available within the plan. Regarding (3), for example, if the plan does not cover cosmetic surgery or routine dental services, one should be able to purchase insurance for these services to the extent that private insurers are willing to provide them and insofar as they are efficacious and cost-effective.

The need for the relatively restrictive plan structure advocated here will become evident below when I explore the reasons for the continuing escalation of health care costs. At this point I will explain, however, the simple ideas that make the plan both feasible and fair. The plan’s universal menu of benefits is limited to cost beneficial care because there are perverse incentives to consume health care resources beyond the point at which their benefits justify their costs. Moreover, it is not fair to expect certain persons to subsidize other persons’ consumption of non-cost beneficial care. The plan does not allow insurance for out-of-plan provision of items within the plan’s benefits package because everybody should have access to minimum, decent care, and widespread out-of-plan provision of care made possible by insurance could draw substantial resources away from, and thereby undercut, the plan’s basic benefits package. This restriction loses its moral force, however, if the plan does not deliver timely care. Moreover, while the plan does not ask the relatively wealthy to subsidize anything other than cost beneficial care, it does require that they accept relatively light limitations as a show of good faith and solidarity. The plan allows purchase of insurance covering items not within the plan’s universal package of benefits because persons have a moral and fundamental constitutional right to purchase non-basic care such as routine dental care and cosmetic surgery. However, the plan only allows purchase of insurance covering care that is both efficacious and cost-effective. This restriction is imposed because although persons have a moral and constitutional right to purchase insurance for care the government does not generally provide, this right should and constitutionally can be limited to care that is efficacious and cost-effective.

This article will not offer any refinements or details concerning the universal

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16 See infra notes 33-38.
17 See infra text accompanying note 122-124.
18 Id.
health care plan advocated above. Beyond the limitations already discussed, moreover, the article does not take a position regarding the particular form universal health care should assume. Possibilities include a single-payer, private delivery plan such as in Canada; a single-payer, government delivery plan such as in Great Britain; and combinations of government, employer, and/or individual payer with private delivery. Whatever form it takes, however, a universal health care plan must have a basic, limited benefits package.

All countries that have implemented universal health care programs have encountered the problem of limiting the effects of out-of-plan provision of care, whether that care is within or outside the basic benefits package, and they have taken different approaches to ameliorating these effects. The most direct approach—one taken in the Clinton Health Care plan, in a universal health care plan passed by the California legislature in 2006, and in certain provinces in Canada—is to prohibit supplemental insurance that covers items within the plan's universal benefits package. Other approaches designed to achieve similar results followed in other countries and certain provinces in Canada, include forcing providers to work in either the government plan or the alternative but not both, forcing providers to bill the same amounts for care within or without the government mandated plan, not allowing the public plan to pay for care provided outside of it, or limiting either the number of providers who can practice or the amount of care each provider can offer outside the government mandated plan. Even now the United States must deal with the effects of private health care markets on our government-funded programs, Medicare and Medicaid. Although the benefits packages in those programs are more limited than those in most private insurance policies, there is pressure for Medicare and Medicaid eventually to adopt goods, services, and amenities available in the private sector.

20 See infra text accompanying notes 64, 71 and 75-77 respectively.
21 Flood, supra note 19, at 282-93. It is beyond the scope of this article to consider possible restrictions on persons seeking care in another jurisdiction or country.
22 For example, the Medicaid statutes allow states to determine whether to cover transplants and United States Courts of Appeals are split on whether Medicaid plans are required to offer all "medically necessary" care among the categories of goods and services required for a state to participate in the program. DeSario v. Thomas, 139 F.3d 80, 96 (2d Cir. 1998). Although the public programs are more limited, there is pressure for them to expand to cover care initially available only within the private sector. SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 154-55 (1997).
Suggestions for limitations on care to protect or assure the financial viability of government mandated health care plans inevitably meet with moral and legal objections. Without such limitations, however, a universal health care plan will either never be adopted or eventually founder. The purpose of this article is to defend the set of limitations suggested above, focusing on constitutional analysis. Although I will not undertake any extended economic analysis, the constitutional analysis here is informed by consideration of basic traditions, values, interests, and principles imbedded in the applicable legal materials.

Such constitutional analysis is timely because potentially fatal constitutional attacks are likely to be launched against some limitations in any viable universal health care program. This is certainly true concerning the universal plan advocated here. For example, in 2005 the Canadian Supreme Court’s decision in *Chaoulli v. Quebec* 23 struck Quebec’s prohibition on the purchase of supplemental insurance covering care within Canada’s government mandated and financed universal health care program. A slim majority of the Justices reasoned that excessive waiting times for certain care, waiting lists it found to put patients at risk of death or serious injury, trenched on rights protected by either the Canadian or the Quebec “constitution,” at least when persons were not allowed to avoid the waiting lists by purchasing “private”/supplemental health insurance. 24

The situation addressed in *Chaoulli* poignantly pits poorer persons’ legislatively

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23 *Chaoulli v. Quebec*. [2005] 1 S.C.R. 791, 2005 SCC 35, 2005 S.C.R. LEXIS 32. The Court’s opinion was not definitive because one of the Justices comprising the four person majority relied on the Quebec, rather than the Canadian, Charter, three Justices joined a dissent, two Justices did not participate, and both Charters contain provisions allowing legislators to “set aside” such rulings for a certain time period. ACCESS TO CARE: ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA xxi-xxiii (Colleen Flood et al., eds. 2005). On August 4, 2005, the Court issued a ruling delaying its judgment for one year from when it was issued on June 9, 2005. CANADIAN SUPREME COURT BULLETIN, August 12, 2005. Quebec has responded by promulgating a program to shorten wait times for certain procedures and then to extend such ameliorative efforts on an ongoing open-ended basis. LA DIRECTION DES COMMUNICATIONS DU MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, GUARANTEEING ACCESS: MEETING THE CHALLENGES OF EQUITY, EFFICIENCY AND QUALITY 33-52 (February 2006). This was implemented, at least in part, by National Assembly Bill 33 (2006, chapter 43), assented to December 13, 2006, and National Assembly Bill 37 (2006, chapter 16), assented to June 13, 2006. The latter, which included an allocation of $50,000,000 (Canadian) “mainly to shorten waiting lists and increase the hours of operation of operating rooms.” The latter was repealed in 2007. Bill 4 (2007, Chapter 6), assented to June 21, 2007.

enacted right to reasonable, "medically necessary" physician and hospital care against relatively wealthier persons' claimed constitutional right to purchase supplemental insurance necessary to assure timely health care when it is not promptly available in the publicly financed system.  

One cannot dismiss either Chaoulli or the situation it addressed as an aberrant Canadian phenomenon. A situation similar to that in Chaoulli could have arisen in the August 2006 universal health care plan passed by the California legislature had that plan not been vetoed by Governor Schwarzenegger. California's plan was predicted by opponents to lead to waiting lists just like those addressed in Chaoulli because of the limitations on financing they associate with government-mandated universal health care systems.

The possibility and viability of constitutional attacks on health care reforms based on the right to purchase health care is enhanced by the 2006 ruling of a panel of United States Court of Appeals for the District of Columbia's in Abigail Alliance For Better Access To Developmental Drugs v. V-on Eschenbach. There the court held that terminally ill cancer patients have a fundamental right to purchase certain experimental drugs. Although overruled, this opinion represents a fairly common viewpoint that persons, especially those suffering from deadly illnesses, should be able to purchase experimental medicines, organs for transplantation, or medicinal marijuana. If patients have a fundamental right to purchase experimental drugs, organs for transplantation, or medicinal marijuana, then many would argue that persons surely have a fundamental right to purchase standard care and insurance necessary to obtain that care. If so, substantial limitations on that right would trigger strict scrutiny. In turn, this scrutiny might prove fatal given that it posits placing heavy burdens on the government in areas subject to substantial lack of data and an abundance of factual and normative uncertainty. A similar threat to universal health care programs is posed by the possibility

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25 See infra text accompanying note 75 re Canada's system and its universal coverage of "medically necessary" physician and hospital care. The majority opinions in Chaoulli support a right to reasonably prompt care, a concept found illusory by the dissenters. Chaoulli, [2005] 1 S.C.R. 791 at ¶ 163.


27 See infra text accompanying notes 66-74 regarding the California plan and criticisms of it.


29 See infra text accompanying note 177.

that the Court would apply some form of intermediate scrutiny.

This article argues that although there is a fundamental right to purchase care, it is limited to goods and services that the government authorizes for general use or sale. It does not include purchase of experimental care, treatments (such as marijuana) the government subjects to general criminal prohibition, or interventions that the government has determined to be otherwise wasteful (i.e., care that is not efficacious or not cost-effective, at least for certain patients) or immoral (e.g., transplantation requiring purchased organs). Therefore, although a fundamental right to purchase care can trigger scrutiny that might limit universal health care reforms at the margins, it does not threaten a plan that includes the restrictions advocated in this article—provided that the government timely delivers the care it includes within its universal benefits package.

The first section of this article explores the sources of inflationary pressure on health care expenditures in the United States and the resulting need for limitations on care in any health care system designed to provide universal coverage regarding a “basic” package of benefits. The second section gives brief summaries of the Clinton Health Care Plan, the August 2006 universal health care plan passed by the California legislature, and the Canadian universal health care plan. This will give readers an appreciation of some of the features and concerns inherent to universal health care plans.

The third and final section analyzes constitutional arguments that might be made against both the restrictions within the universal health care program advocated in this article and even arguably more severe restrictions such as those addressed in Chaoulli.

The specific restrictions addressed will be: (1) a prohibition on supplemental health care insurance needed to obtain timely care that is covered within, but not timely provided by, a universal plan; (2) a prohibition on supplemental health insurance covering care unless that care is both efficacious and cost effective. Examination of these restrictions should serve as useful guides to proper analysis concerning other limitations, mentioned here or not, that might arise within various universal health care plans.

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11 See infra text accompanying notes 133-152 and 177-237. Although taking this position as a matter of constitutional law, I do not intend to endorse any governmental position solely on policy grounds; this includes governmental views concerning medical marijuana and the sale of organs.
reform proposals. This section will include a brief summary of *Chaoulli v. Quebec* because the factual data, empirical contentions, and constitutional analysis at issue there are similar to those that would likely be presented before our Court.

It will also include a thorough consideration of the possible due process and equal protection arguments that might be presented to our Court, including consideration of threshold claims, justifications for strict or intermediate scrutiny, and possible applications of such scrutiny to specific challenges to certain limitations on the right to purchase access to care contained in the universal care program advocated here.

I. SOURCES OF THE NEED FOR LIMITATIONS ON HEALTH CARE IN PUBLIC AND PRIVATE PROGRAMS AND POLICIES

Health care is different from most other goods and services. First, although it is something people usually hope they will not have to obtain, they are often willing to pay large sums to get it if there is any hope that it will enhance health or well being or ameliorate injury, illness, or pain—perhaps, in extreme cases, to pay almost anything. Second, it is usually chosen for them by health care providers, primarily physicians, who either have a financial incentive to offer care or wish to provide their patients with any and all care that might have any beneficial impact. Third, most care is covered by private or public insurance supplied by an employer or the government. The patient, and often his physician too, are relatively isolated from decisions concerning whether the cost of care is justified by its expected benefits. Therefore, third party payment creates a situation in which there are insufficient incentives to control costs. Fourth, there are limitations on health care consumerism even if patients or physicians focus on costs. Patients are arguably often not capable of understanding all the relevant data. Moreover, relevant data is often not available to patients or physicians. Fifth, health

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32 Examples of an array of additional restrictions are regulations short of prohibition that de facto lead to an inability to purchase supplemental insurance or care and a prohibition on supplemental health care insurance covering care that is timely delivered within a universal program.

33 I realize there are certain counter-incentives, including financial schemes directly intended to limit care physicians offer. See, e.g., MARC RODWIN, Physicians’ Conflicts of Interest in HMOs and Hospitals, in Conflicts of Interest in CLINICAL PRACTICE AND RESEARCH 197-227 (R. Spece et al. eds., 1996).

34 Id. at 1354-56.

35 Regarding patient understanding, see chapter nine by that title in RUTH FADEN & TOM BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT, 298-336 (1986). Regarding the absence of data, even for providers, see JUDITH AREEN, ET AL., LAW, SCIENCE AND MEDICINE 867 (2d ed. 1996). See also Catherine McLauglin, Health Care Consumers: Choices and
care emanates from a huge medical industrial complex that is constantly developing new
diagnostic and therapeutic goods and services that it wishes to dispense to the widest
possible market;\textsuperscript{36} there is even a multi-billion dollar experimental care sector.\textsuperscript{37} These
technologies are often extremely complex and expensive in terms of developmental
costs, of charges for the finished products, and of personnel needed to utilize them.
Sixth, decisions to limit health care inevitably impact identifiable persons or cost specific
individuals their lives. These events are therefore very visible and lead to publicity and
resulting pressure to vitiate the associated limitations. Limiting health care is therefore
more difficult than restricting other potentially life-saving or safety measures such as
carefully designing and maintaining highways. The latter generally only impact
unidentifiable or "statistical" persons and lives.\textsuperscript{38}

These five features are the primary contributors to an ongoing cycle of inflation
in health care costs to government, industry, and individuals. Of the five, technological
innovation is an underlying vector that potentiates the other features. For example,
medical insurance once was, and might still be, insignificant without technological
advances that made medical care effective and therefore more important. Regardless,
given these features, Medicare and Medicaid expenditures constitute significant portions
of federal and state budgets.\textsuperscript{39} Education and Medicaid are the major expenditures
within state budgets, and Medicaid expenditures significantly impact the ability of states
to improve educational, housing, and other essential programs.\textsuperscript{40} Health care insurance
costs constitute significant portions of large employers' budgets and small employers

\textsuperscript{36} Glied, supra note 22, at 91-93.
\textsuperscript{37} SUSANNAH FOX & LEF RAINIE, VITAL DECISIONS: HOW INTERNET USERS DECIDE WHAT
INFORMATION TO TRUST WHEN THEY OR THEIR LOVED ONES ARE SICK, (2002),
http://www.pewinternet.org (73 million people a year go on the internet in search of health
related information, and 48\% of these have looked for information about alternative or
experimental treatments or medicines); Tom Abate, Experiments on Humans: Business of Clinical
Trials Soars, but Risk Unknown, SAN FRANCISCO CHRONICLE, Aug. 4, 2002, at A1(20 million
Americans participate in 41,000 clinical trials in the multi-billion dollar industry).
\textsuperscript{38} James Blumstein, Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis, 59 TEX. L.
REv. 1345, 1353-54 (1981). Other features add to the spiraling costs of medical care, including
our aging population and the greater costs associated with treating elderly persons. Berhanu
Alemayehu & Kenneth Warner, The Lifetime Distribution of Health Care Costs, Health Services
\textsuperscript{39} Comment, Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision, 73 U. CHI. L. REv.
\textsuperscript{40} Id. at 673.
wish to, but often are unable to offer health care benefits to attract employees. A typical private policy, moreover, costs thousands of dollars per year, and for a family the average annual cost is over $10,000 per year.

Private insurance policies commonly cover all “medically necessary” physician and hospital expenses with certain exclusions such as dentistry and cosmetic surgery. “Medically necessary” is a term of art that has been the subject of several cases and articles. I will stipulate a definition for the purposes of this article: care prescribed by a licensed provider that is neither experimental nor rejected in the medical and scientific community as having no benefit for the condition for which it is being prescribed. To be sure, this definition does not require that care be shown to be efficacious to be considered medically necessary; it simply requires that the care not be shown to not be efficacious. Nevertheless, contrary to my stipulated definition, some courts have held that experimental care is “medically necessary” simply if it is prescribed by one’s health care provider; medical consensus is deemed irrelevant. Courts’ tendency to give considerable, if not dispositive, weight to treating providers’ opinions regarding medical necessity, even when the care is experimental, practically vitiate this contractual condition as a “limitation.”

Medicare and Medicaid plans are generally more limited in scope than private insurance policies. For example, the Medicaid statutes allow states to determine whether to cover transplants and United States Courts of Appeals are split on whether Medicaid

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41 Senator Olympia Snowe, Small Business Health Plans: A Critical Step in Solving the Small Business Health Care Crisis, 43 HARV. J. ON LEGIS 231 (2006); Jost, supra note 8 at 574.
42 See supra notes 1 and 6 regarding government efforts. Regarding private employers see Montwieler, see supra note 10.
46 Id. at § 30[a].
47 Hall & Anderson, supra note 44, at 1654-57.
plans are required to offer all “medically necessary” care among the categories of goods and services required for a state to participate in the program. Although the public programs are more limited, there is pressure for them to expand to cover items of care initially available only within the private sector. Most politicians, academics, and policy analysts agree that the government can only afford to provide “decent,” “adequate,” or some other limited degree of health care rather than all care that an individual and her physician might want to receive. This is one of the central reasons for dissatisfaction with restrictions on supplemental insurance, or supplemental care itself.

Unfortunately, the term “rationing,” an emotionally charged term of art associated with wartime and other disasters, has been somewhat abused. It has often been applied, by persons interested in health care reform or ethics, to limiting care to less than what the individual and her physician might want—even if it is experimental or considered by most persons in the medical and scientific community to be inefficacious. This term has extremely negative connotations to the average person as well as to many judges and some academics. It might advance dialogue and informed deliberation if the term “rationing” were replaced with a label such as “setting reasonable limits.” In any event, the unique aspects of health care mentioned here create strong incentives, and in some cases market failures, leading to allocation of resources to health care beyond the point at which marginal costs are justified by marginal benefits. Some persons even suggest that our system creates incentives for

48 DeSario, 139 F.3d at 96.
49 Glied, supra note 22 at 154-55.
50 See the articles in, Symposium, The Law And Policy Of Health Care Rationing: Models and Accountability, 140 U. PA. L. REV. 1505 (1992), especially Paul Kalb, Defining an “Adequate” Package of Health Care Benefits, Id. at 1987; Richard Laumer, Rationing of Health Care: Inevitable and Desirable, Id. at 1511; Joseph Califano, Jr., Rationing Health Care: The Unnecessary Solution, Id. at 1525 (articulating the minority view implicit in the title of his article).
51 In ordinary language “rationing” connotes a severe restriction on food or other necessities to meet emergency conditions such as war. Yet, rationing is used in health care policy debates to cover a broad range of limitations, including governmental refusal to pay for unlimited care—even if that care is experimental or considered by most scientists to be inefficacious. Out of deference to tradition, I use rationing in its broadest sense, but I realize the term can obscure analysis. See, e.g., Theodore Marmor & Jan Blustein, Introduction to Rationing, 140 U. PA. L. REV. 1539-42 (1992) (economists equate rationing with allocation while policy analysts distinguish between macro-allocation and micro-allocation; rationing is not dictated by financial restraints because more funds can be allocated to health care, and “tragic choices” only occur when there is a true scarcity such as one organ available for transplantation when several persons are in need).
52 Hall & Anderson, supra note 44, at 1662.
53 See supra text accompanying notes 33-38.
54 Clark Havighurst, The Rising Cost of Health Care: Growing Pains or Something Worse?, in HEALTH
the provision of care that is actually harmful.\textsuperscript{55}

Professors Hall and Anderson have succinctly described the problems private insurers have had in attempting to enforce "medically necessary" limitations in health care policies:

The medical technology literature identifies three levels of evaluation for medical procedures, drugs, and devices. They can be found (1) safe and efficacious, (2) cost effective, and/or (3) cost beneficial. The first level, which is employed by the Food and Drug Administration to evaluate all new drugs and devices, asks only whether the procedure is safe and provides some medical benefit, however small. The second level asks whether this medical benefit is superior to what can be achieved by other procedures at equal or lesser cost. Only the third level asks whether a net increase in medical benefit is worth the cost.

Health insurers have historically operated only at the first level, seeking to justify their coverage denials primarily as a means to protect patients from harmful or fraudulent care. They have not even asked whether a beneficial therapy might be more cheaply performed without sacrificing any benefit, let alone whether a marginally increased benefit is simply too expensive to be worthwhile. . . Even with this extreme trepidation, they consistently lose in court.\textsuperscript{56}

The need for limitations on care that the government will provide is explored in DeSario \textit{v.} Thomas.\textsuperscript{57} There, two subclasses of plaintiffs and an intervener argued that Connecticut had violated the Medicaid statutes by refusing to cover durable medical equipment ("DME") such as air purifiers, air conditioners, room size humidifiers, environmental control units, electronic devices that centrally control multiple appliances (costing $7,000-$8,000), and "RIK" mattresses (filled with an oil based liquid and costing $840 a month to rent). The district court did not accept plaintiffs' argument that

\textsuperscript{55} IVAN ILLYCH, MEDIC U. NEMESIS 26-32 (1977). \textit{See also} INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 1999) (especially the latter half of chapter 3).

\textsuperscript{56} Hall & Anderson, \textit{supra} note 44, at 1659-60.

\textsuperscript{57} 139 F.3d 80 (2d Cir. 1998).
the State violated the law by using a list to determine coverage of DME used in home care. However, it agreed with the plaintiffs that the State too narrowly defined DME and erroneously refused to cover certain medically necessary items it admitted met the definition of DME. The United States Court of Appeals for the Second Circuit reversed on both points.

As to the first issue it found that the district court had erroneously held that the State was precluded from limiting the DME component of home health care by defining it to exclude items "which are not primarily and customarily used to serve a medical purpose, and which are customarily used for other purposes." It observed:

DSS's definition of DME establishes a rational distinction between equipment that is primarily medical in nature, and devices principally employed for non-medical purposes that might incidentally benefit someone with a particular condition. It is not unreasonable for a state to refuse funding for air conditioners or room size humidifiers, even for those whose doctors can point to some medical need. Moreover, in addition to limiting coverage to purely medical devices, Connecticut's definition has the added benefit of guarding against moral hazard; after all, depending on how broad the range of a person's afflictions, plaintiffs' definition of DME would cover all the necessaries of life, and some of its amenities.

Concerning the exclusion of certain items that the State admitted met the definition of DME, the court reasoned:

[A] state may impose coverage limitations that result in denial of medically necessary services to an individual Medicaid recipient, so long as the health care provided is adequate with respect to the needs of the Medicaid population as a whole. Cases that have required states to fund all medically necessary services have also emphasized that the patient's physician deserves almost complete deference in determining medical necessity. Under that interpretation of the statute [adopted in some circuits], states would need to fund all medically necessary services, and a Medicaid recipient's physician would be able to create

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58 Id. at 89.
59 Id. at 89-90.
coverage by prescribing a particular procedure or item of equipment.\(^{60}\)

As DeSario points out, if physicians and patients were allowed to define medically necessary care, they could extend this to the necessities of life (e.g., food, shelter, and clothing) and even some of its amenities. In that event, no government would ever attempt to pursue universal access and would eventually be forced to abandon a more limited program such as Medicaid. It is rational to deal with the inevitable need for limits by, in the court's words, providing care that "is adequate with respect to the needs of the Medicaid population as a whole."\(^{61}\)

The court's view might seem harsh to some, but the reality is that there must be some limits on care that is provided, and this applies to both the public and private health care markets.\(^{62}\) This simple reality has not been accepted by the insured in the United States, and this is probably one reason we have in excess of 47 million persons who have neither public nor private health care insurance. These 47 million uninsured will never be given coverage, even of adequate amount, scope, and duration for most persons within that population, if the need for limits is ignored. Any possibility of reform is doomed if governments attempt to guarantee, or the courts read the Constitution to embody, a utopian right to "all medically necessary care."

II. REPRESENTATIVE UNIVERSAL HEALTH CARE PROGRAMS

Thus far I have explained both the sources of the need for some limitations on access within any universal health care plan and the primary forms those limitations might take. This section discusses specific proposed or existing universal health care plans and the primary limitations associated with them.

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\(^{60}\) Id. at 95-96.

\(^{61}\) Id. at 96.

A. The Clinton Plan

I present a stylized description of the Clinton Plan that might be contradicted in some instances by nuances in the complex plan. Prominent features included the following. Medicaid would have been rolled into the system, while Medicare would have continued to operate. The legislation set a basic standard of health insurance covering doctor and hospital bills, mental health care, and prescription drugs for all Americans. A seven member National Health Board, appointed by the President with the advice and consent of the Senate, would have interpreted and updated the benefits package, overseen the administration of the system by the states, and monitored compliance with budget and premium increase limitations. The actual insurance programs would have been offered and administered by employer and regional health alliances. Companies with more than 5,000 workers would have formed employer alliances and the states would have formed regional alliances.

The alliances would have offered plans established by competing networks of hospitals and health care providers. The alliances would have negotiated with competing networks to achieve the best buys for their insureds. Employer and employee premiums, subsidies from tax revenues, and projected savings from limitations on Medicare expenditures would have financed the plans. Companies would have paid 80% of the average premium in the region for each fulltime employee, and employees would have paid remaining premiums up to 1.9% of their earnings. Low-income persons would have received subsidies and the self-employed would have paid a fixed percentage of their incomes. Small businesses would have been eligible for contribution caps.

Of particular interest here is that the Clinton plan prohibited the purchase of supplemental insurance for any service within the national benefits package. If implemented as proposed, the plan would likely have led to rationing through waiting lists and other mechanisms such as deletions from the benefits package. This is because

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64 Section 1482.
the limitations on budgets and premium increases would have inevitably kept the plan’s budget from keeping pace with the expected rate of increase in the costs of providing health care goods and services. As was reasonably expected at the time, the continued emergence of expensive diagnostic and treatment regimens and a growing elderly population have kept health care inflation significantly above the average for other goods and services. It is perhaps more likely, however, that contempt for obvious forms of rationing, such as severe waiting lists and explicit exclusions of beneficial care, would have led to abandonment or significant loosening of the budget and premium increase limitations.

B. California’s Vetoed Universal Health Care System

The outpouring of new diagnostic and therapeutic techniques, inflationary growth in both private and public health care spending, and massive numbers of uninsured persons that seemed to set the stage for health care reform when Bill Clinton became president have continued and, in some instances, grown. Not willing to await overarching federal reform, many states have implemented or are considering core reforms reaching toward the goal of universal health care coverage. Most pertinent for the purposes of this paper is the universal health care plan passed by the California legislature on August 31, 2006, and then vetoed by Governor Schwarzenegger shortly thereafter. This complex legislation is almost one hundred pages long. It provides universal coverage for a set of basic health care goods and services, establishes a governmental entity as the “single payer,” and involves the government in health care planning, regulation, and negotiation with private providers and provider entities that

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65 Regarding anticipation of the problems of an aging population and escalating technology as contributing to health care costs even during the Clinton administration see D. Yankelovich, The Debate that Wasn’t: The Public and the Clinton Health Care Plan, 13 BROOKINGS REVIEW 3, at 36 (Summer 1995). The rate of increase in health care costs has slowed in recent years, to 7.7% between spring 2005 and spring 2006, but the increases are still twice the general rate of inflation. Doug Trapp, Health Care Premiums Increase More Slowly, AMERICAN MEDICAL NEWS, Oct.23/30, 2006, at 8, col. 1.

66 The number of uninsured increased by 860,000, up to 45.8 million persons from 2003 to 2004. J. Finkelstein, 45.8 Million Now Uninsured, 48 AMERICAN MEDICAL NEWS 35, at 1-2 (2005). The number of uninsured is now estimated at 47 million. Montwieler, supra note 10. See also supra note 10 (discussing controversy concerning the number of uninsured persons). See supra note 9 and accompanying text regarding the rate of inflation.

67 See supra note 1.

68 Senate Bill No. 840, passing the California Senate on August 31, 2006 and the Assembly on August 28, 2006.

69 See supra note 26.
will dispense the majority of care in the jurisdiction. The California plan was to be funded “by redirecting funds for existing federal, state, and local health care programs and close to $1 billion from savings in state and local employee health benefits programs” as well as employer and employee payroll taxes, a self-employed business income tax, a tax on unearned income, and a surcharge on incomes over $200,000.”

Some of the plan’s central features are delineated in the following “analysis” by California’s Office of Senate Floor Analyses:

This bill:

1. [Creates and] requires the CHIA [California Health Insurance Agency] to be headed by a commissioner appointed by the governor, and to be comprised of the Health Insurance Policy Board, the Office of Patient Advocacy, the Office of Health Planning, the Office of Health Care Quality, the Health Insurance Fund, the Public Advisory Committee, the Payments Board, and the Partnerships for Health.


3. Allows any eligible individual to choose to receive services under CHIS from any willing professional health care provider participating in the system, allows all health care providers licensed or accredited to practice in California to participate in the CHIS, and establishes a broad benefit package.

4. Prohibits health plan and health insurance contracts, except for the CHIS plan, from being sold in California for services provided by the system.

5. Establishes a California Health Insurance Premium Commission (CHIPC) to determine the aggregate costs of providing health insurance coverage under this bill, to develop an equitable and affordable premium structure that will generate adequate revenue and ensure stable and actuarially sound funding for the CHIS, requires the premium structure to meet specified criteria, and requires the CHIPC to submit a detailed recommendation to the Governor and the Legislature

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for a premium structure on or before January 1, 2009.\textsuperscript{71}

The legislation provided that the plan would not become operative until the state Secretary of Health and Human Services certified that there were adequate monies in the plan's state insurance fund.\textsuperscript{72} It also provided processes and broad standards for cost control measures or premium increases that might become necessary over time.\textsuperscript{73} The Senate Floor Analysis summarized some of the arguments against the plan:

Opponents argue that this bill is based on two flawed premises: (1) that government systems are more efficient than private businesses, and (2) that a single payer system would cost less than the current private system. Regarding the first premise, opponents assert that patients in Canada and England, both of which have single health insurance programs, face lengthy waiting times for services and their medical outcomes are poor compared to those in the US and California. Opponents cite Canadian experiences with long waiting times for treatment after diagnosis, rationed hospital care, and sub-average supplies of medical technology such as MRI units and CT scanners. Regarding the second premise, opponents acknowledge that a single payer system would generate some amount of administrative savings but question whether the bulk of administrative costs would be eliminated under such a system. . . .

Opponents argue that this bill does not address the underlying costs impacting the price of health insurance and state their belief that competitive forces do play a role in mitigating increases in health care costs and as evidence point out that California's health care premiums are lower than those of other large states...

Finally, opponents state that single payer systems in European nations and Canada have tended to discourage investment in biotechnology and advanced medical devices because they use price controls to restrain spending.\textsuperscript{74}

\textsuperscript{71} Id. at ¶ 4.
\textsuperscript{72} Id. at 30.
\textsuperscript{73} Id. at 19-26.
\textsuperscript{74} Id. at 18-19.
C. The Canadian Health Care System\textsuperscript{75}

1. Generally

As with my description of the Clinton plan, this is a generalized description. The Canadian health care system is a complex combination of public and private elements. The primary element of the system is a publicly financed plan for universal access to medically necessary hospital and physician services. This plan involves cooperation between the federal and provincial governments. As a condition for receiving federal funds, each province must provide universal medically necessary physician and hospital care. Physician, hospital, and diagnostic care are covered without any cost to the patients. Private personnel and non-profit hospitals provide the care. Physician services and diagnostic tests are paid for by the government on a fee-for-service basis pursuant to a schedule negotiated between each province and its medical association. Hospitals are allotted annual budgets determined by the provincial Ministries of Health. Some provinces provide care that exceeds the minimums required by the central government.

Patients choose their general physician. Referrals to specialists and hospital admissions are theoretically within the patient’s choice, but they generally depend on the primary care physician’s hospital privileges and referral patterns. Access to publicly funded drugs, non-physician health care provider services (e.g., dental care), and institutional care outside hospitals differ among the provinces. The universal publicly funded coverage consumes less than half of annual government health care expenditures, and public monies account for only approximately 70\% of total Canadian health care spending.

In summary, although Canadian health care includes basic uniform services and is primarily publicly financed, it varies among the provinces, is generally dispensed by private health care providers, and is significantly privately financed. Canadian provinces have different approaches to private financing of health care. Of primary importance here, several but not all of the provinces prohibit supplemental insurance covering services within the publicly financed plan.

\textsuperscript{75} This description of the Canadian health care system is based on R. Evans, “Special Section: Reconsidering the Role of Competition in Health Care Markets,” 25 J. HEALTH POL. POL’Y & L. 889-97 (2000); and Robert Steinbrook, Private Health Care in Canada, N. ENG. J. MED.354:1661 (April 20, 2006).
2. Restrictions On “Supplemental” Or “Private” Care In Quebec And Other Provinces

Justice Deschamps’ opinion in Chaoulli v. Quebec summarizes the limitations Quebec and other Canadian provinces have implemented to discourage care outside the government-funded system for providing a universal package of benefits to all Canadians. He first addresses Quebec, explaining that it not only prohibits the purchase of “supplemental” or “private” insurance, but that it requires that care within the universal package of benefits either be provided by physicians under contract with the government (“participating physicians”) or by physicians “who have withdrawn” but receive no fees in addition to those paid by the government. Moreover, although private hospitals are not prohibited, they must obtain a permit from the government. Given that the government frowns on such private care, “any proposal to develop private professional services [is] almost illusory.”

Justice Deschamps’ then addresses the other provinces:

The approach to the private sector taken by the other nine provinces of Canada is by no means uniform. In addition to Quebec, six other provinces have adopted measures to discourage people from turning to the private sector. The other three, in practice, give their residents free access to the private sector. Ontario . . ., Nova Scotia . . ., and Manitoba . . . prohibit non-participating physicians from charging their patients more than what physicians receive from the public plan . . . It is worth noting that Nova Scotia does not prohibit insurance contracts to cover health care obtained in the private sector. Ontario and Manitoba prohibit insurance contracts but refund amounts paid by patients to non-participating physicians.

Alberta . . ., British Columbia . . ., and Prince Edward Island . . . have adopted a very different approach. In those provinces, non-participating physicians are free to set the amount of their fees, but the cost of the services is not refunded and contracts for insurance to cover services offered by the public plan are prohibited. This is the same policy as has been adopted by Quebec.

Saskatchewan . . ., New Brunswick . . ., and Newfoundland and Labrador.

...are open to the private sector. New Brunswick allows physicians to set their own fees. In Saskatchewan, this right is limited to non-participating physicians. The cost is not refunded by the public plan, but patients may purchase insurance to cover those costs. Newfoundland and Labrador agrees to reimburse patients, up to the amount covered by the public plan, for fees paid to non-participating physicians. In Newfoundland and Labrador, patients may subscribe to private insurance to cover the difference.  

The limitations ventured by the various provinces can lead to waiting lists, as has been the case in Quebec, a subject addressed in the next subsection.

3. Waiting Lists Within The Publicly-Financed Plan

The waiting lists associated with Quebec's version of Canada's publicly financed plan were described as follows in Chaoulli:

Not only is it common knowledge that health care in Quebec is subject to waiting times, but a number of witnesses acknowledged that the demand for health care is potentially unlimited and that waiting lists are a more or less implicit form of rationing....

Dr. Daniel Doyle, a cardiovascular surgeon, testified that when a person is diagnosed with cardiovascular disease, he or she is "always sitting on a bomb" and can die at any moment. In such cases, it is inevitable that some patients will die if they have to wait for an operation. Dr. Doyle testified that the risk of mortality rises by 0.45 percent per month. Dr. Eric Lenczner, an orthopedic surgeon, testified that the usual waiting time of one year for patients who require orthopedic surgery increases the risk that their injuries will become irreparable. [A] person with chronic arthritis who is waiting for a hip replacement may experience considerable pain. Dr. Lenczner also stated that many patients on non-urgent waiting lists for orthopedic surgery are in pain and cannot walk or enjoy any real quality of life.  

In a study of 200 subjects aged 65 and older with hip fractures the

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77 Id. at 75-77.
78 Opinion of Justice Deschamps, Id. at ¶¶ 39-42.
risk of death within six months after surgery increased significantly by 5 percent, with the length of pre-operative delay.... Dr. Lenczner also testified that 95 percent of patients in Canada wait well over a year, and many two years, for knee replacements.... In addition to threatening the life and the physical security of the person, waiting for critical care may have significant adverse psychological effects.... Studies confirm that patients with serious illnesses often experience significant anxiety and depression while on waiting lists.79

Some persons would likely question the quoted descriptions' assessment of risks and even argue that sometimes too much or too quick care might lead to iatrogenic injuries.80 Others would add that the waiting lists are even worse than described because of the apparent lack of substantive or procedural standards governing the distribution of waiting risks to groups of patients or to specific patients.81

Having described the Clinton plan, a California universal health care plan vetoed in September of 2006, and the current Canadian universal health care system with a focus on limitations on care associated with those programs, I will move to consideration of constitutional arguments that might be made against various such restrictions.

III. HOW OUR COURT MIGHT ANALYZE CERTAIN LIMITATIONS ON CARE WITHIN A UNIVERSAL HEALTH CARE PROGRAM

The foregoing sections outline both the practical necessity of limits on universal health care proposals, and the kinds of limits found in proposed plans in the United States and actual plans in various Canadian provinces. The next question is whether these limits are constitutional. In this section, I will summarize aspects of Chaoulli v. Quebec because the Canadian decision raises factual and legal issues that would occur in similar situations in the United States. My focus is on the rationales that were asserted and considered in defense of the particular limit on universal health care at issue in

79 Opinion of Chief Justice McLachlin and Justice Major for themselves and Justice Bastarache, Id. at ¶¶ 113-17. Quebec's response to Chaoulli includes a plan to limit waiting times for certain care. See supra note 23.

80 The Chaoulli dissenter argued that there was no strong evidence in the record concerning significant harms caused by the waiting lists. Id. at ¶ 220. Regarding iatrogenic disorders see IVAN ILLICH, MEDICAL NEMESIS 41-43 (1977).

81 See, e.g., Walter Williams, Why Canadians Purchase Private Health Insurance, CAPITALISM MAGAZINE, June 20, 2005.
Chaoulli: a prohibition on the purchase of supplemental insurance for items ostensibly covered by a universal health care program but not actually timely available within it. Next, I will examine possible substantive due process, equal protection, and, to a very limited extent, procedural due process challenges to both such a restriction and additional restrictions proposed for the universal health care plan I have advocated here.

I argue that a prohibition such as that struck in Chaoulli would likely meet a similar fate in the United States. At the same time, however, I argue that the restrictions I have proposed as part of a sound general universal health care plan would likely withstand any constitutional attacks. I develop the constitutional arguments in great detail because: (1) it is easy to mistakenly reason that all significant restrictions within universal health care programs should meet the same fate as the prohibition struck in Chaoulli; (2) such mistaken reasoning can deter adoption of needed reforms; and (3) the detailed consideration of specific restrictions here should assist analyses of other or future restrictions both on alleged fundamental constitutional rights generally and on asserted fundamental constitutional rights to health care specifically.

I will focus in particular on whether there is, as Abigail Alliance holds, a fundamental right that encompasses the right to purchase care, such as experimental treatment, that the government withholds from general use.\(^{82}\) If so, such a broad right would encompass a fundamental right to purchase care, or insurance for care, that the government subjects to limitations significantly short of prohibition. It would trigger strict scrutiny and likely would prove fatal to many limitations that might be included within universal health care systems. I argue that there is a fundamental constitutional right to purchase care that the government has allowed into general use or commerce. Conversely, I argue that there is no fundamental constitutional right to purchase care that the government has withheld or allowed into use under significant restrictions. Consequently, the courts would apply to such limitations a deferential standard of review which would pose little or no risk to government programs containing the restrictions. The restrictions that are likely to be implemented in any universal health care program in the United States fall within this latter category.

\(^{82}\) See infra text accompanying notes 177-237. Whenever I refer to Abigail Alliance without specifying which opinion therein I am referring to I mean the three judge panel's majority opinion as opposed to the dissent or the Court of Appeals' en banc decision.
A. Chaoulli And Its Consideration Of Rationales For The Prohibition It Struck

The Canadian Supreme Court majority and dissenting Chaoulli opinions embody essentially the same structural four step process that American courts follow in analyzing substantive due process and equal protection challenges under the United States Constitution. These steps are to determine: (1) whether there is a protected right or interest; (2) whether there is an action or classification that sufficiently intrudes on the right or interest; (3) what standard of review or scrutiny is appropriate; and (4) what decision should follow from application of the standard of review. I do not claim that the Canadian Court's approach is identical in meaning to whatever approach would be taken in U.S. Courts, nor that they would reach the same outcomes despite some differences in meaning.

Addressing Quebec's limitation on the purchase of supplemental insurance for items ostensibly covered within its universal care program but not actually timely available, all the Chaoulli opinions agreed that rights to life, liberty, security, and/or inviolability under the Canadian and/or Quebec Charter were sufficiently impaired so as to require some justification. Each of the two opinions constituting the majority applied what in our system could be characterized as either strict or intermediate scrutiny, while the dissent applied what seemed to be the equivalent of our rational basis test. The opinion of Justice Deschamps summarizes the rationales that were offered to justify the prohibition he and the other justices in the majority found unconstitutional.

Justice Deschamps relied solely on the Quebec Charter and found that the prohibition on supplemental insurance was not necessary because each of the following deleterious effects posited by the government was unlikely, irrelevant, or manageable through less intrusive restrictions: (a) "the emergence of the private sector would lead to a reduction in popular support in the long term because the people who had private insurance would no longer see any utility for the public plan;" (b) "the quality of care in the public plan would decline because the most influential people would no longer have any incentive to bring pressure for improvements to the plan;" (c) "[t]here would

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84 Id. at ¶ 46-99, 154-59.
85 Id. at ¶ 235-42.
86 Id. at ¶ 63.
87 Id.
be a reduction in human resources in the public plan because many physicians and other health care professionals would leave the plan out of a motive for profit;” 88 (d) “[a]n increase in the use of private health care would contribute to an increase in the supply of care for profit and lead to a decline in the professionalism and ethics of physicians working in hospitals;” 89 (e) “[t]here would be an increase in overall health expenditures” from “individuals who decide to take out private insurance” and “the cost of management of the private system by the state;” 90 (f) “[i]nsurers would reject the most acute patients, leaving the most serious cases to be covered by the public plan;” 91 and (g) “physicians would tend to lengthen waiting times in the public sector in order to direct patients to the private sector, from which they would derive a profit.” 92

Having briefly described the basic structure within the Chaoulli opinions and the government rationales rejected by the majority there, I will turn to the basic structure of the constitutional analyses that would be applied by American courts. I will describe the elements necessary to state prima facie constitutional claims, the need to state more than a prima facie claim to justify the invigorated scrutiny that is necessary to offer any significant chances of success, and the forms such invigorated scrutiny might take. I will focus in particular on what is necessary to establish a fundamental constitutional right.

88 Id.
89 Id.
90 Id. at ¶ 65.
91 Id.
92 Id.
B. Prima Facie Claims and Application of the Appropriate Scrutiny

1. Prima Facie Or Threshold Due Process And Equal Protection Claims

A prima facie or threshold due process claim, either substantive or procedural, consists of: (1) government action, (2) significantly intruding upon, (3) a person’s, (4) "life, liberty, or property," (5) absent certain actions or factors required for due process of law. A prima facie equal protection claim consists of: (1) government action, (2) treating a person or group less favorably than other similarly situated persons, (3) causing harm the courts recognize as constitutionally significant ("harm in fact").

2. Lax Or Stict Scrutiny: The Rational Basis Or Compelling State Interest Test

If there is a prima facie substantive due process or equal protection claim, the presumptively applicable standard of review is the rational basis test. It requires the plaintiff to show that there is no conceivable legitimate government interest imaginably advanced by the government’s action or classification.

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93 Although the U.S. Supreme Court and commentators do not commonly use the terms, I will refer to prima facie or threshold claims as the set of elements that must exist to require justification for an action or classification that intrudes on a constitutionally protected interest (including interests in not being classified in certain ways, as well as interests usually couched in the language of "fundamental (or basic) rights"); this justification occurs through the application of some standard of review or scrutiny. I use these terms because they convey the idea that if the requisite elements are alleged to exist, a constitutional claim will likely be able to withstand a motion to dismiss or demurrer. Subsequent proceedings will determine whether there has been a violation of due process or equal protection as a bottom-line matter. This could help the plaintiff get access to discovery, to avoid sanctions for filing a frivolous claim, or to prevail if the government’s action is arbitrary. It should be noted, however, that if the justification required is determined by application of the rational basis test, it might be possible to dismiss a case on the pleadings because it is clear therefrom that the government’s action is irrational.

94 I include the requirement of injury because a person must be a target of government action to have standing to state an equal protection claim. However, the law is nuanced in this area. On the one hand, the Court has stated that intentional, facial use of race by government is inherently stigmatizing and thus creates injury that must be justified under the compelling state interest test. Parents Involved In Community Schools v. Seattle School Dist. No. 1, 127 S.Ct. 2738, 2751-2752 (2007). However, it has also indicated that when there is a facially neutral law, there must be both a discriminatory purpose and a discriminatory effect. Palmer v. Thompson, 403 U.S. 217, 224-225 (1971); Wash. v. Davis, 426 U.S. 229, 239-240, 244-246 (1976).

To have significant prospects of victory under either a due process or equal protection theory, plaintiffs who wished to challenge limits on a universal health care plan would have to convince the Court to apply some form of invigorated scrutiny: either the strict scrutiny of the compelling state interest test or some form of intermediate scrutiny. The Court's choice of a standard of review seems to turn on the special nature of the right or interest invoked by the plaintiff, the dubiousness of any classification drawn, or the degree of intrusion wrought by the government's action or classification.96

It is necessary to briefly explore the general notion of a special or fundamental right before considering, below, specific approaches and criteria relevant to that determination. Sometimes the Court either engages in a pre-consideration of the strength of the government's interest, a pre-balancing of the relative strength of the competing individual and state interests, or considers its limited capacity or traditional role in a specific category of cases when determining, or when it would be expected to determine, whether a right should be found special or fundamental.97 If the government's interest is salient and strong or the Court's competence or traditional role weak or limited, the Court is apt either to not even reach the question whether there is a fundamental or special right, to reach the question and refuse to find a fundamental or special right, or to find a fundamental or special right and apply what would otherwise be expected to be strict or invigorated scrutiny in an uncommonly deferential manner. Another way to conceptualize this is to realize that because a substantial intrusion on a fundamental or special right mandates strict or invigorated scrutiny, the Court approaches the question whether there is such a right with a broader question in mind. That question is whether it should apply strict or invigorated scrutiny in the case before it, and such choices, in general, heavily affect the outcome.

Given these preliminary qualifications, the Court generally will apply strict scrutiny or the compelling state interest test if there is either a substantial intrusion on a fundamental right or a suspect classification has been used.98 This test requires that the government meet a heavy burden of showing (1) its actual interest, (2) is a compelling one, (3) that is substantially advanced, and (4) that there is no less restrictive

97 See infra cases discussed in text accompanying notes 225-235.
alternative. 

3. Forms Of Intermediate Scrutiny

In substantive due process or equal protection adjudication, the Court often applies some form of scrutiny beyond the traditional rational basis test but short of the compelling state interest test—so called "intermediate scrutiny"—without explaining why it has done so. The Court might apply one or more of these intermediate tests in cases involving restrictions within universal health care programs. In gender discrimination cases it has applied a specific form of intermediate scrutiny because it considers gender classifications to be quasi-suspect. Although this is the only context in which the Court has explicitly used the term quasi-, as in quasi-suspect or quasi-fundamental, in other cases it seems to have applied intermediate scrutiny because the right or interest involved is quasi-fundamental or because there is both a quasi-fundamental right and a quasi-suspect classification. Here I will simply include examples of intermediate tests the Court has used, any one of which might be applied in one or both of the specific situations discussed below. I will not apply the distinct forms of intermediate scrutiny to these situations, but I will consider how various elements of the various specific forms of intermediate scrutiny might affect one or more of those situations. The elements I refer to are (1) requiring government interests to be more than merely conceivable, (2) requiring government interests to be more than legitimate, (3) requiring means-ends connections to be more than conceivable, (4) requiring the use of less intrusive or better tailored alternatives, and (5) placement of burdens of proof on the government.

For example, the Court applied an intermediate test in Pcerer v. Doe, seemingly because of the total deprivation of education involved and because it considered (without saying so) undocumented school children to constitute a quasi-suspect classification and education to be a quasi-fundamental right. It concluded that the Equal Protection clause of the Fourteenth Amendment prohibited Texas from barring undocumented children from its public schools. The Pcerer Court's standard can be

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99 Spece, note 95, at 119-120, 127, 131, and 147.
101 The Court does not explicitly use the term quasi-fundamental, nor does it explicitly refer to use of an intermediate test, but its opinions nevertheless seem to support such an approach. See infra cases discussed in text accompanying notes 102 to 110; and Between The Tiers: The New(est) Equal Protection and Bush v. Gore, 4 U. PA. J. CONST. L. 373, n.57 and text thereat (2002).
described either as a unique balancing test that weighs national and state interests as well as individual interests against the state’s asserted interests or as a test that requires more than a legitimate (“substantial”) interest and proof of a close connection between the state’s interest(s) and its classification, or an ill-defined combination of both.

Similarly, as indicated above, the Court has applied a distinct form of intermediate scrutiny in gender discrimination cases. In these cases, however, the Court has been fully explicit in explaining why it applies invigorated scrutiny and in identifying its standard of review. The test applied in this context requires that the government show that its proffered interest was its actual interest, that this interest is “important,” and that the state’s action is “closely tailored” to or “substantially advances” its interest.

The Court applied still another intermediate test in Youngberg v. Romeo, where it considered the rights of an involuntarily confined mentally retarded man to freedom, safety, and habilitation within a government institution. It applied a standard other than the rational basis test, and the most plausible explanation for this use of a form of intermediate scrutiny is that it implicitly considered his liberty interests to be quasi-fundamental. The Court explained its standard of review as follows:

[W]hether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests. If there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury. We therefore turn to consider the proper standard for determining whether a State adequately has protected the rights of the involuntarily committed mentally retarded. We think the standard articulated by Chief Judge Seitz affords the necessary guidance and reflects the proper balance between the legitimate interests of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints. He would have

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103 See supra note 100. The Court has added ambiguity by referring to the government’s need to establish an “exceedingly persuasive” justification. See, e.g., Mississippi University For Women v. Hogan, 458 U.S. 718 (1982) (striking state statute that excluded males from enrolling in a state-supported nursing school and suggesting that failure to use less discriminatory alternative approach called the state’s alleged benign purpose into question). This seems simply to refer, however, to the stringency of the required showing of an actual, important government interest that is substantially advanced by the government’s action or classification.

104 Id.

held that 'the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.'

Similarly, in *Washington v. Harper* the Court addressed the right of a mentally ill prison inmate to refuse antipsychotic drugs. Here too it seemed implicitly to recognize a quasi-fundamental right because it applied an intermediate form of scrutiny. It articulated this test as a specific application of the general "reasonably related to legitimate penological interests" standard applicable to determine the validity of prison regulations claimed to infringe on prisoners' constitutional rights, and it explained that there are three aspects of the reasonableness determination in the refusal of psychotrophic medication context:

First, there must be a "valid, rational connection' between the... regulation and the legitimate governmental interest put forward to justify it." ...Second, a court must consider "the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally." ...Third, "the absence of ready alternatives is evidence of reasonableness of a prison regulation," but this does not mean that prison officials "have to set up and then shoot down every conceivable alternative method of accommodating the claimant's constitutional complaint."

Finally, a plurality of the Court arguably reduced the liberty to choose to have an abortion from a fundamental to a quasi-fundamental right in *Planned Parenthood of Southeastern Pennsylvania v. Casey.* The plurality's opinion did not apply the compelling state interest test but instead explained the appropriate scrutiny as follows:

a) To protect the central right recognized by *Roe* while at the same time accommodating the State's profound interest in potential life, we will employ the undue burden analysis.... An undue burden exists, and

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106 *Id.* at 321.
108 *Id.* at 224-25.
therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability. . . .

(c) As with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.

d) Our adoption of the undue burden analysis does not disturb the central holding of Roe. . . . [A] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.

(e) We also reaffirm Roe's holding that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."\textsuperscript{110}

4. How Does One Determine Whether There Is A (Quasi-) Fundamental Right?

Below I will briefly discuss criteria relevant both to determining whether there is a suspect or quasi-suspect classification and, very briefly, to whether there is a substantial intrusion. Given the central importance of determining the special or fundamental status of litigants' rights or interests, however, here I will consider at length how the Court determines whether there is a fundamental or quasi-fundamental right. This issue is crucial concerning the likely outcome of attacks on limitations imposed by various universal health care reforms. The most important issue in any constitutional attack on restrictions within a universal health care program is likely to be whether the plaintiff can establish either a fundamental or quasi-fundamental right.

There is substantial controversy over how fundamental rights are to be identified, and perhaps even greater controversy concerning quasi-fundamental rights. Presumably, quasi-fundamental rights are those that almost, but do not quite fully, meet the requirements for fundamental rights. As to the latter requirements, the Court's

\textsuperscript{110} Casey, supra note 109, at 878.
opinions support at least five sets of criteria or methods. These methods are not necessarily mutually exclusive, and some are arguably just more general or specific iterations of the others. Nevertheless, they at least represent different paths of emphasis the Court has followed or might follow in given situations. Before explaining these methods, I must recall my observations above that, when determining whether there is a fundamental or special right, the Court sometimes preliminarily (or perhaps simultaneously) engages in consideration of its limited expertise or traditional role in a category of cases or in a pre-balancing of the individual and governmental interests that are at issue.111 Given that reminder, I will turn to the five specific approaches the Court has used to divine fundamental rights. First, the Court has said that fundamental rights are those that are essential either to the survival of our society or the functioning of important institutions within it.112

Second, the Court's opinion in Washington v. Glucksberg113 speaks to the requirements for finding fundamental rights. They must be "precisely" or narrowly described, "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty" such that 'neither liberty nor justice would exist if they were sacrificed."114 None of the five methods mentioned here except this one has been suggested as the exclusive way to identify fundamental rights or interests. Yet, Glucksberg can be interpreted to require only that the precisely described right is either "deeply rooted in this Nation's history and tradition" or "implicit in the concept of liberty, such that neither liberty nor justice would exist if they were sacrificed," rather than both. Of course, many persons might argue that if a right is "implicit in the concept of liberty" it ipso facto must be deeply rooted in our traditions.

The full passage announcing the tradition and implicit in liberty criteria reads as follows: "[W]e have regularly observed that the Due Process Clause specifically protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition,' and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed'" (citations omitted).115 The "and" in the quoted language can be read as either conjunctive or disjunctive. Of course, even if in the alternative, the two criteria are especially demanding.

111 See infra text accompanying notes 226-236.
112 Spece, supra note 96, at 1059-73.
114 Regarding applications of this method see infra text accompanying notes 133-144.
115 Glucksberg, 521 U.S. at 720-21.
One of Chief Justice Rehnquist’s main purposes in his opinion for the majority in *Glucksberg* was to limit judicial activism and subjectivity. It seems, therefore, that he sought to both ground fundamental rights in tradition and limit them to rights thought to be necessarily connected to liberty and justice. So read, *Glucksberg* establishes perhaps the most stringent method for identifying fundamental rights.

A third method the Court has employed to determine the existence of fundamental rights is to determine whether they relate to intimate and important decisions about one’s life or relationships, rights often described as within the fundamental right to privacy. A fourth method is to ask, more narrowly, whether the right is essential to the very ability to formulate and express the intimate and important decisions about one’s life or relationships spoken about in the third method.

A fifth method is to determine whether the right shares characteristics—in numbers and weight previously found sufficient to identify a fundamental right—already found relevant, by the Court, lower courts, or commentators, to identification of fundamental rights. The relevant characteristics include those identified in the first four methods as well as (a) having a close nexus to other rights or interests previously found to be fundamental, (b) being specifically described in the text of the Constitution, (c) being previously or, better, repeatedly recognized in precedents, (d) being non-economic, (e) being important to the individual, (f) being a claim against paternalistic intervention, (g) being recognized as special or essential by other nations and peoples, and (h) being a claim against interference rather than an assertion of entitlement to government-supplied benefits.

Having explained the elements opponents of restrictions in universal health care plans would have to establish to make out prima facie claims and to justify invigorated

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117 Note, Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana, 118 HARV. L. REV. 1985, 1989 (2003) (finding right of access to medical marijuana in patients who prove it as their only effective treatment because denial of the same would impede the very process of self-definition, trenching on fundamental rights to life, dignity at the end of life, and avoidance of pain).


119 *Id.* at 1059-1073.
scrutiny as well as the various forms such scrutiny might take, I will turn to consideration of specific restrictions and how they would likely be analyzed.

C. Specific Constitutional Claims


Assume that the government adopts the universal plan I advocated above, one that covers a basic set of cost beneficial care, and only allows supplemental insurance covering care that is both efficacious and cost-effective. Posit further than the plan is beset with waiting lists that place persons at significant risks of morbidity or mortality. Would such a plan pass constitutional muster? The hypothetical is very similar to that faced in Chaoulli, with two differences. The similarities are, first, that the government generally does not impose any limitations on the direct purchase of care outside the universal plan's benefits package. This is realistic; I have not been able to find reports of any nation that prohibits both the purchase of "private" or "supplemental" insurance and direct purchase of such care. Second, the plan is beset with waiting lists, and this is a problem that has faced many universal health care plans. Third, as with any financially feasible plan, the universal plan's benefits package only covers certain goods and services. It excludes certain care, even though it might be cost beneficial, because it is not considered "basic" or "essential."

The differences between the plan posited here and that at issue in Chaoulli are, first, that all care within the universal package must be cost beneficial, i.e., its marginal benefits must exceed its marginal costs. Second, if the care falls outside the universal benefits package because it is not cost beneficial, one can purchase insurance for it only if it is both efficacious and cost effective.

The first difference is irrelevant from a constitutional standpoint because persons have no affirmative right to government supplied health care, and therefore can not complain if the government provides care but limits that care to that which is cost beneficial. The second difference is potentially important because persons might have a fundamental right to purchase insurance for efficacious care even if that care is not

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120 Flood, supra note 19, at 281.
121 See supra note 12.
The limitations in the situation posited in this subsection raise two categories of constitutional claims. Given the assumption of substantial wait lists, the first category concerns access to timely care necessary to avoid risks of morbidity or mortality. Second, because I have stipulated that, in certain circumstances, one is only allowed to purchase insurance for cost effective care, persons might sue, arguing that they should be allowed to choose among equally effective alternatives without regard to costs. After all, the doctrine of informed consent indicates that in the United States we allow persons to make their own choices about relative benefits and costs of care.\(^{123}\)

I argue that the first category of claims relating to care necessary to avoid risks of morbidity or mortality involves a fundamental right to purchase care that the government has released into general use by including it in the universal benefits package. The second category of claims, however, involves no such fundamental right, because the government has not authorized the care for general use, but has, instead, found that it is wasteful and against the public interest. If, following the three judge panel's capacious conception of the fundamental right to purchase care in *Abigail Alliance For Better Access To Developmental Drugs v. Von Eschenbach*,\(^{124}\) this second category of claims were found to involve a fundamental right, then the strict scrutiny that right would likely lead to would jeopardize a wide range of possible limitations within universal health care programs. I argue against the reasoning of *Abigail Alliance*, and extension of a fundamental right to purchase care to encompass non-efficacious or non-

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\(^{122}\) Before moving to the claims that might be brought against the limitations set forth in this subsection, I must point out that care can fail to be cost beneficial or cost effective both as a general matter as to all persons, to certain subsets of persons, or as applied in situations facing relatively few or, theoretically at least, only one individual. It is obvious that the implementation of the universal program I have recommended would benefit from ongoing research as to the benefits and costs of various care—a continuation or even escalation of the evidence based medicine movement. It would also require a set of rules or guidelines and an administrative mechanism to apply the cost beneficial and cost effective requirements. This apparatus might raise certain procedural due process questions such as rights to notice, hearings or other review, and appeal. It is beyond the scope of this article to examine these issues.

\(^{123}\) A similar set of claims would arise if the government were to limit the purchase of supplemental insurance for care not within the universal benefits package to care that is cost beneficial. Such claims might be stronger because then individuals could complain that they are not only being denied a choice between equally effective alternatives; they are not being allowed to purchase care that has some benefit just because the government doesn't believe the benefits justify the costs of the treatment. I will address this category of claim in a longer work.

cost-effective care, as a matter of doctrine and policy. I consider the two categories of claims in separate subsections immediately below.

a. Claims of a right to purchase timely care covered by the universal benefits program but not timely delivered there

Plaintiffs attacking this situation, one virtually identical to that in Chaoulli, likely could establish two prima facie claims: substantive due process and equal protection. Plaintiffs would establish their due process claim by demonstrating that (i) government action (mandating a system with waiting lists and a prohibition on supplemental insurance) (ii) substantially intruded upon (by creating a risk of morbidity and mortality) their (iii) right to “life, liberty, or property.” Plaintiffs would establish their equal protection claim by showing (i) government action (same as above) (ii) treated them less favorably than other similarly situated persons (those wealthy enough to pay directly for supplemental care), (iii) causing harm (threatened morbidity and mortality) the courts recognize as constitutionally significant (“harm in fact”).

It is likely that, for both claims, the plaintiffs would also be required to prove that they could not afford to purchase care directly but could and would have purchased supplemental insurance if the prohibition had not existed. They might also be required to prove either that they are currently in need of treatment that is not promptly available within the government mandated plan or that they have already been physically or mentally injured by a delay in care.

If there were relatively short delays in care, it is possible that the Court could find either that persons do not have a “life,” “liberty,” or “property” right in obtaining care so prompt that there is virtually no increased risk from any delay or that the intrusion of slight delay is insufficient to establish a prima facie case. Relying on the abortion funding cases, the Court could buttress this conclusion by observing that persons still have a (theoretical) right to directly purchase care, the government not being responsible for any particular person’s inability to afford such care.

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125 The patient in Chaoulli might have had a hard time establishing such facts because he was sixty-five years of age and had pre-existing hip and heart conditions that would deter insurers from covering him, at least at less than an astronomical premium. Flood, supra note 19, at 309-310.

126 The appellants in Chaoulli were not required to make such individual showings because they were allowed to sue as representatives of the public. [2005] 1 S.C.R. 791 at ¶ 35.

127 See infra notes 130-131, 161.
If the Court found a sufficient intrusion on a protected interest to establish a prima facie due process or equal protection claim, there would still be a question regarding the requested remedy. The plaintiffs might simply request that the government supply timely care because it would be too late to wait for supplemental insurance to hit the market subsequent to any ruling that the prohibition on such insurance is unconstitutional. However, this would bring into play the strong presumption against affirmative or welfare claims. There is a slight possibility that the Court might nevertheless uphold a claim to timely care if the plaintiff could show that the prohibition on private insurance has vitiated any reasonable chance of such insurance becoming available in the reasonably foreseeable future after the striking of the prohibition. In that event, the Court might order the government to supply the plaintiff with prompt care. It might, however, apply the rational basis test and reason that there is nevertheless a legitimate government interest in preserving scarce health care resources by rationing through waiting lists. This was the position of the dissenters in *Chaoulli* who, unlike the majority, applied what seems to be Canada’s counterpart to our rational basis test.¹²⁸

There is also a possibility that the Court would stretch to find a “life, liberty, or property” right to extremely prompt care, reject a substantive due process argument insofar as it would require that care be given at government expense, but then, under substantive and/or procedural due process, impose some substantive rules and/or procedural mechanisms controlling how the risk of delay should be equitably distributed. For example, it might require that patients who reach the threshold of some specified risk of morbidity or mortality be jumped to the front of any waiting lists, and that there be a rudimentary review procedure to challenge a physician’s or official’s determination concerning application of the threshold rule.

Still more, there is the possibility that the Court might reason that the government could not be held responsible for private insurers’ lingering fear, created by a subsequently struck prohibition on supplemental insurance, of what they perceive to be a hostile regulatory milieu and simply order that the plaintiff be allowed to purchase supplemental insurance should it ever become available.

Considering all these possibilities, as in *Chaoulli*,¹²⁹ it would seem best for the


¹²⁹ Although one of the appellants in *Chaoulli* was a patient alleging questionable injury from the waiting lists, Chaoulli himself was a physician who wished to be able to provide supplemental care. Both appellants sought abrogation of the prohibition on supplemental insurance, and they
class of individuals facing waiting lists and a prohibition on supplemental insurance to initially argue that the prohibition on supplemental insurance should be struck. Then the plaintiffs would simply be asking for the freedom to purchase access to care rather than to have the government provide timely care to them or grant them some substantive or procedural protection in the distribution of risk from the waiting lists.

In any event, in this context an equal protection claim would be easier to establish than a substantive due process claim. First, the claimants would not have to establish a "life," "liberty," or "property" right; they could rely on harm in fact to their interest in avoiding injury or death. It is arguably easier to establish harm in fact than it is to establish the "life, liberty, or property" right or degree of deprivation necessary to support a substantive due process claim. Furthermore, here the government would likely be less successful by pointing to the theoretical possibility of directly purchasing care. In fact, the equal protection claim would be founded on the disparate treatment between the less wealthy who need to purchase supplemental insurance to obtain timely care but are not allowed to do so and the more wealthy who can afford to directly purchase timely care and are allowed to do so.

If a prima facie or threshold substantive due process or equal protection claim were recognized, it would be defeated if the rational basis test were applied. Here the government could assert an imaginable legitimate interest in preventing damage to its plan that conceivably could be caused by diversion of scarce medical resources to supplemental care. Moreover, if even called on to justify the difference in treatment between those able to directly purchase supplemental care and those only able to access supplemental care through insurance, the government could prevail by arguing that the

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130. Harris v. McRae, 448 U.S. 297 (1980), illustrates the difference in equal protection and due process requirements. There the Court recognized a prima facie equal protection claim by applying the rational basis test to Medicaid's provision of child-birth related care and concomitant refusal to fund therapeutic and non-therapeutic abortions (other than those necessary to save the woman's life or for pregnancies resulting from promptly reported rape or incest). The Court found that the government's action was "rationally related to the legitimate governmental objective of protecting potential life." \textit{Id.} at 324. However, no doubt relying on the strong presumption against affirmative governmental duties to provide even the necessities of life, the Court refused to find a prima facie due process claim because there was no intrusion on a life, liberty, or property right.

131. The extreme deference entailed in the rational basis test is evidenced in Harris v. McRae, \textit{supra} note 130. \textit{See also} Maher v. Roe, 432 U.S. 464 (1977) (upholding Connecticut's decision to cover childbirth and therapeutic abortions but not nontherapeutic abortions).
former group is presumably so small as not to threaten any significant diversion of resources. Furthermore, policing a prohibition against direct purchase of care might be very costly and involve Draconian measures, while policing the insurance markets might be easier and less costly. For example, policing whether physicians were dispensing efficacious but not cost effective care while also providing care within a universal benefits package might require visits to their offices. Policing whether insurance policies were written to cover efficacious but not cost effective care could simply require review of policies written by insurers.

i. Would the Court find a (quasi-) suspect classification?

The Court has refused to find wealth classifications suspect, but it has struck certain government actions in part because they strongly impact poor persons. It is beyond the scope of this article to fully analyze these cases, but they seem to require both a wealth classification and a severe impact on a special right or interest. In other words, they do not apply invigorated scrutiny based merely on the existence of a quasi-suspect classification, but on the simultaneous presence of a quasi-suspect classification and a quasi-fundamental right or interest. They are similar to Pyfer v. Doe discussed above, although there the undeserved undocumented status of children rather than indigence per se was the quasi-suspect classification. A similar form of reasoning could apply to a government program that allowed persons to directly purchase supplemental care, but not supplemental insurance for care, not timely available in a government mandated program. Such a program would favor those wealthy enough to directly purchase supplemental care over those who could only afford supplemental insurance.

This wealth classification could be deemed quasi-suspect and the right to purchase insurance for care might be characterized as a quasi-fundamental interest. Even if the Court were not willing to attach any suspicion to the wealth classification, it might apply some form of invigorated scrutiny based solely on a quasi-fundamental interest to purchase insurance for care. (See section ii. immediately below regarding (quasi-) fundamental rights and interests.) This is to be distinguished from a claim by those too poor to buy care or insurance that they are denied a fundamental interest in access to care. In the latter scenario, the Court would find no (fundamental) right or interest because the individual would be asserting that the government should pay for the care—just another way of arguing that it should not allow waiting lists in the

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132 Some of these cases are discussed in James Blumstein, Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health, 40 LAW & CONTEMP. PROBS. 231, 258-262 (Autumn 1976).
government mandated program.

ii. Would the Court find a (quasi-) fundamental right or interest?

There is nothing particularly salient or strong in the government’s interest in rationing care through wait lists, either considered alone or weighed against persons’ interests in care needed to avoid significant risks of morbidity or mortality. Moreover, there is no reason to believe that the Court does not have the competence or role of deciding whether the government should either promptly deliver care it has determined to be cost-beneficial and included in its universal benefits program or allow persons to access that care outside the government’s program.

One might suggest, to the contrary, that the government has a salient and strong interest in assuring universal access to a basic level of health care by rationing through waiting lists. I disagree because, first, the government is not likely to have the temerity to admit when it creates a universal health care system that it is doing so with waiting lists in mind that will serve the function of rationing care. An interest in rationing through waiting lists is not only not salient but unlikely to be embraced by the government, even as a post hoc rationalization. Moreover, creating a universal health care plan with rationing through waiting lists but hiding this intent is a sham and an illegitimate means to achieve the goal of making a universal health care plan politically or economically feasible. The Supreme Court has indicated that means as well as ends of government can be illegitimate and thus fatal to legislation.\textsuperscript{133}

As to specific methods to discern fundamental rights, \textit{Glucksberg}, as indicated above, establishes a particularly stringent one. Yet, the freedom to purchase insurance needed for timely access to cost beneficial care within a universal plan’s benefits package but not timely delivered within the plan seems to qualify as fundamental even under this demanding method. At the least, it should qualify as quasi-fundamental, assuming that the government has allowed the care to enter commerce and become available to all residents by placing it on the menu in its universal program.

Recall that one of the \textit{Glucksberg} requirements is that the right be precisely or narrowly defined.\textsuperscript{134} The precise right here is the right to purchase supplemental insurance covering care that the government has conceded is cost beneficial and has allowed into general use. Concerning the other two \textit{Glucksberg} requirements ("tradition"

\textsuperscript{132} See supra text accompanying note 114.
and "necessary aspects of liberty and justice"), the Court articulated its method while also observing that it had previously "assumed and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."\textsuperscript{135} In other words, the right to refuse treatment met its stringent criteria for fundamental rights.

\textit{Glucksberg} relied upon \textit{Cruzan v. Director, Missouri Dept of Health},\textsuperscript{136} where the Court had reasoned:

Before the turn of the century, this Court observed that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person." This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." \textit{Schloendorff v. Society of New York Hospital}, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent. ... (citations omitted).\textsuperscript{137}

In \textit{Cruzan} the Court stated that the right to refuse treatment is merely a corollary to the informed consent doctrine. \textit{Glucksberg} nevertheless reaffirmed this right to refuse treatment as a right that met its stringent criteria for "fundamental" rights. \textit{Glucksberg} actually understates the force of \textit{Cruzan} on the right to refuse treatment issue because it characterizes \textit{Cruzan} as making an assumption regarding the existence of a right to refuse treatment. \textit{Cruzan} in fact held that there is a fundamental right to refuse treatment. Nevertheless, the Court held that this right was counterbalanced by Nancy Cruzan's right to life as well as strong interests in protecting her and other incompetent patients' best interests and possible preferences.

\textsuperscript{135} The \textit{Glucksberg} Court's reference to an assumption in \textit{Cruzan} is incorrect. \textit{Cruzan}'s observations regarding the right to refuse treatment constitute a holding.

\textsuperscript{136} 497 U.S. 261 (1990).

\textsuperscript{137} Id. at 269-70.
One thus must carefully analyze *Glucksberg* and *Cruzan* to appreciate their implications for the right to purchase insurance to obtain cost beneficial care. First, the right to refuse treatment is not merely a corollary of the informed consent doctrine, as *Glucksberg* suggests. Rather, it is a constituent part of that doctrine. Moreover, informed consent is not the core right honored in *Cruzan*, and then in *Glucksberg*, as being sacred and deeply entrenched in the common law. Rather, the core rights directly spoken to in *Cruzan* were the rights to bodily integrity and to self determination regarding one’s bodily integrity.

Furthermore, the history, theory, and actual practice of informed consent establish that the right to self determination in choosing to receive particular care thought beneficial to one’s bodily integrity is at least as important as, and arguably more important than, the right to refuse treatment. As to history, the early manifestations of the practice, going back to the 19th Century, evidence a willingness to require disclosures for the purpose of getting the patient to go along with, or benefit from, treatment proposed by the physician; the point was facilitating care not rejecting it.  

As to theory, the early domination and continued preponderant influence of the physician-oriented perspective, rather than a patient need-to-know approach, regarding disclosure requirements show a deference toward physicians’ desires to have their patients accept what they recommend. The same is true as to the therapeutic privilege physicians have to withhold disclosures if they establish that such disclosures would be detrimental to their patients. Similarly, the overwhelming acceptance of an objective (plaintiff must show that a reasonable patient would have refused care if full disclosure had been made) rather than a subjective (plaintiff need only show she would have refused) standard of causation distinctly favors receipt, rather than rejection, of treatment. The same bias in favor of treatment over refusal is manifested in the emergence of negligence, and its requirement of actual damages, over battery, and its right to at least nominal dignitary damages, as the primary informed consent theory. Finally, the application of informed consent to the informed refusal context manifests a concern that patients not mistakenly refuse treatment.

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139 MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 206, n. 8 (Mark Hall et al. eds. 2005).
140 Id. at 222, n. 2.
141 Id. at 218, n. 3.
142 Id. at 217, n. 7.
Concerning the actual clinical practice, physicians’ concerns include that disclosure requirements will scare patients into refusing needed treatment, make patients ill at ease and therefore at greater risk, consume time with no results other than confusing patients, and lead to litigation. Physicians therefore commonly fall short of what legal theory requires. Clinical practice favors facilitating receipt, not rejection, of care.

Consideration of the history, theory, and practice of informed consent shows that one of its central concerns is to enable patients to choose treatment in consultation with their physicians, not just to enable them to refuse treatment. This right to choose is essential to, and a constituent part of, controlling one’s bodily integrity and exercising one’s self determination. These latter rights are both deeply embedded elements of our common law traditions and sacred or necessary aspects of liberty. It logically follows that there must be a right to purchase insurance for care when it is the only way one can timely access the care that is allowed to be dispensed by her physician. The right to purchase insurance for such care therefore meets the Court’s demanding approach to identification of fundamental rights articulated in Glucksberg. The argument would be particularly strong when life-saving care is at issue. Then “liberty” and “life” would be directly threatened.

Other methods of deriving fundamental rights likewise indicate that there is a fundamental right to purchase insurance covering care the government has allowed into general use, though this outcome is perhaps less clear under the first of these methods. Under method one—identifying rights “essential to the survival of our society or the functioning of important institutions within it”—the freedom to purchase insurance for care likely might not be found fundamental. The “institutions” referred to in the quoted language might just be constitutionally mandated structural institutions such as representative democracy and federalism.

Nevertheless, it is conceivable the Court would recognize the physician-patient relationship to be an institution with sufficient tradition and weight to qualify within

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143 Faden & Beauchamp, supra note 138, at 138-139. I am not endorsing physician pressure tactics, but simply explaining that our traditions—coexisting with the full range of autonomy and informed consent considerations—include an opt-for-treatment approach.
144 Id. at 203-204, n. 2.
“the essential to survival of important institutions” formulation. Further, the right of the patient to choose care is arguably necessary to survival of the physician-patient relationship. In the early abortion cases the Court made much of the right of women to choose “in consultation with their physician.”\textsuperscript{146} This reasoning has been debunked insofar as it might serve as a source for physicians’ rights,\textsuperscript{147} but it makes sense as a source of patients’ rights. The argument is that the patient isn’t just expressing emotional preferences, but is instead making choices among reasonable alternatives described by her physician. Moreover, even if not sufficient to justify strict scrutiny, the existence of the physician-patient relationship might, alone or with other factors, justify a finding of a quasi-fundamental right and application of intermediate scrutiny.

Moving to method three, which characterizes as fundamental rights to make intimate and important decisions about one’s life or relationships, it is hard to imagine more intimate and important decisions than ones relating to health care. The right to determine one’s health care also would seem to qualify as fundamental even under the narrower criterion of method four, which finds fundamental only those interests that directly impact on one’s very ability to formulate and make intimate and important decisions.

Finally, the right to make decisions about one’s health care, including the right to purchase supplemental insurance if that is the only way to implement such decisions, is fundamental under method five’s approach of considering all the criteria within the first four methods as well as several other criteria the Court and commentators have considered relevant to determining whether rights are fundamental. All the factors discussed as to each of the first four methods can be interpreted to point toward fundamental right status for the right to purchase health care. Arguably, each of methods two, three, and four alone is sufficient for such status.

Concerning the other factors relevant within method five, the right to purchase cost beneficial care (1) has a close nexus to previously recognized fundamental or special rights to choose abortion,\textsuperscript{148} control one’s reproduction apart from abortion,\textsuperscript{149} 

\textsuperscript{147} LAURENCE TRIBE, AMERICAN CONSTITUTIONAL LAW §15-10 at 1352-1353 (2d ed. 1988).
refuse psychotropic medication, and refuse treatment generally; (2) is arguably within the core meaning of the Due Process Clause's reference to "liberty" because it rests on bodily integrity and self determination, which are among the interests liberty most obviously includes; (3) has not been adjudicated previously; (4) is obviously non-economic even though it involves "purchase;" (5) is important to the individual; and (6) is a claim against interference rather than an assertion of entitlement to government-supplied benefits. There is arguably no previously recognized non-enumerated fundamental right that has so many methods of analysis and criteria pointing to its special status than does the right to purchase insurance necessary to gain timely access to cost beneficial care.

In summary, the right to purchase insurance necessary to gain timely access to cost beneficial care is arguably fundamental under each of the various methods of deriving fundamental rights discussed above, and it is highly likely that our Court would find it to be either fundamental or quasi-fundamental.

iii. Would the Court find a sufficient deprivation or intrusion to justify strict/heightened scrutiny?

The Court might find a sufficient intrusion on a fundamental right to make out a prima facie case, but nevertheless only apply rational basis scrutiny because the intrusion is not severe enough. It is therefore necessary to ask whether prohibitions on purchases of health insurance accompanied by waiting lists would be considered substantial enough to trigger strict scrutiny. It is beyond the scope of this article to examine either the literature concerning waiting times or the authorities that examine what constitutes an intrusion sufficient to trigger strict scrutiny. I will point out that the Court has made clear that regulations short of prohibitions can be sufficient to trigger strict scrutiny, and that the Court is sensitive to threats to persons' health and lives. None of the Justices in Chaoulli found only an economic right to be implicated. The mere fact that a purchase is involved can not negate the existence of a fundamental right. There is obviously a difference between disallowing the purchase of an important commodity or service that the government allows into general use or interstate commerce, on the one hand, and completely barring it or only allowing limited or experimental use of it, on the other hand. See text accompanying notes 176-235 regarding the importance of this distinction.

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mortality from prohibitions on supplemental insurance when the government does not provide timely care suggest that it is highly likely that our Court would find similar intrusions resulting from a universal health care program here to be more than sufficient to justify strict scrutiny. An important question for further development is whether regulations, rather than prohibitions, with similar or less potent effects should be considered sufficient to demand strict scrutiny.\(^{155}\)

Given the likelihood that the Court would find a substantial intrusion on a fundamental right, I will consider the application of strict scrutiny to a prohibition on purchase of supplemental insurance for care that is covered by a universal plan but not timely delivered within it. Anticipating the possibility that the Court might nevertheless refuse to find a fundamental right, but instead only a quasi-fundamental right and/or a quasi-suspect classification, I will also indicate how invocation of intermediate scrutiny of one form or another might make a difference at the various stages of analysis—more specifically, determining what government interests will even be considered, how weighty those interests must be, what means-ends connections will be required, and the role of less restrictive or more narrowly or precisely tailored alternatives.

### in. Strict or intermediate scrutiny applied

(a) What would the Court find to be the government’s actual interests?

The Court has indicated that it will probe the government’s actual interests under strict scrutiny—not just those offered \textit{post hoc} by counsel or others. The only intermediate test used in substantive due process or equal protection adjudication that explicitly incorporates this form of scrutiny is the test applied in gender discrimination cases.\(^{156}\) It is important to identify the government’s actual interests, because if any of those interests is both illegitimate—i.e., prohibited by the Constitution—and a factor that contributed to the challenged government action, that action will be judged unconstitutional.\(^{157}\)

\(^{155}\) The Court might also apply a “penalty” analysis, relying on an analogy to the cases that invoke equal protection to strike down waiting times for access to basic benefits in the right to travel context. See Shapiro v. Thompson, 394 U.S. 618 (1969) (striking one year residency requirement for welfare eligibility); Mem’l Hosp. v. Maricopa County, 415 U.S. 250 (1974) (striking one year residency requirement for access to medical welfare).

\(^{156}\) See \textit{supra} text accompanying notes 100-110.

Government interests advanced in Chaoulli and that are likely to be at issue in a similar case before our Court include (1) assuring political support for the government mandated system by persons who would otherwise simply obtain supplemental care; (2) encouraging political pressure for improvement of the government system by persons who would simply access supplemental care if they had that option; (3) promoting equality in access to health care; (4) preventing diversion of scarce resources from the most important endeavor of providing a basic package of care for everybody; (5) containing overall health care expenditures; (6) preventing physicians from becoming more financially-oriented and thus supposedly less professional; (7) preventing burdening the public program with only the toughest cases; and (8) preventing physicians from purposely exacerbating waiting lists to increase the pool of private patients they might be able to treat.\textsuperscript{158}

One factor to consider concerning all but the last of the eight governmental interests listed above is that any United States mandated health care plan likely to be adopted would, like Canada, leave room for a very significant supplemental health care system covering items outside the universal benefits package. For example, in Canada there is a robust privately funded health care system that, depending on the province, provides drugs, institutional care outside hospitals, care by non-physician providers, and other care not covered by the government program. Allowance of such a supplemental health care system seems to indicate that there is less than total devotion to any of the first seven listed goals. This might not be sufficient to convince the Court that the goals are not the government's actual reasons for its actions. For example, the government might argue that although it can tolerate a significant amount of privately-funded or supplemental care, its goals would be undercut by the even more significant amount of supplemental care that would be added by allowing supplemental health care insurance for even that broad array of care already covered within the government system. The "inconsistency" of allowing certain private care but not such care if it is both covered within the government mandated program and funded by supplemental insurance might not be enough for the Court to reject the government's proffered reasons for its actions as pretexts. Even so, the inconsistency might influence the Court's application of the other aspects of strict or intermediate scrutiny addressed below.

(b) Would the Court find the government's interests legitimate and substantial, and important or compelling?

\textsuperscript{158} See supra text accompanying notes 86-92.
All forms of scrutiny require at least a legitimate state interest, while strict scrutiny requires a compelling interest. The intermediate test for gender discrimination cases requires an important interest, while other intermediate tests described above speak about balancing the individual and government interests or requiring a "substantial" state interest. I will focus on the legitimate and compelling requirements below, but I will offer some speculations concerning possible application of the other requirements concerning the nature or weight of the government's interest.

(i) Legitimate?

Encouraging political support for the government system and inducing political pressure for improvements in it sound innocuous. However, these goals might actually be illegitimate. They can be characterized as intentions to manipulate persons to support, advocate, or vote for either the existing government mandated plan or improvements in it. The manipulation would be preventing persons from seeking supplemental care and from then determining, through further exercise of their free choice, whether to believe in, vote, or advocate for improvements in the government mandated system. This commandeering conceivably could be found to interfere with constitutional freedoms to think, speak, refuse to speak, or vote.\textsuperscript{159}

On the other hand, the Court might determine that the disputed goals represent legitimate government interests in channeling public attitudes toward favoring government mandated health care programs that will help all persons, especially those who are too poor to buy care or supplemental insurance.\textsuperscript{160} The Court has reasoned in the abortion funding cases that the government can structure health care programs in a way to encourage childbirth over abortion to further a legitimate interest in supporting

\textsuperscript{159} Regarding the right to control one's own thoughts, \textit{see}, e.g., \textit{Stanley v. Ga.}, 394 U.S. 557 (1969). Regarding the right to speak \textit{see}, e.g., \textit{Brandenburg v. Ohio}, 395 U.S. 444, 447 (1069) (KKK leader's advocacy of political reform through violence protected by the First Amendment because it was neither directed to inciting nor likely to incite persons to imminent lawless action); \textit{Conant v. Walters}, 309 F.3d 629, 637-638 (9th Cir. 2002), cert den. 540 U.S. 946 (2003)(physicians' freedom to speak to patients about medical marijuana). Regarding the right not to speak \textit{see}, e.g., \textit{Wooley v. Maynard}, 430 U.S. 705 (1977) (persons had right to cover motto "live free or die" on vehicle license plates if it was repugnant to their moral or religious beliefs); \textit{W.Va State Bd. of Educ. v. Barnette}, 319 U.S. 624, (1943) (children could not be required to participate in flag salute). Regarding the right to vote, \textit{see}, e.g., \textit{Kramer v. Union Free} (1966); \textit{JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW} § 14.31 (7th ed. 2004).

\textsuperscript{160} This could be analogized to the encouragement of support for childbirth over abortion characterized as a legitimate interest in \textit{Harris v. McRae}, 448 U.S. 297 (1980). \textit{See supra} note 130.
the sanctity of life. In *Rust v. Sullivan* it also allowed the government great leeway in directly controlling what physicians can say about reproductive options within government funded health care programs. It might be found, however, that indirect but intentional channeling of persons’ attitudes, beliefs, behavior, and voting are more objectionable than explicit programs. The former are insidious and commensurately insulated from attack. The latter are visible and welcome challenge.

The two dissenting Justices in *Chaoulli* emphasized promotion of equality of access to health care as a strong government interest. Two aspects of this government interest, however, might be considered objectionable. First, if the government prohibits only supplemental insurance for care covered by the government mandated program, the equality sought is tainted by the arguably contradictory willingness both to allow those rich enough to do so to directly purchase supplemental care covered by the government mandated program and to allow everybody to purchase supplemental care, or insurance for care, not covered by the government mandated program. This contradiction suggests that the government’s actual goal is not an admirable version of equality but a particular form of equality bound up with the above-described and possibly illegitimate governmental attempt to commandeer support, advocacy, and votes for the reigning administration’s specific beliefs about how health care should be financed and delivered.

At the least, the equality sought through the limited prohibition on supplemental insurance for plan covered care might be outweighed by the inequality created because those who can afford health insurance for care covered by the government mandated program are not treated as favorably as either of two other classes: those who are able to directly purchase care covered by the government mandated program or those who are allowed to purchase supplemental health insurance for care not covered by the government mandated program. The discrimination in favor of those who are allowed to purchase supplemental health insurance for care not covered by the government mandated program might be particularly objectionable because the care not covered by the government program is, by definition, not essential or basic care.

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Second, one understanding of the equality sought is that it concerns simply the dignitary harm or frustration poorer residents experience when they learn that the “rich” who can directly purchase supplemental care, or also many “ordinary” persons who can access private health care through supplemental insurance, have greater access to care. In other words, this understanding of equality does not tie it to improving the care given to those who cannot afford to purchase supplemental care or insurance, and, when the government has prohibited only supplemental insurance for care covered by the public program, it represents only an increase in an inequality that the government already tolerates. Such intangible harm can arguably be classified along with moral arguments advanced in support of laws against, say, victimless crimes.

For example, frustration because of knowledge that another person might have greater access to health care, although certainly more justifiable, is arguably in the same category as frustration some persons feel from knowing that gay couples have relationships. These frustrated persons might secure laws against gay relationships based on their moral beliefs. The Court’s recent decision in *Lawrence v. Texas*\(^\text{164}\) can be read to make such abstract moral beliefs, regardless how widely accepted, illegitimate bases for government action. On the other hand, the frustration of the poor might be distinguished from that of homophobes by arguing that it is entangled with palpable physical or psychological suffering endured because of lack of access to certain care. Moreover, the equality sought might be argued not to be an abstract ideal or feeling of angst that might be associated with its denial, but, rather, the physical harm, and even death, that could befall masses of unidentified poor people if at least the amount of inequality targeted by the government is not stamped out.

An answer to the last argument in favor of the form of equality advanced by advocates of a system such as Quebec’s is that concrete harm to the government program in the form of siphoning political support or scarce medical resources from it is a separate government interest that should be analyzed on its own merits rather than conflated with the moral or symbolic aspects of equality. Such conflation should not shield factual claims about loss of political support or sufficient medical resources for the government program from empirical scrutiny. Preventing harm to the government program wrought by resource shortages, for example, obviously protects those who can only receive care within the program, and it is certainly a legitimate state interest. However, it might not hold up under scrutiny that requires more than just a conceivable legitimate government interest.

\(^{164}\) 539 U.S. 558 (2003).
The other possible actual government interests identified above—limiting overall health care expenditures (presumably, overall costs represent demand that generates higher costs for keeping the public program running); preventing physicians from manipulating waiting lists; preventing doctors from becoming less professional; and avoiding saddling the government program with a disproportionate number of tough cases—seem legitimate. This would be true even if the goals of preventing resource shortages within the government mandated system and limiting overall health care expenditures were less than fully pursued because of toleration of a significant supplemental health care system for care not covered within the government program.

(ii) Compelling, important, substantial, or sufficiently weighty?

Although establishing fundamental rights is an elusive endeavor, there is even more ambiguity in identifying compelling state interests. The Court has characterized certain interests as compelling (e.g., survival of the nation) or not compelling (e.g., fiscal concerns and administrative convenience). It is also clear that compelling interests must lie toward the top of a hierarchy of interests. Beyond this, the Court has not offered any methods for identifying compelling interests. A good place to start, however, is to posit that, at least, governmental interests in preserving fundamental rights are compelling. As to important, substantial, or government interests sufficient to outweigh the costs to individual rights or interests, all I will say here is that it would

165 Schneider v. N.J., 308 U.S. 147, 162-63 (1939) (burden of cleaning and caring for streets—obviously a fiscal concern—not sufficient to justify ban on leafleting, an activity within the fundamental right to freedom of speech); Carrington v. Rash, 380 U.S. 89, 94 (1965) (states may not casually deprive a class of individuals of the right to vote because of some remote administrative benefit to the State); Korematsu v. U.S., 323 U.S. 214, 216-221 (1944), reh'g den. 324 U.S. 885 (1945) (internment of Japanese-Americans, including U.S. citizens, in World War II upheld as necessary to our defense against sabotage and invasion). But see JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW § 6.11, n.5 ("Korematsu should not be considered good law as to its specific result").

166 Wisc. v. Yoder, 406 U.S. 205, 215 (1972) ("The essence of all that has been said and written on the subject is that only those interests of the highest order ... can overbalance legitimate claims to free exercise of religion"); Swanner v. Anchorage Equal Rights Comm'n, 513 U.S. 979, 982 (1994) (Thomas, J., dissenting) (preventing discrimination on the basis of marital status not compelling because not "of the highest order").

167 Grutter v. Bollinger, 539 U.S. 306, 324-328 (2003) (academic freedom concerning educational diversity a compelling state interest justifying law school's affirmative action program in which race was taken into account along with other factors); Roberts v. Jaycees, 468 U.S. 609, 628 (1984) (preventing gender discrimination was compelling interest justifying limitation on fundamental right of freedom of association).
presumably be easier to meet any one of these requirements than it would be to meet the requirement of showing a compelling state interest.

A particular ambiguity exists concerning whether identifying compelling interests requires a comparison with the competing fundamental right involved in each case, and, if so, whether one is to compare the competing values in the abstract or in light of how much of each is at stake. I assume that, to be classified as compelling, a government interest must be at a position in a hierarchy of values roughly equivalent to the position of the competing fundamental right. In other words, both fundamental rights and compelling government interests are in the top tier of a hierarchy of values. I also assume that the amount of the government interest is considered at the stage of determining whether it has been substantially advanced, and that, for a substantial advancement to be found, the amount of the government interest at stake must be enough to allow the gain to the government to outweigh the loss involved considering the nature and amount of the fundamental right at stake.  

Given the above thoughts concerning discernment of compelling state interests, I return to consideration of the specific government interests in equality and in commandeering persons into believing in, advocating, and voting for the government mandated plan discussed above. Even if these interests are not illegitimate, they should not qualify as compelling. Toleration of a significant supplemental sector for care not covered within the public program would be especially likely to prevent a finding that equality and indirect protection of the government mandated program are compelling rationales.

But what about the other rationales for the government's actions? First, consider preventing a shortage of resources in the government mandated plan. Such shortages might jeopardize what was argued above to be a fundamental right to select one's health care from the menu of care released by the government for general use. Therefore, this rationale might qualify as compelling. On the other hand, a willingness to tolerate a significant supplemental health care sector for care not within the universal plan's benefits package in any event might prevent a finding that preventing shortages is a compelling goal.

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168 This incorporates balancing into the means-ends analysis prong of strict scrutiny, but this is not the equivalent of generalized balancing, i.e., a single balance that alone defines the standard of review. For example, in order to be considered relevant, government interests have to be actual, and to be characterized as compelling they have to lie toward the top of a metaphorical hierarchy of interests or values.
Next, consider the argument that allowing supplemental insurance would lead to an increase in overall health expenditures. This seems to be a fiscal concern, and one of the few points the Court has clarified is that fiscal concerns are not compelling.\textsuperscript{169} On the other hand, one might successfully argue that more than money is involved because an overall increase in health care expenditures could drive up the price of health care the government wishes to purchase for the poor. Once again, however, this argument might be undercut by the willingness to allow a significant supplemental health care sector for care not covered by the universal benefits package. It is also vulnerable to the argument that the general concern with health care expenditures extends to the private choices of a large segment of the population. Why should the government be able to discourage persons from purchasing health care rather than, say, pet food?

Another rationale is that physicians might manipulate waiting lists to direct patients into the supplemental sector. This targets a form of fraud that might put patients at risk by forcing them to wait longer for needed treatment. It strikes at the very right to determine one’s health care that I have argued to be fundamental, and it would therefore seem to be compelling.

The discussion in \textit{Chaoulli} concerning prevention of physician deprofessionalization and of loading the government mandated system with tough cases is hard to analyze. The idea seems to be that “for-profit” medicine in competition with a sector that serves all persons breeds a callous attitude that makes it less likely that a physician will be other- or patient-regarding rather than self-regarding. Although this interest seems legitimate, it is sufficiently weak to keep it from qualifying for any status beyond being simply legitimate. The notion of loading the government system with tough cases is weak because we are dealing with the assumption that those who seek care outside the government system will still pay taxes and subsidize the government program. This would seem to take a burden off the government program. The idea might be that physicians will be deterred from working within the universal plan because of a desire to encounter a range of cases rather than just difficult cases. Alternatively, physicians working within the universal plan might become frustrated and ineffective because of their difficult patient load. The interest in avoiding loading the universal benefits providers with difficult cases seems legitimate, but nothing beyond that.

\textsuperscript{169} See supra note 165 and accompanying text.
Would the Court find a substantial, actual, reasonable, or sufficient means-ends connection? 170

The compelling state interest and gender discrimination intermediate tests require a "substantial" means-ends connection, while the other forms of invigorated scrutiny mentioned above refer to or imply that the connection must be "actual," "reasonable," or sufficient to make the amount of government interest at stake weightier than the individual interests. All these terms—substantial, actual, reasonable, or sufficient—are ambiguous. Arguably, the only way to cabin "substantial" and prevent it from being a concept within the absolute discretion of judges to define case-by-case is to interpret it to mean sufficient to make the amount of government interest at stake weightier than, equal to, or some specified portion of the individual interests at issue. Nevertheless, "substantial" might just mean a connection of a degree, indicated by a line of precedents, to be sufficient to justify the government's action insofar as means-ends analysis is concerned. The "actual" requirement might just mean that there must be proof that it is more likely than not that at least some positive amount of the government's interest is advanced by its action. "Reasonable" might be construed to be something akin to, but a little less than, "substantial." Such an interpretation could be based on the rationale that if the compelling state interest test and the fairly stringent intermediate test of the gender discrimination cases require a "substantial" connection, less stringent tests should require something less than a "substantial" connection.

I obviously cannot resolve the meaning of these various terms here. I can nevertheless examine how the possible meanings of the terms suggested here might apply to the various governmental interests at issue. Consider first equality in the form of preventing dignitary and emotional harms to those too poor to purchase supplemental care or insurance. There likely would be many thousands of persons who could not purchase supplemental health care or insurance and many of those persons could be expected to suffer by becoming aware that many persons do purchase supplemental health care or insurance. Therefore, there would seem to be at least an "actual" (some positive number) means-ends connection if even some of this suffering were prevented by prohibiting the inequality. Examination of precedents involving findings of "substantial" means-ends connections might suggest that here the "substantial" requirement might be met. If so, it would be even more likely that the "reasonable" connection requirement would be met, given that it seems to connote something short of "substantial."

170 See supra text accompanying notes 98-110.
However, in a regime that allowed direct purchase of supplemental care but not purchase of supplemental insurance, the frustration of the poor would have to be considered in light of “middle class” persons who would be barred from purchasing supplemental health insurance for care covered by the government program. The latter could feel discriminated against because of other persons’ ability to purchase either care supplemental to that ostensibly, but not timely, available within the government program or supplemental insurance for care not covered by the government program. An advocate for the prohibition on supplemental insurance for care covered within the government program might argue that the much greater frustration would be felt among the poor, but this amounts to doing a relative cost-benefit analysis concerning two forms of loss of equality. The very process of doing such a cost benefit analysis might threaten equality. Equality arguably is not substantially advanced, and possibly attenuated, by such a contradictory, utilitarian posture toward it. Finally, the poor might feel discriminated against even if there are prohibitions on purchase of supplemental care, or insurance for care, covered by the government mandated program. This is because it is assumed here that there would be a private health care sector that provides care not covered by the universal benefits package, i.e., people will be able to directly purchase care not within the government’s universal plan.

Moreover, as pointed out above, the government’s assertion of an equality rationale might be a pretext, the government’s actual purpose being to commandeer persons into supporting, advocating or voting for the universal program the government has created and desires to perpetuate regardless of citizen’s preferences. This possibility seems to dilute the strength of the equality claim, as does the fact that persons who want to purchase supplemental care or insurance for care covered by the public program are treated differently from persons who want to purchase either: (1) almost any other item imaginable, especially non-medical goods or services that might enhance health or wellbeing, or (2) insurance for care not covered by the universal benefits package. The prohibition on purchasing supplemental insurance for plan-covered care might, moreover, spur either resentment or a backlash against the government system. Even if these points do not prevent the equality goal from being considered legitimate, compelling, important, substantial, or sufficiently weighty to justify the intrusions at stake, they should prevent a finding of either a “substantial” advancement of equality or a “sufficient” means-ends connection between the prohibition and the posited goals.

I turn now to the goal of preventing diversion of health care resources from the government mandated plan. As indicated before, this might be what the abstract discussion of equality is really all about. The evidence might show, however, that
persons obtaining insured care in the supplemental system would actually ameliorate the
burden on the government mandated plan. The probability of such a finding is
enhanced by the likely parallel existence of a wholly legal supplemental sector for care
not covered within the universal benefits package. Expanding that otherwise limited
supplemental sector might yield economies of scale. If there were nevertheless proof
that a serious diversion would actually occur without a prohibition on purchase of
supplemental insurance for care covered by the government mandated program, the goal
of avoiding attenuation in the quality of care would seem to be substantially advanced.
However, a question might remain as to whether such attenuation would be outweighed
by either the overall quantity and quality of care that would be made possible by both
government mandated and supplemental sources of care or the degree of freedom of
access destroyed by a prohibition on supplemental insurance.

As to the goal of containing overall health care costs, it is likely that maintaining
the strength of the government’s monopoly by prohibiting supplemental insurance
would enable the government to limit what it pays for health care resources. Therefore,
this goal would likely be found to be substantially advanced. On the other hand, it is
conceivable that efficiencies in an entirely open market would actually hold down total
health care costs or that any savings would be outweighed by the benefits lost by
prohibiting supplemental insurance. The government’s indirect control on prices might,
for example, engender inefficiencies such as encouraging scarce health care personnel to
limit their time and efforts directed toward providing health care services.

Another governmental rationale to consider is preventing physicians from
manipulating waiting lists. This goal would likely be substantially advanced because a
prohibition on supplemental insurance would reduce opportunities to serve patients on
waiting lists by transferring them to the supplemental sector. However, the government
would probably have to provide evidence that there would be a substantial amount of
such fraud. It is unlikely the Court would find even total elimination of a slight or rare
problem to be the sort of “substantial advancement” that justifies intrusion on a
fundamental right.

Consider finally the goals of preventing deprofessionalization of physicians and
overloading of the government program with tough cases. The idea that physicians (or
any health care providers) will be deprofessionalized by working for profit or in the
private sector seems wholly speculative and nothing more than conceivable.171 (Of

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171 See Iglehart, Health Policy Report: Health Care and American Business, 306 NEW ENG. J. MED. 120,
120 (1982); Boyer & Greenberg, Medical Care and Procompetitive Reform, 34 VAND. L. REV. 1003,
course, saying anything about this topic requires some consensus on what “deprofessionalized” means). The same is true of the idea that the quality of care delivered within the universal benefits package will be compromised if government plan providers handle a disproportionate number of tough cases. University medical centers often pride themselves on handling tough cases, and there is no evidence to support the notion that tough cases make a bad medical system. An overload of tough cases could conceivably lead to physician frustration or public misunderstanding and loss of reputation, but these possibilities are speculative.

The concern about case mix might not relate to deprofessionalization, but instead be tied to the notion that an insurance pool should have a good mix of cases so that risks can be spread. This notion supports the idea of mandatory community rating, which in effect forces the healthiest patients to subsidize the less healthy. This concept does not seem to fit in the context of a government program that is publicly funded and will not have to provide care to persons who seek it outside the program but nevertheless remain liable for their contributions to the government program. (In Canada that is by way of general taxes).

(d) Would the Court find less restrictive or otherwise relevant alternatives?

The compelling state interest test requires use of the less restrictive or better tailored alternatives. The gender discrimination intermediate test is usually articulated as not requiring use of less restrictive alternatives, but sometimes the Court refers here either to the existence of less restrictive alternatives as calling in question the government’s actual purpose or to “narrow tailoring” in the sense of an alternative, non-discriminatory approach. The other intermediate tests discussed above either ignore alternatives or refer to them as relevant to judging the “reasonableness” of the connection between the government’s means and its ends.

Judging how the Court might view possible alternatives is particularly difficult, and I can do little more here than speculate regarding some points the Court might


172 See supra text accompanying notes 98-99.
173 See supra text accompanying notes 100, 103-104.
174 See supra text accompanying notes 102-110.
The Court generally will not force the government to use alternatives that are appreciably more expensive or less effective. Alternative ways to encourage support for the government mandated system or improvements in it might be to educate people about the positive aspects of the system and to appoint ombudspersons to identify problems and push for improvements in the system. However, these alternatives would likely be rejected as misleading, too expensive, or ineffective.

Turning to preventing shortages of resources within the government plan, less restrictive alternatives to prohibiting supplemental insurance might be to limit the amount of time physicians can practice outside the government plan, forcing all physicians to spend a portion of their time providing care within the government plan, and limiting the extent to which capital resources can be devoted to supplemental care. These restrictions might relate only to care covered by the government program or to all care. These too might either be found to constitute required alternatives or be found more intrusive, ineffective, or too expensive. Here too they might drive providers to other countries, be difficult to enforce, or entail tremendous administrative costs.

A less restrictive way to prevent manipulation of waiting lists might be to strengthen the content and enforcement of anti-fraud laws. This might be found dispositive. On the other hand, it might be found ineffective or too expensive for the same reasons discussed concerning the alternatives discussed in the preceding two paragraphs.

Finally, a less restrictive way to prevent deprofessionalization of physicians might be to require better ethics instruction within training and continuing education programs. One way to prevent overloading public programs with tough cases would be mandatory and random assignment of a certain portion of such cases to the private sector. These alternatives, however, might be either more expensive or less effective.

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175 Spece, supra note 95 at 147-49.
176 See, e.g., Steven Pearlstein, O Canada! A National Swan Song?; U.S. Economic, Cultural Weight Threaten Nation's Identity, WASH. POST, Sept. 5, 2000, at A1 (“Increasing numbers of [Canada’s] best and brightest are seeking their future in the United States. In recent years, about 25,000 Canadians have permanently moved south each year, including 1 percent of taxpayers who earn more than $100,000 a year, significant chunks of the dean’s list from top universities and enough nurses and doctors to fill one-quarter of the seats in Canadian medical and nursing schools”).
b. Claims of a right to purchase insurance for care that is prohibited because the care is not efficacious or not cost-effective

Persons claiming a right to purchase insurance for care that is not efficacious or cost-ineffective would argue that their right is identical to the fundamental right developed in the immediately preceding sub-section (a) concerning a right to purchase insurance necessary to obtain timely care that the government has included in a universal benefits package but does not make available in a timely manner. They could buttress this claim by citing to the three judge panel’s majority opinion in *Abigail Alliance*,177 which, once again, holds that there is a fundamental right to purchase even certain experimental care. They could also support their argument by invoking the alleged “right to medical self-defense,” including access to experimental treatments and purchase of organs needed for transplantation, recently developed by Professor Eugene Volokh in the Harvard Law Review.178 If there is a fundamental right to purchase experimental care or organs for transplantation, they would argue, there certainly must be a right to purchase insurance for care that is available for direct purchase outside the government’s universal health care plan.

I will establish, however, that although there might be an ordinary right or interest to purchase insurance for care that the government has withheld or withdrawn from general use because it is considered dangerous, inefficacious, inefficient, or generally against the public interest, any such right is not fundamental. The rights to purchase experimental treatment or organs for transplantation are analogous to the right examined here to purchase care that the government has withheld from the insurance market because it considers it wasteful and against the public interest.

I must admit, before analyzing *Abigail Alliance* and Volokh’s assertion of a right to medical self-defense, that one might argue that, contrary to my assertions above, there is a significant difference between claiming a fundamental constitutional right to purchase experimental care or organs for transplantation, on the one hand, and asserting such a right to purchase insurance for care that the government allows to be directly purchased outside its universal health care plan but makes uninsurable because it is not efficacious or cost effective, on the other hand. In the former situations, there are general prohibitions based on considerations of safety, efficacy, equality, access, or


morality, but in the latter the care at issue is open for direct purchase but uninsurable because of, most directly, determinations concerning efficacy and efficiency. I argue, to the contrary, that the government's interests are salient and strong in all these contexts, that the Court's role is similarly limited in each situation, and that the methods and criteria for deriving fundamental rights indicate that there is no fundamental or special right in any of the scenarios. Most importantly, although the limitations on insurance focus on inefficacious or inefficient care, they are implemented to protect universal health care and its provision of basic health care to virtually the entire population. I will, in order, summarize and criticize, first, Abigail Alliance and, second, Volokh's recent article. I will explain why neither their reasoning, nor any argument, supports a fundamental right to purchase experimental therapies, organs for transplantation, or insurance covering care the government has determined is inefficacious or cost-ineffective.

i. Abigail Alliance and the three Glucksberg requirements

Abigail Alliance specifically holds "that where there are no alternative government-approved treatment options, a terminally ill, mentally competent adult patient's informed access to potentially life-saving investigational new drugs determined by the FDA after Phase I trials to be sufficiently safe for expanded human trials warrants protection under the Due process Clause" and requires "the FDA's policy barring access to post-Phase I investigational new drugs" be shown to be "narrowly tailored to serve a compelling government interest." Abigail Alliance, supra note 177, at 478 n. 9. It thus finds not only a right to "life, liberty, or property," but a fundamental right. It recognizes that government approved alternative care might well be a reason for rejecting the existence of any right because it specifically limits its holding to situations in which there is no such alternative.

A claimed fundamental right to purchase insurance covering inefficacious or cost ineffective care is distinguishable and weaker. Insofar as it relates to care determined to be inefficacious, it is weaker because the right at issue in Abigail Alliance relates to care that, although not shown to be safe and effective, has also not been determined to be inefficacious. Insofar as the right considered here relates to care determined to be cost ineffective, it too is weaker because by definition it is a claim of access to care for which there is an equally effective but less costly alternative. Conversely, the right at issue in Abigail Alliance is described as pertaining to care for which there is no alternative.

179 Abigail Alliance, supra note 177, at 478 n. 9.
More generally, *Abigail Alliance* reasons that there is a fundamental right because purchasing Phase II drugs is part of the right to preservation that meets *Washington v. Glucksberg*’s three criteria for the existence of a fundamental right (i.e., method (2) among the five methods of diving fundamental rights discussed in subsection III.B.4. above): (1) carefully described, (2) deeply rooted in tradition, and (3) implicit in the concept of liberty.\(^{180}\)

The *Abigail Alliance* court reasons that the right at issue is carefully described because it does not entail a claim to access to “all new or investigational new drugs,” to government subsidy for drug treatments, to drugs regulated by Congress under the Controlled Substances Act, or, free of government regulation, to substances deemed harmful to the public health, safety, and welfare.\(^{181}\) The dissent correctly argues, to the contrary:

> [T]he majority infers its new right from several broad principles, none of which would meet Glucksberg’s careful description requirement [mentioning rights to “control over one’s body,” “self-defense,” “self-preservation,” “act in order to save one’s own life,” “take action, even risky action, free from government interference, in order to save one’s own life,” “decide whether to assume any known or unknown risks of taking a medication that might prolong life,” and “access to lifesaving treatment”]. *** The majority infers from these principles a liberty interest in procuring and using experimental drugs. But *Glucksberg* does not authorize courts to create substantive due process rights by inference. These principles are precisely the type of “abstract concepts of personal autonomy” that do not constitute evidence of a fundamental right. They are indeterminate concepts that cannot meet *Glucksberg*’s careful description requirement.\(^{182}\)

The dissent’s argument is persuasive in that there is a huge, and thus non-particularized, range of rights encompassed between the majority’s referenced traditional rights to “control of one’s body” and to choose risks of a drug that *might* prolong one’s life. As the dissent also observed: “[T]he level of benefit a patient will have to show, in order to demonstrate that under the majority’s right a drug is potentially life-saving,

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180 *Abigail Alliance*, supra note 177, at 472.
181 *Abigail Alliance*, supra note 177, at 486.
182 *Abigail Alliance*, supra note 177, at 493. The full court assumed for purposes of argument that the careful description requirement was met.
remains an enigma. Considering the potential benefits of an experimental drug in light of its risks will require the District Court to step into the role of the FDA.\footnote{Abigail Alliance, supra note 177, at 500.}

As to the second Glucksberg requirement (deeply embedded in tradition), the court reasons that the right to post-Phase I drugs is part of the deeply rooted common law rights to “control over one's body,” to self-defense, and to self-preservation. Focusing on self preservation, it refers to the common law principle of necessity (“one may sacrifice the personal property of another to save his life or the lives of his fellows”) and the rule of liability for “[o]ne who, without privilege to do so, intentionally prevents a third person from giving to another aid necessary to his bodily security.”\footnote{Abigail Alliance, supra note 177, at 480.}

Rejecting the FDA's argument that “government control of access to potentially life-saving medication is now firmly ingrained in our understanding of the appropriate role of government,” the court contrasts the long-standing tradition favoring self-preservation with the recent origin of regulation of access to new drugs. It argues that there was essentially no drug regulation until the Pure Food and Drug Act of 1906 prohibited misbranded and adulterated foods or drugs from entering interstate commerce; there was no requirement of testing for safety until the 1938 Food Drug and Cosmetic Act replaced the 1906 law; the category of prescription drugs was not created until the 1951 Durham-Humphrey Amendment; “only in 1962 did Congress require drug manufacturers to provide empirical evidence of the effectiveness of a drug as opposed to merely the drug's safety”; and even now physicians are allowed to prescribe drugs licensed for a particular purpose for new and unproven uses (“off label prescribing”).\footnote{Abigail Alliance, supra note 177, at 481-483.}

The dissent also has strong responses to this part of the majority's argument. It first notes:

At common law, “[a] necessity defense ‘traditionally covered the situation where physical forces beyond the actor’s control rendered illegal conduct the lesser of two evils.” United States v. Oakland Cannabis Buyers’ Cooperative, \footnote{United States v. Bailey} [quoting United States v. Bailey]. Setting aside the difference between a common law defense and a constitutional right, I have serious doubts about how a court can know, as a matter of constitutional law, that the lesser of two evils will be achieved by providing all terminally ill patients access to all Phase I
experimental drugs, given the risks these drugs present. In any event the Supreme Court's guidance in *Oakland* indicates that the common law doctrine of necessity is not deeply rooted in this Nation's history and traditions. In *Oakland*, a group of patients seeking access to marijuana for medicinal purposes argued that "because necessity was a defense at common law, medical necessity should be read into the Controlled Substances Act." As an initial matter, the Court noted that "it is an open question whether federal courts ever have authority to recognize a necessity defense not provided by statute." Id. (Emphasis added) "Even at common law, the defense of necessity was somewhat controversial. And under our constitutional system, in which federal crimes are defined by statute rather than by common law, it is especially so." Id. . . . The Court did "not decide, however, whether necessity can ever be a defense when a federal statute does not expressly provide for it," id. at 491, because "[u]nder any conception of legal necessity, one principle is clear: The defense cannot succeed when the legislature itself has made a determination of values. . . ." The structure of the FDCA does just that: Congress has prohibited general access to experimental drugs. . . . Given the Supreme Court's conclusion that the common law defense of necessity remains controversial and cannot override a value judgment already determined by the legislature, I cannot see how the majority's proposed right is supported by the common law doctrine of necessity. 186

The dissent then persuasively answers the majority's claim that a right of access to experimental drugs is deeply embedded in our traditions because of the absence of regulation:

The remainder of the majority's analysis sets out to prove an unremarkable proposition: the federal government has only regulated drugs for approximately 100 years. From the lack of federal regulation prior to 1906, the majority infers a constitutional right to be free from regulation. It is not difficult to see the sweeping claims of fundamental rights such an analysis would support [including traditions protecting the use of marijuana and narcotics]. But this is not the law. A prior lack

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186 *Abigail Alliance*, supra note 177, at 492. The full court agreed, rejecting the existence of a tradition manifest in principles of necessity, tortious interference with rescue efforts, and self-defense.
of regulation suggests that we must exercise care in evaluating the untested assertion of a constitutional right to be free from new regulation. Indeed, in considering an asserted fundamental right, Glucksberg directs us to "exercise the utmost care whenever we are asked to break new ground in this field." . . . But the fact that the Government has not always regulated a concern tells us little about whether an individual has a constitutional right to pursue that concern. See United States v. Morton Salt, . . . ("The fact that powers long have been unexercised well may call for close scrutiny as to whether they exist; but if granted, they are not lost by being allowed to lie dormant, any more than nonexistent powers can be prescribed by an unchallenged exercise.") 187

The dissent also contradicts the majority's historical account of drug regulation:

In this Nation, the Colony of Virginia passed an act in 1736 addressing the dispensing of more drugs than was "necessary or useful" because that practice had become "dangerous and intolerable." [The court goes on to note over a score of examples of additional early legislation.] The majority's historical analysis of the FDCA demonstrates that Congress has expressed a keen interest in regulating drugs as science has progressed. Congress has responded to evolving medical technology with evolving regulation. But, unlike the majority, I do not see how the decision by Congress to regulate an area of concern in the early part of the twentieth century demonstrates a fundamental right to be free from regulation today. 188

A further flaw in the majority's reasoning is that it assumes that both fundamental rights and the government's traditional powers must be precisely and narrowly described. Although the Court has required a precise or narrow description of fundamental rights, it does not follow that there must or should be a narrow definition of the traditional scope of state governments' "police powers" or the federal government's analogous powers to deal with health, safety, and welfare concerns under

187 Abigail Alliance, supra note 177, at 493-494. [Bracketed material added.] The full court's analysis was very similar.

188 Abigail Alliance, supra note 177, at 494-495. [Bracketed material added.] Once again, the full court was in agreement, focusing on regulation of safety but claiming a sufficient historical interest in efficacy as well.
the commerce and spending clauses of the Constitution.\textsuperscript{189} To the contrary, the Court has consistently given a broad definition to state and federal powers in the areas of health, safety, and welfare.\textsuperscript{190} Even in the \textit{Lochner} era it assumed that governments could intrude into “private” markets “affected with a public interest.”\textsuperscript{191} Government powers have long and consistently been interpreted to allow regulation to protect the public’s health, safety, and welfare, and this includes protection of consumer welfare.\textsuperscript{192} Government can call on its wide-ranging powers when the need arises. Just as the widening use of drugs revealed a need for greater regulation, the growing complexity and cost of our health care system might lead to a considered determination that we must place limitations on access to inefficacious or cost-ineffective care. The absence of an earlier determination does not create an affirmative traditional right to be free of such limitations.

The \textit{Abigail Alliance} majority finally addresses the third and final \textit{Glucksberg} requirement—whether the right is “implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if [it] were sacrificed.” It reasons that the right is a corollary of the fundamental right to refuse life-saving treatment assumed by the Court in \textit{Cruzan}, and states: “If there is a protected liberty interest in self-determination that includes a right to refuse life-sustaining treatment, even though this will hasten death, then the same liberty interest must include the complementary right of access to

\textsuperscript{189} The states have a broad police power, and although the federal government has no general police power, its other powers arguably coalesce to approach or exceed the realm of health, safety, and welfare occupied by the states’ police power. Richard Levy, \textit{Escaping Lochner’s Shadow: Toward a Coherent Jurisprudence of Economic Rights}, 73 N. C. L. REV. 329, 33-343 (1995); Randy Barnett, \textit{The Proper Scope of the Police Power}, 79 NOTRE DAME L. REV. 429 (2004).

\textsuperscript{190} Id.; Nebbia v. N.Y, 291 U.S. 502, 537 (1934) (“a state is free to adopt whatever economic policy may reasonably be deemed to promote public welfare,” so long as it is not arbitrary nor discriminatory); Slaughter-House Cases, 83 U.S. 36, 62 (1873) (States have traditionally had great latitude under their police powers to legislate as “ ‘to the protection of the lives, limbs, health, comfort, and quiet of all persons.’ ” (quoting Thorpe v. Rutland & Burlington R. Co., 27 Vt. 140, 149 (1855))).

\textsuperscript{191} \textit{Lochner} v. N.Y., 198 U.S. 45, 57 (1905); \textit{Crowley} v. Christensen, 137 U.S. 86 (1890) (“possession and enjoyment of all rights are subject to conditions...essential to safety, health...good order...of the community”); \textit{Munn} v. Ill., 94 U.S. 113, 130 (1876) (state could regulate grain elevators because they were affected with the public’s interests).

\textsuperscript{192} Plumeley v. Mass., 155 U.S. 461, 479-480 (1894) (upholding state’s power to regulate the sale of oleomargarine that might otherwise be confused with butter); Medtronic, Inc. v. Lohr, 518 U.S. 470, 475(1996) (noting in a strict liability case involving the manufacture of unsafe pacemakers that several States have exercised police powers to protect health and safety of their citizens); Hillsborough County, Fla. v. Automated Med. Lab., Inc., 471 U.S. 707, 719 (1985) (“health and safety matters...primarily, and historically [are] a matter of local concern”). \textit{See also infra}, note 206.
potentially life-sustaining medication, in light of the explicit protection accorded ‘life’ [in
the Constitution]." 193 The majority’s argument must be distinguished from my
argument above that there is a fundamental right to purchase care that the government
has released for general use but does not make timely available. My argument rests, in
part, on the tradition of honoring a patient’s right to choose treatment that his physician
selects from the armamentarium of approved therapies. It does not relate to
experimental medicines that might be both inefficacious and dangerous, and that have
consequently been barred from interstate commerce.

The Abigail Alliance majority also rejects the FDA’s argument that two United
States Court of Appeals’ opinions have refused to recognize a right of access to
experimental drugs, specifically focusing on the Tenth Circuit’s opinion in Rutherford v.
United States:

The Tenth Circuit rejected a right to laetrile, reasoning that the choice
of a particular treatment or medication is “within the area of
governmental interest in protecting public health.” .. Of course, the
government interest in regulating has no bearing upon the identification
of a fundamental right. Rather, its interest is to be considered only if,
and after, a court recognizes a fundamental right; at that point, the
burden shifts to the government to demonstrate a narrowly tailored
“compelling interest” in burdening that right. Because the FDA had
neither eliminated the possibility that Laetrile was a poison nor
approved the drug for basic human testing in Phase I trials, the
government’s interest in Rutherford might well have been sufficiently
compelling to warrant restricting access to the drug. In this case, the
government’s interest may prove to be weaker because the Alliance
seeks only access to investigational new drugs that the FDA, after
Phase I human trials, has deemed safe for human testing on a
substantial number of human beings. In other words, the Alliance
seeks for its members the same right of access enjoyed by those
terminally ill patients lucky enough to secure a spot in Phase II trials. 194

The quoted language contains erroneous reasoning. First, one is not necessarily
lucky to be enrolled in a Phase II study. This can simply be a ticket to false hope, severe

193 445 F.3d at 484-485 [bracketed material added].
194 Id.at at 486.
side effects, and a lower quality of life during one's final time on earth. That is why there is a substantial apparatus to ensure informed consent in the experimental context, an apparatus that goes far beyond the standard common law doctrine of informed consent. Similarly, winning a right to purchase inefficacious or cost ineffective care would be a pyrrhic victory.

Second, Phase I studies do not show that a drug is "sufficiently safe." Safety is monitored through Phase II and III studies, and even some severe risks are not even found until Phase IV studies or adverse reaction reports that occur after drugs are licensed and put on the market. As to a claimed fundamental right to purchase insurance for the care of one's choosing, it relates to care already determined to be inefficacious or cost-ineffective.

Third, if patients are able to access drugs even though they are not accepted for Phase II or III studies, this could undercut patients' willingness to enter such studies. Why should they enter a study and risk being put in a control group that will not receive the desired medication when they can simply have their physician prescribe it? Similarly, if a right to purchase insurance for inefficacious or cost ineffective care were recognized, resources could be drained from the health care sector that supplies the basic care covered by a universal health care program.

Fourth, it is fallacious to argue that courts do not or should not consider governmental interests when they decide either whether there are life, liberty, or property rights or whether, if so, those rights are fundamental. For example, one

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195 By definition, drugs being tested during Phase II clinical trials are still experimental and their use carries inherent risks. See, e.g., PRINCIPLES AND PRACTICE OF CLINICAL RESEARCH 225-226 (John Gallin, et al eds. 2002). During Phase II trials, researchers often discover the drug has poor efficacy and/or adverse toxic effects. See, e.g., Denduluri, Phase II Trial of Ixabepilone, an Epothilone B Analog, Given Daily for Three Days Every Three Weeks, in Metastatic Breast Cancer, INVESTIGATIONAL NEW DRUGS. 25(1):63-7, Feb. 2007 (patients continued with experimental treatment until researchers found unacceptable toxicity and, or progressive disease).

196 MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 244-246 (Mark Hall et al., eds. 2005).

197 Phase IV studies, which involve much larger pools of patients and take place once the drug has been approved by the FDA, attempt to fine tune the most effective treatment protocols – especially when used in combination with other therapies – but also look for long term effects including adverse interactions with other drugs. In some cases the results of Phase IV trials can lead to the withdrawal of the drug from the market. See, e.g., Bresalier, Cardiovascular Events Associated with Rofecoxib (Vioxx) in a Colorectal Adenoma Chemoprevention Trial. NEW ENG. J. MED. 2005;352(11): 1092-102 (negative results in a Phase IV trial led to the withdrawal of Vioxx from the market).
obvious reason to consider the governmental interest even at these early stages is to determine whether it is in an area traditionally left to other branches of government either because of the saliency and power of the government's interest (considered alone or compared to individual interests) or the Court's relative lack of capacity or traditional refusal to deal with issues in the particular area of concern. 198 The processes of finding whether rights exist, and, if so, whether they are fundamental are not so crisp and clean as that the Court solely examines the asserted right. To the contrary, the Court often goes back and forth between evaluating the claimed right and the overall government interest in the field (which may be great) or judicial competence in the area (which may be limited).

Moreover, the procedural history of Rutherford, especially the Supreme Court's involvement, 199 indicates that the Court would sharply disagree with Abigail Alliance and would not recognize a right of access to experimental, inefficacious, or cost-ineffective care. The Court would likely either refuse to find even an ordinary life, liberty, or property right in purchasing experimental care or inefficacious or cost ineffective care, or, even if there were prima facie claims, reject them under the rational basis test. The same conclusion follows from the Court's general body of case law and approach to its institutional role.

Rutherford came to the Court from the United States Court of Appeals for the Tenth Circuit. The appellate court had found that the federal Food, Drug, and Cosmetic Act contained an implied exemption from its requirement that safety and efficacy be demonstrated for terminally ill patients whose physicians had recommended the unapproved drug Laetrile. 200 The Supreme Court overturned this decision. It reasoned that "[u]nder our constitutional framework, federal courts do not sit as councils of revision, empowered to rewrite legislation in accord with their own conceptions of prudent public policy," and it remanded the case to the Court of Appeals for further consideration—most likely a decision on the plaintiffs' alternative contention that the Act was unconstitutional insofar as it could be construed to deny the

198 See infra text accompanying notes 226-236. C.f. Rebecca Brown, The Fragmented Liberty Clause, 41 WM. & MARY L. REV. 65, 67, 92 (1999) (arguing for a return to traditional constitutional adjudication in which "the nature of reasons that a state offers for restraining liberty is a key component of the meaning of liberty itself," thus avoiding the approach in the Warren Court and thereafter in which the "more modern understandings of the public interest and of legislative motivations blur the once-bright line between laws that serve the common good and those that do not" and thereby allow liberty to be "swallowed up by any plausible claim of state interest").
200 582 F.2d 1234, 1237 (10th Cir. 1978).
plaintiffs access to Laetrile treatments.  

Likely relying on the Supreme Court’s hostile reaction to its statutory analysis and on the Supreme Court’s obvious embrace of deference to the FDA’s medical and scientific expertise concerning what treatments should be made available for general public use, the Court of Appeals concluded that “in the context with which we are concerned, the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health.” The Supreme Court then denied plaintiffs’ Petition for Writ of Certiorari requesting a review of the Court of Appeals’ constitutional ruling. The quoted language is cryptic and can be explained as either a ruling that there was no prima facie claim stated or that such a claim was defeated by the government’s legitimate safety interest. However, the court’s omission to even mention a standard of review and its bifurcation of choice into whether to have any treatment, on the one hand, and what treatment to have, on the other, suggests that the court refused to find any right to choose among treatments. It is indisputable that the court certainly did not find any fundamental right of choice extending to treatments that the government had not allowed into general use. It referred to the need to defer to the FDA’s exercise of medical and scientific expertise to protect public health and safety. The same deference would be owed to the administrative body that, as part of the government’s universal health care system, would be called upon to make determinations regarding the efficacy and cost effectiveness of care.

The significance of the Supreme Court’s opinions in Rutherford and Oakland has been pointed out above. In addition, the Abigail Alliance dissent correctly notes that the Supreme Court stated in Gonzales v. Raich when holding that Congress can prohibit the medicinal use of marijuana even if states wish to allow it, that “the dispensing of new drugs, even when doctors approve their use, must await federal

201. 442 U.S. at 559.
204. The 10th Circuit did cite to cases that used the rational basis test. 616 F.2d at 457.
approval.” It also correctly observes that “contrary to the tradition asserted by the majority, there is a tradition of courts rejecting arguments that the Constitution provides an affirmative right of access to particular medical treatments reasonably prohibited by the government” and “[n]o circuit court has acceded to an affirmative access claim.”

207 445 F.3d at 496, citing Gonzales v. Raich, 125 S.Ct. at 2212 (2005) (full court’s opinion).
208 Id. at 496 and n. 6, citing Mitchell v. Clayton, 995 F.2d 772, 775 (7th Cir.1993) (“most federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider”); N.Y. State Ophthalmological Soc’y v. Bowen, 854 F.2d 1379, 1389 (D.C.Cir.1988) (“We disagree that the constitutional right to privacy comprehensively protects all choices made by patients and their physicians or subjects to ‘strict scrutiny’ all government interference with choice of medical treatment. There is no basis under current privacy case law for extending such stringent protection to every decision bearing, however indirectly, on a person’s health and physical well-being.”), cert. denied, 490 U.S. 1098 (1989); Carnohan v. U.S., 616 F.2d 1120, 1122 (9th Cir.1980) (“Constitutional rights of privacy and personal liberty do not give individuals the right to obtain [the cancer drug] laetrile free of the lawful exercise of government police power.”); Rutherford v. U.S., 616 F.2d 455, 457 (10th Cir.1980) (“The patient[s] ... selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health. The premarketing requirement of the [FDCA], 21 U.S.C. § 355, is an exercise of Congressional authority to limit the patient’s choice of medication. This is clear under the [Supreme Court’s] decisions ...”), on remand from 442 U.S. 544 (1979), cert. denied, 449 U.S. 937 (1980); see also, Sammon v. N.J. Bd. of Med. Examiners, 66 F.3d 639, 645 n. 10 (3d Cir.1995); U.S. v. Burzynski Cancer Research Inst., 819 F.2d 1301, 1313-14 (5th Cir.1987); cf. Lambert v. Yellowley, 272 U.S. 581, 588, 590, 596-97 (1926) (where Congress determined, in implementing Prohibition, that “practicing physicians differ about the value of malt, vinous, and spirituous liquors for medicinal purposes, [and] that the preponderating opinion is against their use for such purposes,” the Court rejected a physician’s claim of a constitutional right to “use ... such medicines and medical treatment as in his opinion are best calculated to effect [his patients’] cure and establish their health,” holding that “there is no right to practice medicine which is not subordinate ... to the power of Congress to make laws necessary and proper .... High medical authority being in conflict as to the medicinal value of spirituous and vinous liquors taken as a beverage, it would, indeed, be strange if Congress lacked the power to determine that the necessities of the liquor problem require a limitation of permissible prescriptions ....”); Watson v. Md., 218 U.S. 173, 176 (1910) (“It is too well settled to require discussion at this day that the police power of the states extends to the regulation of certain trades and callings, particularly those which closely concern the public health. There is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine.”).” The opinion of the United States Court of Appeals for the Ninth Circuit on remand from the Supreme Court in Gonzales v. Raich can be added to the authorities hostile to any right of access to therapies the government has withheld from interstate commerce. Raich v. Gonzales, 2007 WL 754759 at 11 & 12 (2007) (“federal law does not recognize a fundamental right to use medical marijuana prescribed by a licensed physician to alleviate excruciating pain and human suffering”; it is neither “deeply rooted in this Nation’s history and tradition” nor “implicit in the concept of ordered liberty”). The en banc court’s opinion is in
Finally, even if there were a limited right of access to experimental drugs as claimed in *Abigail Alliance*, the majority’s opinion there nevertheless indicates that there is no right of access to inefficacious or cost-ineffective care. As indicated above, the court specifically limited its holding—which itself only extended to whether there was a fundamental right requiring strict scrutiny as opposed to applying such scrutiny and reaching a bottom-line determination—to post Phase I drugs. It also explicitly emphasized that it did not challenge the government’s authority to criminalize the use of certain drugs. Therefore it strongly implied, if it did not directly reason, that the fundamental right to purchase care does not encompass *either* a claim to an exemption from generally applicable criminal laws if one contends that a banned substance (e.g., marijuana) has medicinal properties *or* a claim of access to drugs that have not even passed through Phase I studies. There is no fundamental right in these circumstances because of the manifest strength of the governmental interest. Furthermore, it is highly likely that the court did not want to imply that it is either within the role or the competence of courts to strictly scrutinize the nation’s drug laws or basic safety screening mechanisms such as the FDA’s Phase I program. If so, any recognition of a fundamental right—from the get-go—would require that the right be framed as involving access only to fully approved drugs—possibly not even extending to off-label uses. Similarly, the government’s interest in preserving resources within the sector that supplies care within its universal plan by prohibiting insurance for inefficacious or cost ineffective care is salient and strong. In the same vein, it is not within the competence or role of the Court to make determinations concerning the efficacy and efficiency of health care when a majority of persons support a universal health care system regardless of limitations it places on them.

**ii. Volokh’s argument in favor of a right to medical self-defense and Glucksberg’s “tradition” requirement**

Volokh’s argument in favor of a right to medical self-defense is very similar to, but broader than, the right recognized in *Abigail Alliance*. It is similar in that it only purports to establish a fundamental right that triggers strict scrutiny; application of that scrutiny can lead to limitations on the right if the government establishes strong reasons. It is broader because it explicitly encompasses treatments that are not necessary to save one’s life. It is slightly (but not significantly) different, moreover, because it is based on the traditional recognition of the defense of self-defense rather than the traditional defense of necessity. From an advocative point of view, this makes sense, as the dissent

accord at pages 29-30, particularly note 18.

209 445 F.3d at 478.
in *Abigail Alliance* points out, the Supreme Court has essentially eliminated the defense of necessity as a source of a right of access to drugs the government has chosen to bar from interstate commerce.\(^{210}\) Regardless, all the arguments made above concerning the invalidity of necessity as a source for a right of access to care are equally persuasive against attempting to use self-defense as a source of such a right. Self-defense is basically a form of necessity defense. \(^{211}\) (Indeed, as will be seen below, Volokh defines the right to medical marijuana as going beyond lethal self-defense’s limitation to imminent threats and extending to situations wherein the treatment is one of “necessity” within, say, a matter of months.)\(^{212}\) Moreover, virtually all the arguments made above concerning the non-existence of a fundamental right to care that the government has prohibited or significantly restricted apply to Volokh’s asserted right to medical self-defense. This is particularly true concerning my arguments about the Court’s limited role and expertise, issues Volokh virtually ignores.

Volokh begins with a moral argument involving an analogy between lethal self-defense and medical self-defense: “If I may kill a human or an animal to protect my life, why shouldn’t I be presumptively free to protect my life using medical procedures that don’t involve killing, such as compensated organ transplants or use of experimental drugs? My hope is that people who feel strongly about the right to lethal self defense (as I do) will agree that the moral case for medical self-defense is at least as strong as the case for lethal self-defense.”\(^{213}\)

The analogy is not as compelling as Volokh assumes. Self-defense readily conjures up notions of rare instances of virtually reflexive human action of one or a few persons in response to a threat of immediate extinction posed by one or a few persons. Purchasing experimental drugs and organs for transplantation immediately imply, on the other hand, thousands or millions of planned high risk possibly low gain transactions that can widely affect the government’s attempts to regulate to protect the public health and safety.

Next Volokh examines the constitutional status of lethal self defense: “Lethal self-defense is so broadly accepted that courts have rarely encountered grave restrictions

\(^{210}\) See *supra* text accompanying note 186.

\(^{211}\) Wayne LaFave & Austin Scott, *CRIMINAL LAW* § 5.4 at 443 (2d ed. 1986) (“It has been said that self-defense is part of the law of necessity which has attained relatively fixed rules”).

\(^{212}\) See *infra* text accompanying note 218.

\(^{213}\) Volokh *infra* note 178, at 1818. I recognize but will not discuss that characterizing self defense as reflexive raises the issue of whether it should be a matter of justification or excuse.
on it, and thus haven't squarely decided whether the federal Constitution protects it. Yet some lower court opinions have said that there is a constitutional right to lethal self-defense stemming from substantive due process (though one could equally argue for it under the Ninth Amendment).214 As noted in the immediately preceding footnote, Volokh does not even cite the cases he refers to, but, rather, one of his forthcoming articles.

Volokh goes on to argue that the right to lethal self-defense is grounded in tradition and is therefore a fundamental constitutional right under the Supreme Court's *Glucksberg* opinion. He does not admit, as even the *Abigail Alliance* majority does, that *Glucksberg* must be read to require tradition and careful description, and that it is often read to require that the alleged right meet the third criterion of being implicit in the concept of liberty. He argues:

The Court's holding [in *Glucksberg*] that "the Due process Clause specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition'" supports such a right. Founding-era sources call defending life a natural right. *** The right to lethal self-defense is secured by forty-four state constitutions [either explicitly or by securing a right to keep and bear arms in defense of self]. *** Finally, if the Court concludes that the Second Amendment secures an individual right—a view explicitly adopted by Congress, by the Office of Legal Counsel, and by several state appellate courts, but by only two federal circuits—then some right to self-defense might be inherently protected through the Second Amendment.215

To this point Volokh has only argued for the existence of a constitutional right to lethal self-defense. He does not develop a *constitutional* argument that medical self-defense is part of, or can be derived from, lethal self-defense. To be most generous to him, he must believe that this relationship is readily apparent given his above-referenced *moral* argument by way of analogy between the two rights. However, this failure of development might explain why Volokh ignores *Glucksberg*'s statements that a fundamental constitutional right must not only be deeply rooted in tradition but also carefully described and shown to be implicit in the concept of liberty.

214 Rather than citing to cases, however, he cites to a forthcoming article he has authored. Volokh *supra* note 178, at 1919, n. 16.
215 Volokh *supra* note 178, at 1818-1821.
The requirement that an alleged fundamental right be carefully described is meant to cabin judicial discretion in fashioning new rights. It at least implies that there must be a fairly close relationship between an established tradition and the claimed fundamental right. There is nothing more than a remote relationship between the right to lethal self-defense and the medical self-defense right argued for by Volokh. The only development Volokh engages in concerning the constitutional relationship between lethal self-defense and medical self-defense is by way of considering how the limitations on the former should apply to the latter. This is not an affirmative line of reasoning, but, rather, a defensive explanation of why the alleged right to medical self-defense should not be subject to the same limitations imposed on the purported right to lethal self-defense.

Volokh concedes that the right to lethal self-defense is uniformly accepted only when “deadly force is necessary to defend one’s life, or at least to prevent serious harm (not just a bruise or a petty theft).” He argues that “[s]imilarly the right to medical self-defense should exist only in the face of deadly or at least radically debilitating threats (such as paralysis or dementia, not against the common cold).” This only specifies that he interprets the right to medical self-defense to extend to treatments needed to deal with conditions more serious than the common cold. Even then, it does not specify how likely the (net) danger must be or how remote a benefit must be before the right of access ceases to be fundamental.

Volokh addresses another limitation on lethal self-defense and its implications for medical self-defense:

Lethal self-defense is generally allowed only in response to imminent threats of harm, usually measured in minutes; medical self-defense would often be used to prevent deaths that are likely in months. But for medical self-defense, it makes sense to treat imminence as simply requiring a present life-threatening medical condition—that is to say, as a type of necessity requirement—not as requiring that death be likely within the hour. The best proxies for necessity are the present medical threat (your kidneys are actually failing) and the lack of a satisfactory permitted therapy.

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216 Volokh supra note 178, at 1821.
217 Volokh supra note 178, at 1821.
218 Volokh supra note 178, at 1824.
But what if you have a cancer that is inactive but could, in perhaps years, become active and kill you? Does the right to medical self-defense entitle you to purchase an experimental drug that you want to try but which might be both dangerous and completely worthless? The right to medical defense is highly ambiguous.

This offends both the careful description requirement and the implicit in the concept of liberty requirement. I call the latter a requirement because it is obvious that tradition itself is not an adequate, sufficient criterion for recognizing fundamental rights. The “implicit in the concept of liberty” requirement adds the notion that rights must be important to individuals or society in order to be recognized as fundamental. Many practices fall within our traditions but are of relatively little importance to individuals. For example, although it is certainly one of our traditions to display fireworks on the 4th of July, this practice is not likely sufficiently important to elevate it to (fundamental) constitutional status. Rather, limitations on the practice, and even prohibitions, to avert safety hazards would not likely be subject to strict scrutiny, if any scrutiny at all. It is difficult to characterize the right to purchase experimental treatments that might be harmful and yet offer no offsetting benefit as particularly important.

Volokh next argues:

The Supreme Court has already recognized medical self-defense in one context: abortion needed to protect the woman’s life or health. Roe and Casey held that the Constitution protects two kinds of abortion rights. The first is the highly controversial right to abortion as reproductive choice, which generally allows previability abortions for all women who choose them. The second is the right to abortion even after viability but only when necessary “to preserve the life or health of the mother”—a right to use medical care, even when this requires destroying the source of the threat. *** Lethal self-defense and abortion-as-self-defense share a moral core: the principle that people should generally be free to defend themselves against that which is threatening their lives. The Supreme Court has so far recognized the medical self-defense right only in abortion cases. Yet the right can’t logically be limited to situations in which the defensive procedure is abortion and rejected when a woman needs to defend herself using experimental drugs or an organ transplant. Nothing about therapeutic post viability abortion makes it deserve protection more than any other
Volokh concludes by arguing that post-viability abortions cannot be distinguished from a general medical self-defense right either as involving reproductive choice (it ending with viability) or control over the woman’s body (both involving adding and removing items from the body). Volokh is so anxious to stretch Roe and Casey to support his claimed fundamental right to medical self-defense that he ignores the Supreme Court and other precedents that, as explained above, the Abigail Alliance dissent shows undercut any fundamental right of access to medical care that the government has prohibited or significantly restricted. Moreover, although Volokh seems to believe that his analogy between post-viability abortion and medical self-defense is a matter of logic and that “nothing” can be asserted against it, his argument is actually illogical. It seems to characterize matters that involve normative judgments as wholly within the ken of logic. Logic is a necessary, but not sufficient, condition to making correct normative judgments. I argue that it is logical, and advances commonly held norms and public policy, to distinguish between the abortion context, on the one hand, and purchase of experimental therapies or organs for transplantation situations, on the other hand. First, reproductive choice does not completely drop out of the equation post-viability even though the choice value alone only supports pre-viability abortions. The reality is that both choice and self-preservation are at issue and might affect a woman’s decision-making in the post-viability context. Justices might well take this into account when fashioning rules concerning post-viability abortions. Ruling out the possible role of choice in this context risks attenuating the value of reproductive choice in other situations.

Second, it is logical and advances commonly held social norms and public policy to argue that there is a significant difference between post-viability abortion and purchase of experimental therapies or organs for transplantation. As Volokh points out, in Roe v. Wade even the dissent of then-Justice Rehnquist supported a right to abortions necessary to save the mother’s life. Justice Rehnquist’s reasoning was that it would be irrational, within the meaning of the rational basis test, to protect a non-person

219 Volokh supra note 178, at 1824-1826.
220 Volokh supra note 178, at 1826.
221 See supra text accompanying notes 186 and 208.
223 Volokh, supra note 178, at 1825.
at the expense of risking the life of a person. This is not how everybody would view the situation, but it is entirely plausible. In this perspective, the abortion-to-save-the-mother context pits person against non-person.

However, in the purchase of experimental drugs and organs for transplantation situations it is manifest that, even if one concedes arguendo that there is some value for the individual, individual interests are pitted against the interests of a broad public made up of existing persons. These interests could include protection of the integrity of the clinical trials process and the development of safe and effective therapies, preventing physical injuries and deaths, avoiding exploitation of desperate individuals and families, preventing coercion and pressure to sell one's body parts, preserving voluntary donations of organs, and averting stark inequalities concerning the burdens and benefits of transplantation. As to the respective individual interests in the competing contexts, abortion does usually suggest some significant improved chance for survival when it is necessary to attempt to save the woman. On the other hand, individuals can be at great risk and without much expectation of benefit in the purchase of experimental therapies, and, to a lesser extent, purchase of organs for transplantation contexts.

In summary, neither Abigail Alliance nor Volokh's article successfully defends a fundamental right to purchase care, or insurance for care, that the government has prohibited or significantly restricted. They certainly do not support a right of access to care that the government has restricted because of determinations of inefficacy or cost-ineffectiveness.

**iii. Methods and criteria other than the Glucksberg approach for deriving fundamental rights and a claimed fundamental right to purchase care the government has prohibited or significantly restricted.**

Turning to whether the right to purchase experimental treatments or organs for transplantation or inefficacious or cost-ineffective care meets any of the other methods for deriving fundamental rights, they too are not essential to the survival of either our society or important institutions within it (method 1 discussed in subsection III.B.4.).

Whalen v. Roe is a case on point concerning methods three (related to intimate and important decisions about one's life or relationships) and four (essential to the very ability to formulate and express the intimate and important decisions about one's life or
relationships spoken about in method three).\textsuperscript{224} There, the Court reasoned in \textit{dicta} that the State of New York could completely prohibit the use of Schedule II drugs even though it currently allowed physicians to prescribe such drugs subject to a record keeping system. Appellees, who were physicians and patients, attacked the system as violating a fundamental right to privacy both in decision making about care in consultation with one's physician and in control of information about one's intimate affairs.

Although I argue above\textsuperscript{225} that the \textit{Whalen} Court applied the rational basis test because of the insubstantial nature of the intrusion there, even though it seemed to assume that a fundamental right to informational privacy was involved, there obviously would be a substantial intrusion if Schedule II drugs were completely banned. Therefore, the only logical way to explain the \textit{Whalen} Court's \textit{dicta} regarding the government's ability to ban Schedule II drugs completely is that it did not find any capacious fundamental right to privacy in the choice of care. To the contrary, if it assumed any such right existed, it did not construe it to extend beyond care that the government allows in commerce based on findings of \textit{general} safety of the community, efficacy, and efficiency. At best it considered any broader right to be ordinary, not fundamental, and its summary dismissal of the possibility of the government being restrained from completely prohibiting the use of Schedule II drugs for medical purposes implies that it might have felt that there was no right whatsoever. As explained above, the same or similar concerns that drove the \textit{Abigail Alliance} en banc court to its conclusions in support of governmental regulatory power apply to the context of protecting a universal health care plan by placing limitations on supplemental insurance covering inefficacious or ineffective care.

Method five (whether the claimed right shares characteristics with previously recognized fundamental rights) also cuts against any fundamental right to purchase experimental medicine or organs for transplantation \textit{or} ineffective or cost-ineffective care. The first four methods are part of this multi-factored approach, and none of them supports access to experimental medicine or organs for transplantation \textit{or} inefficacious or cost-ineffective care as a fundamental right. Most of the other factors also cut against any such finding. A right to purchase experimental medicine or organs for transplantation \textit{or} inefficacious or cost-ineffective care does not concern imposing affirmative duties on the state; it is a negative right and it is non-economic. However, it does not have a close nexus to other rights found to be fundamental, is not specifically

\textsuperscript{224} 429 U.S. 589 (1977).
\textsuperscript{225} See \textit{supra} note 153 and accompanying text.
described in the text of the Constitution, has been rejected in prior opinions, is not primarily a claim against paternalistic intervention, has not been recognized as special or essential by other nations and peoples, and is not of particular importance to individuals. This is true even as to the right to purchase organs for transplantation because it is speculative whether organs sales would in fact enhance access to safe organs for transplantation.

Finally, my assertion that there is no fundamental right to purchase care that the government has withheld from use—either because it is experimental, inefficacious, cost-ineffective, dangerous, or otherwise impairs the general health, safety, and welfare—is also consistent with two other concerns I explained above as influential in the Court’s processes of determining whether rights exist, and, if so, whether they are fundamental: (1) pre-balancing of individual and government interests, and (2) consideration of the Court’s limited capacity or traditional involvement in a category of cases. This becomes evident upon consideration of specific precedents. Consider, for example, Jacobson v. Massachusetts, 226 where the defendant claimed that forcing him to be vaccinated against smallpox under penalty of a fine and imprisonment violated his liberty under the Due Process Clause of the Fourteenth Amendment. He argued that he reacted badly to vaccination as a child, that his son and others he had observed had negative reactions to vaccination, and that he was at risk, albeit not determinate, of serious injury or death. The Court rejected his argument, reasoning that the government can subject persons to vaccination just as it can send them into battle and quarantine them to protect the public health or safety. As to the standard of review, it alluded to the government’s strong interest in public health and then indicated that public health was not an area in which it was the Court’s proper role to actively review the legislature, stating:

If there is any . . . power in the judiciary to review legislative action in respect of a matter affecting the general welfare, it comes within the rule that, if a statute purporting to have been enacted to protect the public health, the public morals, or the public safety, has no real or substantial relation to those objects, or is, beyond all question, a plain, palpable invasion of the rights secured by the fundamental law, it is the duty of the courts so to adjudge. . . . 227

This is the language of the rational basis test (although it seems to acknowledge

226 197 U.S. 11 (1905).
227 Id. at 31.
that stronger review would be needed for invasion of fundamental rights), and the Court's deference to the state was manifest. Its reasoning exhibits not only concern with its limited competence in the area of public health, but the strong government interest in protecting public health and the speculative risk to the defendant. It explained that defendant only made vague, unsubstantiated contentions that he might have a bad reaction to vaccination. Yet the Court indicated that its limited role in public health would dictate the same deference even if the individual were subject to the drastic intrusions of quarantine or placement on the battlefield. \textit{A fortiori}, the Court should defer to legislative and administrative judgments that protect the public health, safety, and welfare by prohibiting or limiting the use of experimental medicine, organs for transplantation, or inefficacious or inefficient care. Here, the government's interest is manifest, while the individual interests are, at best, speculative.

\textit{Jacobson's} precedential value was reaffirmed by the Court's 1997 opinion in \textit{Kansas v. Hendricks}.\textsuperscript{22} The latter opinion itself is another example of the Court applying deferential scrutiny because of the strength of the government's interest and the Court's limited competence and traditional role concerning the subject matter of the suit. This is true even though the case involves a massive deprivation of liberty. In \textit{Hendricks}, the Court rejected respondent's argument that Kansas violated due process by indefinitely committing him as a sexually violent predator because he was dangerous (evidenced by past convictions for molesting children) as the result of the legislative construct of "mental abnormality" (pedophilia) rather than a medically recognized "mental illness." It reasoned:

\begin{quote}
There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members." \textit{Jacobson v. Massachusetts}. . . Accordingly, States have in certain narrow circumstances provided for the forcible civil detainment of people who are unable to control their behavior and who thereby pose a danger to the public health. We have consistently upheld such involuntary commitment statutes provided the confinement takes place pursuant to proper procedures and evidentiary standards. [Later the Court goes on to consider Hendricks's argument that due process requires a finding of "mental illness" prior to involuntary commitment.] [W]e have never required state legislatures to adopt any particular nomenclature in drafting civil
\end{quote}

\textsuperscript{22} 521 U.S. 346 (1997).
commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance. [In the part of its opinion dealing with whether the commitment was criminal and therefore violated the prohibition on double jeopardy, the Court stated:] The State may take measures to restrict the freedom of the dangerously mentally ill. This is a legitimate nonpunitive governmental objective and has been historically so regarded.229

Although the Court reasoned in Cruzan, and reaffirmed in Glucksberg, that there is a right to refuse treatment grounded in the rights of bodily integrity and self determination, Jacobson and Hendricks indicate that the right against treatment is limited in ways that parallel limitations on the right to treatment. The fundamental right to refuse treatment extends to micro decisions that primarily affect oneself and only indirectly affect others. However, Jacobson and Hendricks show that when macro decisions about public health or safety are implicated, there may be no fundamental right of individuals to refuse care that will be recognized even at the threshold. Rather, there is only an ordinary liberty interest that will be analyzed under the rational basis test or a similar deferential standard of review.

Hendricks shows that even the massive curtailment on liberty entailed by indefinite civil commitment will not necessarily be subject to strict scrutiny. As indicated in Hendricks, the Court does require certain procedural due process protections. Moreover, the Court assumes there is some substantive constraint on civil commitment by discussing the requirement of a mental impairment that takes away one's volition. However, this is a relatively minor requirement given the massive curtailment of liberty at stake. The Court is nevertheless deferential in this context, giving the States wide latitude to frame the descriptions of maladies that impair volition without following the dictates of the medical community. The Court's deferential tone

is manifest in its statement quoted in fuller context above: "The State may take measures to restrict the freedom of the dangerously mentally ill. This is a legitimate nonpunitive governmental objective and has been historically so regarded."\textsuperscript{230}

Identifying the proper level of scrutiny through analysis of the relative strength of the individual and government interests as well as the Court's competence and role in the area of concern, as done in \textit{Jacobson} and \textit{Hendricks}, is appropriate in the context of considering any rights to purchase experimental treatment or organs for transplantation or inefficacious or cost-ineffective care. Given that the Court has indicated that a deferential stance is appropriate concerning involuntary civil commitment, sending soldiers into harms way, compulsory vaccination, and mandatory quarantine, it is instructive to compare the relative strength of the individual and government interests and the Court's competence and traditional role in those areas to the same factors in the context of rights to purchase (insurance for) experimental medicine or organs for transplantation or inefficacious or cost-ineffective care.

The individual interests in the areas of civil commitment, sending soldiers into harms way, compulsory vaccination, and mandatory quarantine are either similar to or significantly greater than those involved in the contexts of a right to purchase experimental care or organs for transplantation or inefficacious or cost-ineffective care. Although the average person's risk from vaccination is negligible and speculative and therefore very similar to the opportunity costs of foregoing experimental or cost-ineffective treatment, civil commitment, quarantine, and soldiering entail massive curtailments of liberty and, as to soldiering, a distinct risk of death. In all of these contexts, the government's interest is salient and substantial. Civil commitment is designed to protect the public or the committed individual from dangerous or deviant conduct. Soldiering is designed to protect the public's physical security. Compulsory vaccination and quarantine are designed to protect the public's physical security. Restrictions on the purchase of experimental care are designed to protect the public from dangerous or ineffective care and to maintain the integrity of clinical studies designed to discover care that can be licensed for the benefit of the public generally. Limitations on organs sales are designed to preserve voluntary donations, hold down the costs of transplantation, prevent coercion of potential organ sellers, and avoid highly visible and stark inequalities concerning the burdens and benefits of transplantation. Restrictions in a universal health care program, such as prohibiting the purchase of inefficacious or cost-ineffective care, are designed to make it feasible to bring health care

\textsuperscript{230} \textit{Id.} at 361.
to the tens of millions of persons who currently have no public or private health care insurance, thousands of whom die every year because of their lack of access to care.\textsuperscript{231}

The pre-balancing just engaged in indicates that rights to purchase experimental care or organs for transplantation or inefficacious or cost-ineffective care should, like the rights spoken to in \textit{Jacobson} and \textit{Hendricks}, be treated as ordinary, not fundamental, rights. The same conclusion follows from consideration of the Court’s lack of expertise and traditional role in the respective areas of concern. \textit{Jacobson} and \textit{Hendricks} refer to the areas of concern that they address directly or by way of analogy as being ones traditionally of primarily legislative, not judicial concern. They also rest on the Court’s relative lack of expertise concerning these medical, scientific, and public security matters.

Rights to purchase experimental medicine or organs for transplantation or inefficacious or cost-ineffective care raise medical, scientific, and policy judgments about the allocation of scarce and uniquely important public resources. The Court has considered these areas of primarily legislative and administrative, not judicial, concern, and this has been based in large part on the Court’s relative lack of expertise in these areas. For example, the Court has held that it must pay substantial deference to medical decision makers when dealing with complex technical issues such as what mental health treatment is appropriate for institutionalized persons or whether persons are disabled.\textsuperscript{232} (I am not saying that these issues are purely technical and empirical—the value components are obvious. I am merely taking the Court’s doctrines as it has set them up. The existence of problems in both empirical and value domains rightly compounds the Court’s reluctance to get involved.)

My allusion in the preceding paragraph to the Court deferring to medical judgments concerning disability is to \textit{Mathews v. Eldridge}, where it reasoned that judicial hearings would be of little help in this medical and scientific context.\textsuperscript{233} There the Court at least found an entitlement that supported a prima facie procedural due process claim; the claim to a pretermination hearing foundered upon application of the balancing test used in the procedural context.\textsuperscript{234} Further support for the conclusion that there is no fundamental right to unfettered access to experimental care or organs for transplantation or inefficacious or cost-ineffective care is found in a case of the same genre as \textit{Mathews—}

\textsuperscript{231} Institute of Medicine, \textit{Care Without Coverage: Too Little, Too Late}. 162 (2002).
\textsuperscript{234} Id.
American Manufacturers Mutual Insurance Company v. Sullivan. In Sullivan, however, the Court did not even find a prima facie due process claim. The Pennsylvania’s Worker’s Compensation Act provided that once an employer became liable for an employee’s work-related injury, its insurer had to pay for all “reasonable” and “necessary” medical treatment. To control costs and assure that only “reasonable” and “necessary” medical treatment was paid for, the State amended its law to allow a self-insured employer or private insurer to withhold payment of disputed medical bills pending an independent “utilization review.” Respondents, employees and employee representatives, attacked the law as denying the right to property without due process of law. The District Court dismissed the suit, but The Third Circuit held that the private insurer’s actions constituted state action and violated the Due Process Clause of the Fourteenth Amendment by withholding payment of medical bills without affording employees an opportunity to submit their view as to the validity of any charges in writing to the utilization review organization.

The Supreme Court reversed, first reasoning that there was no state action by the private insurers. The Court also found that there was no “property” right to support even a prima facie substantive due process claim against the petitioners who were state official employers, observing:

In Goldberg v. Kelly we held that an individual receiving federal welfare assistance has a statutorily created property interest in continued receipt of those benefits. Likewise, in Mathews [v. Eldridge] we recognized the same was true for an individual receiving social security. Respondents’ property interest in this case, however, is fundamentally different. . . . [F]or an employee’s property interest in the payment of medical benefits to attach under state law, the employee must clear two hurdles: First, he must prove that an employer is liable for a work-related injury, and second, he must establish that the particular medical treatment at issue is reasonable and necessary. Only then does the employee’s interest parallel that of the beneficiary of welfare assistance in Goldberg and the recipient of social security benefits in Mathews.

The Sullivan case directly deals only with reimbursement for medical expenses, but it is obvious that the case will influence physicians and patients in their joint and

236 Id. at 60-61.
independent deliberations concerning what care should be undertaken given that ultimate payment is expected from a self-insured employer or a private insurer. This can have very substantial effects on an injured worker’s care and health related to that care. Yet the Court held that there wasn’t even a simple “property” interest involved until after utilization review takes place. This obviously means that the Court did not recognize any right to treatment based solely on a licensed provider’s determination in consultation with her patient that the treatment is reasonable and necessary. Rather, any right is contingent on a third party entity’s determination regarding the reasonableness and necessity of the care. It can be argued that, by the same reasoning, any right to purchase or have access to treatment is subject to the government’s initial decisions regarding safety, efficacy, and efficiency. Even if it is argued that, despite the reasoning in Sullivan, persons have rights to purchase care, one can answer that it would be a huge leap to assume both that there is such a right and that it is fundamental.

In summary, recognizing a fundamental right to purchase care, or insurance for care that the government has allowed into general use does not require the Court to make the complex empirical and normative judgments inherent in the decision to allow such use. Rather, in this context the Court is simply respecting traditional notions of bodily integrity and self determination that have always assumed individuals’ presumptive rights to choose among forms of care that have been released into general use. Once the government allows general use of a medical service or good, the decision of individual patients to purchase such care becomes a private decision that primarily affects the purchaser and it is made in confidential consultation with one’s medical providers.

However, recognizing a fundamental right to purchase care that the government has subjected to a system of prior screening for efficacy and safety (as in Abigail Alliance), has made illegal because it is thought against the health, safety, and welfare (e.g., medical marijuana), has banned as degrading, immoral, or bad policy (e.g., the sale of organs), or bars from use to avoid waste and facilitate universal health care, would thrust the Court into a thicket of a type it has traditionally avoided. Such thickets are, overcrowded with empirical and normative controversies as to which the Court lacks competence or as to which there are no judicially manageable standards.

Another argument in favor of Court deference is that if it closely scrutinizes limitations such as those on the purchase of insurance for inefficacious or cost-ineffective care, it would create an incentive for the government to implement prohibitions rather than limitations. For example, instead of only banning supplemental
insurance, it might completely bar the purchase of inefficacious or cost-ineffective care. This would affect those who have the money to purchase care directly, and would foreclose the opportunity all persons have to at least attempt to obtain contributions for care that they or their family members and friends need but are not able to obtain in a timely manner within the universal health care plan.

I will conclude here by pointing out that even if the Court found an ordinary right to purchase experimental care or organs for transplantation, or to purchase inefficacious or cost-ineffective care, it would nevertheless uphold the FDA three phase scheme or a prohibition on purchase of organs for transplantation or insurance covering inefficacious or cost-ineffective care under the rational basis test. The government's legitimate interest in the experimental context was succinctly described in Judge Griffin's dissent in Abigail Alliance:

Having previously exercised it scientific and medical judgment to "strike the appropriate balance between these two competing goals [early access and safety]," the FDA noted its conclusion that "a reasonably precise estimate of response rate" and "enough experience to detect serious adverse effects" are "critical" in determining when experimental drugs should be made available. Most experimental cancer drugs "have potentially lethal toxicity, with potentially large effects on a patient's remaining quality of life." Accordingly, in the FDA's judgment, "it does not serve patients well to make drugs too widely available before there is a reasonable assessment of such risks to guide patient decisions, and experience in managing them."237

Applying the rational basis test to a prohibition on organ sales, a court could just surmise that the legislature has rationally concluded that the bar is needed to

237 445 F.3d at 490. Encompassed within the quoted language and the entire opinion are the ideas that patients might be exploited because of their terminal conditions, that they might forego standard therapies that might have some benefits, and that the quality and quantity of their admittedly shortened lives might be compromised by the experimental therapy. The conclusion could be different if strict scrutiny were applied. Compare Casenote, The Right To Live: Do The Terminally Ill Have A Constitutional Right To Use Experimental Drugs? Abigail Alliance v. VonEschenbach, 26 J. SCI. TECH. & ENVT. L. 149, 164-165 (2007) (arguing that there is no fundamental right of access, and that, in any event, there are compelling state interests supporting the FDA approval process), with Peter Currie, Restricting Access To Unapproved Drugs: A Compelling Government Interest, 20 J. L. & HEALTH 309, 323 (2007) (arguing that "restrictions on terminally ill patients' access to post-Phase I drugs do not further a compelling government interest").
preserve voluntary donations, hold down the costs of transplantation, avoid coercion of potential organ sellers, or avoid stark inequalities concerning the benefits and burdens of transplantation. Similarly, as to a ban on insurance covering inefficacious or cost-ineffective care, a court could simply observe that the legislature has made a not irrational judgment either that the limitations are necessary to preserve scarce medical resources needed within the sector that provides basic benefits under its universal health care plan or that allowing purchase of such insurance would compromise its ability to hold down health care costs and thereby maximize the care it can provide within its universal plan.

IV. CONCLUSION

It is likely that persons asserting rights to purchase insurance for timely care covered by a government's universal package of basic benefits to avoid risks of morbidity or mortality resulting from wait lists in the government program would be able to establish a prima facie constitutional claim, a fundamental right or interest in health or life, and a substantial intrusion. This would lead the Court to apply strict scrutiny, which would switch the heavy burden of justification to the government. It is possible that the government would fail to meet its burden of justification at one or more stages of this strict scrutiny concerning the government's actual interests, their legitimacy and compellingness, substantial connections between the government's goals and its actions, and the absence of less restrictive alternatives.

The most vulnerable stage of analysis for the government would seem to be proof of the means-ends connection between a compelling interest and the prohibition. The result might be consistent with that reached in Chaoulli—a finding that the prohibition is unconstitutional.

Other limitations within universal health care programs, such as restricting the purchase of care to that which is efficacious or cost effective, would only tread on an ordinary right or interest. They would therefore likely be upheld under rational basis scrutiny. On the other hand, they would be vulnerable to attack under a broader interpretation of the fundamental right to purchase care such as that embraced in Abigail Alliance or Professor Volokh's article. This article has carefully explored how fundamental rights are divined, and has established that such broad interpretations of the right to purchase care are erroneous and ill-advised. We are at a cross-road: there seems to be a moral consensus that we should turn toward universal health care, and there is a constitutionally clear path discoverable through careful consideration.