RESEARCH ARTICLE

Moral Right to Healthcare and COVID-19 Challenges

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Abstract: One fundamental healthcare issue brought to the fore by the current COVID-19 pandemic concerns the scope and nature of the right to healthcare. Given our increasing need for the usually limited healthcare resources, to what extent can we demand provision of these resources as a matter of right? One philosophical way of handling this issue is to clarify the nature of this right. Using the challenges of COVID-19 in the Philippines as the context of analysis, we argue for the view that regards the right to healthcare as fundamentally moral in kind, which should thereby guide its legal and contractual appropriations. In particular, we respond to objections against this view stemming from issues concerning the universality and satisfiability of the right's correlative duty. We deal with such issues by invoking the relative degree of incumbency of moral rights and the capability-relativity of positive duties. We further contend that as these factors define the scope of the moral right to healthcare, they thus constrain what we can demand as a matter of right to meet our healthcare needs in this time of the pandemic.

Keywords: right to health, right to healthcare, pandemic, COVID-19, health ethics

Introduction

The COVID-19 pandemic posed several challenges to healthcare systems around the world. The rapid increase in cases has undermined these systems resulting in a pandemic response that is decentralized and fragmented. Affected countries especially those with weak health infrastructures struggle to make healthcare accessible. Malaysia, Thailand, Vietnam, the Philippines, Cambodia, Laos, East Timor, and Myanmar, among Southeast Asian countries, have raised concern due to rising COVID-19 cases, at risk and completely overwhelmed healthcare systems, and slow vaccination campaigns (Tostevin & Aravindan, 2021). The Philippines had the worst COVID-19 surge in March 2021 with 812,760 total infections (Yap & Calonzo, 2021), dangerously compromising its healthcare system. Twenty-one hospitals reached "critical" threshold for occupancy, and 27 were at high risk with 70% of beds occupied (Tomacruz, 2021). On May 30, 2021, the country reported 7,000 new COVID-19 cases for the third consecutive day, tallying a total of 1.22 million cases (Rappler, 2021a).

Access to quality healthcare has always been a problem in the Philippines. However, the pandemic has wreaked new havoc and introduced a novel set of challenges to an already frail healthcare system. With an initial response that is characterized as either

simplification or spectacularization, the Philippine government has failed to address concerns about the deteriorating status of the country's healthcare system (Lasco, 2020).

A study conducted by the University of the Philippines cited the lack of available critical care beds and health human resources, primarily nurses and doctors, as key hurdles in the Philippine response to COVID-19 (UP COVID-19 Pandemic Response Team, 2020). Philippine hospitals, excluding specialty hospitals, have a total bed capacity of 67,119 and only 2,335 critical beds in 450 intensive care units (UP COVID-19 Pandemic Response Team, 2020). And on the average, there are only 3.7 doctors and 8.2 nurses per 10,000 persons. The World Health Organization (WHO) prescribes a ratio of 1:1,000 for both doctors and nurses (UP COVID-19 Pandemic Response Team, 2020). As of writing, the total number of cases in the country is 566,420 with 30,970 active cases (Marquez, 2021).

At the onset of the pandemic, the quality of healthcare in the Philippines has already been compromised by the initial lack of personal protective equipment (PPE), which reportedly resulted in the death of health professionals, prompting the government to purchase 1.8 billion worth of PPEs (Cepeda, 2020). As of January 2021, there are 14,286 COVID-19 cases among healthcare workers and 78 COVID-related deaths (Sabillo, 2021).

The Philippine government response was also bogged down by controversies and concerns related to COVID-19 testing. With only 200 to 250 people getting tested a day and a limited supply of testing kits at the onset of the pandemic, 2,000 kits for a population of more than 100 million, only 1,793 individuals have been tested by the end of March 2020 (Batino & Jiao, 2020; Magtulis, 2020). By August 2020, cases in the Philippines surged to 120,000, setting the record for the worst outbreak in Southeast Asia (Calonzo & Jiao, 2020).

The Philippine government's flawed response to the pandemic only made the importance of having access to quality healthcare frustratingly evident. The government's response described as a form of securitization that relies on populist rhetoric proved to be inefficient (Hapal, 2021). Calls to improve the healthcare system in the country abound, most recently coming from UHC Watch, a new coalition of health advocacy civil society groups that include Citizen Watch Philippines, the Philippine Alliance of Patient Organizations, Health Justice, and Bantay Konsyumer, Kalsada, and Kuryente or BK3 (BMPlus, 2021).

In a forum attended by the country's top public health officials, UHC Watch presented a manifesto that details specific action plans:

a. For the government to prioritize the implementation of the Universal Health Care Law, together with other health laws and allocate resources for their operationalization based on sound data and evidence-based information.
b. Calls on government for urgent improvement of the public health system and adopt measures that will ensure comprehensive, accessible, quality health services – especially for the most vulnerable sectors of society (e.g. women, children, elderly, person with disabilities and those chronic illnesses)
c. Demand for a transparent and accountable public health system by instituting necessary reform measures to eliminate graft and corruption at all levels.
d. Urge the various key stakeholders–patients, health professionals, patient organizations, local communities, the healthcare industry, and the government to proactively collaborate in the decision-making process so that through this whole-of-society approach the country's health systems could achieve better health outcomes with a greater sense of accountability in healthcare delivery. (BMPlus, 2021)

The manifesto stresses the need for a better access to quality healthcare and proposes a more systemic, proactive, and collaborative approach to healthcare delivery that builds on a more strategic utilization of healthcare resources and a more competent delivery of healthcare services. This is consistent with what is happening globally with citizens demanding health reforms from their government as it becomes increasingly apparent to everyone that health systems are vulnerable and, consequently, health security is compromised.

But perhaps the most pressing healthcare matter in the time of COVID-19 is that of vaccine accessibility. With wealthy countries reserving doses that are more than what they need, poor nations struggle to secure enough doses to vaccinate half of their population

(Twohey et al., 2020). In the Philippines, procurement and liability issues have delayed the country's inoculation program (Robles & Robles, 2021; Tomacruz & Rey, 2021). In response, some local government units have already rolled out their own implementation plans for COVID-19 vaccines, allocating budgets and signing deals with pharmaceutical companies (Rappler, 2021b). Recently, however, the Philippine government has approved and ratified its deployment and vaccination plan, which identifies priority groups and regions (Jalea, 2021). Without comprehensive implementing guidelines and coupled with the many uncertainties that go with a weak health infrastructure already overwhelmed by pandemic-related challenges and burdened by corruption, it is not clear when a vaccine will be available to everyone (Torres, 2021). As of writing, the Philippines has administered at least 4,495,375 doses of COVID vaccines to only 2.1% of the country's population (Reuters, 2021).

These pandemic-related challenges raise fundamental questions involving healthcare ethics, foremost of which concern justice and rights. Given the increasing demand for healthcare resources that are often limited and expensive, it is highly unlikely that everybody's healthcare needs will be satisfied. From the viewpoint of justice, this raises the question of how distribution of such resources can be fair to everyone (Mabaquiao, 2020). From the viewpoint of rights, on the other hand, this raises the question of up to what extent can one demand as a matter of right to be provided by such resources (Daniels, 2009). These two questions being intimately connected for a fair distribution ensures that everyone's right to a fair share in the distribution is respected. Furthermore, a fair prioritization scheme in a distribution requires a morally justified way of weighing the relative degree of importance of competing rights.

In this essay, we take up the rights question. Our aim is to clarify the nature of the right to healthcare to settle questions about its scope and limitations. We argue for the moral view about this right, which regards it as fundamentally moral in kind, by responding to certain objections to this view. For our purposes, we focus on objections arising from the skepticism on the universality and satisfiability of the right's correlative duty. Generally, critics of the moral view contend that universality cannot be granted as a feature of the said duty since doing so would lead to absurdity and the duty's unsatisfiability. Given this, they then claim, following the principle "ought implies can," that this duty along with the moral right that implies it cannot exist. The right to healthcare, for these critics, can only exist as a conventional right in either the legal or contractual form.

As a response, we shall invoke the following factors: that the incumbency of moral rights (that is, their sense of obligatoriness) comes in relative degrees and that the scope of one's positive duty is relative to one's capacity to satisfy the demand of this duty. Applied to the current pandemic, these factors accordingly constrain what we can demand as a matter of right, say from the government or any appropriate bearer of this right's correlative duty, to meet our healthcare needs. Such constraints, we shall contend, do not invalidate the universality and thus the moral nature of the right to healthcare. But before fleshing out the main points of the objections to the moral view and presenting our counterarguments to these objections, we shall first provide an overview of the general classification of rights. This will put the issue in the right perspective while at the same time lay the ground for our arguments against the objections.

Rights and Healthcare

Rights are entitlements. Having them allows us to pursue certain interests or perform certain actions. As our interests or actions come in various forms, so do our rights. There are, however, two general ways of classifying rights (Evangelista & Mabaquiao, 2020). The first concerns the kind of duties or obligations that rights imply or impose. Under this classification, rights are either negative or positive. The second concerns their mode of acquisition. Under this classification, rights are either natural or conventional (legal or contractual). As the first classification concerns the relation between right holders and duty bearers, we may also refer to kinds of rights under this classification as the *relational kinds* of rights. On the other hand, as the second classification concerns the nature of the existence or occurrence of rights, we may also refer to kinds of rights under this classification as the *ontological kinds* of rights. In this light, these general classifications of rights shed light on the relational and ontological features of the nature of rights.

Rights necessarily correlate with duties in that a person's possession of a right implies that another

person has a certain duty or obligation towards the right holder. The duties implied by rights come in two general forms: negative and positive duties. Negative duties refer to duties of noninterference. If a person, for instance, has the right to buy certain types of medicines using his/her own money and decides to do so, then other people have the obligation not to interfere with his/her action. On the other hand, positive duties refer to duties of provision or positive performance. If a person has the right to a certain type of information, say the right to know the result of his/her COVID test or the efficacy rate and side effects of vaccines to be administered to him/her, then some authorized person has the duty to provide him/her with such type of information.

Depending on how one sees it, sometimes the same act may involve both negative and positive duties. Consider, for instance, the suspension of mass vaccination programs in many countries in Southeast Asia (Harris et al., 2021). In Pakistan alone, a total of 40 million children have missed the polio vaccination since April 2020 (Haqqi et al., 2021). We could think of this as an issue of interference and thus as involving negative duties. For in suspending the vaccination programs, the duty not to interfere in the exercise of the right to get vaccinated has not been fulfilled. On the other hand, we could also say that this is an issue of provision and thus as involving positive duties. For in suspending the vaccination programs, the obligation to provide vaccines to people who have the right to them has not been fulfilled.

All rights imply negative duties, but only some also imply positive duties. In this light, rights that only imply negative duties are called *negative rights*, but rights that also imply positive duties are called *positive rights*. (Some refer to negative rights as *liberty rights* and to positive rights as *welfare rights*.) It is important to note that as negative rights only imply negative duties, there is only one way by which negative rights can be violated, and that is when their correlative negative duties are not done. In contrast, as positive rights imply both negative and positive duties, their violation can occur in more than one way. They can be violated when their correlative negative duties, correlative positive duties, or both are not done.

But how do rights get to be classified as either negative or positive? Velasquez (2014), in the course of elaborating on the differences of these kinds of rights, shed light on this question:

> In contrast, positive rights do more than impose negative duties. They also imply that some other agents (perhaps society in general) have the positive duty of providing the holders of the right with whatever they need to pursue what the right guarantees. For example, if I have a right to an adequate standard of living, this does not mean merely that others must not interfere; it also means that if I am unable to provide myself with an adequate income, then I must be provided with such an income (perhaps by the government). Similarly, the right to work, the right to an education, the right to adequate health care, and the right to social security are all rights that go beyond noninterference to also impose a positive duty. (p. 102)

According to Velasquez, a person who holds a positive right is assumed to be unable to provide for himself/herself the resources this right guarantees. We can infer from this that this inability is what creates the positive duty and thus what transforms the right from its general form to being a positive right. Given this, then the positive duty of provision is *capability relative*. That is, a right implies this duty only when the right holder is incapable of providing for himself/herself the resources needed to exercise this right. Velasquez reiterated this point when he pointed out that it was in fact only until the 20th century that people began invoking positive rights. Prior to this, all rights were regarded as negative, only implying duties of noninterference. But later on, society recognized the positive duties likewise imposed by certain rights "when society increasingly provided the necessities of life for its members who were unable to provide for themselves" (Velasquez, 2014, p. 102).

This point (the capability relativity of positive duties and rights) has important consequences in our understanding of rights. First, the classification of rights being positive and negative is likewise capability relative. If rights are positive in virtue of the capability of the right holder, then the whole relational distinction between negative and positive rights is capability relative. Second, if the positive duty imposed by a positive right later on proves to be no longer necessary, say the right holder is already in possession of what this right guarantees, or, for some reasons, cannot be performed, the positive right becomes a negative right, but it does not cease to be a right. Simply, if I already

have the resources that I have the right to, this right of mine does not need to impose a correlative duty to some persons to provide me such resources. But still, they have the duty not to interfere with my use of these resources provided that I do not violate their rights in the process. Third, the extent of satisfying a positive right is defined by the extent by which the bearer of its correlative positive duty is capable of satisfying the demand of the positive duty. When can we say, for instance, that parents have satisfied the right to education of their children? Presumably, it is when parents have done so to the best of their abilities, that is, in the best possible way that they are capable of.

In terms of their mode of acquisition, rights are either natural or conventional. Natural rights are acquired through natural possession of certain morally relevant qualities such as sentience and rationality. They correspond to what we call "moral rights," as these qualities are the same ones defining moral persons. These are rights that are not conferred on their holders or that are acquired not as a result of human agreements or conventions. When referring to the moral rights of humans, it is usual to also refer to them as "human rights." Sometimes, however, the expression "human moral rights" is used instead for this purpose in order to distinguish such rights from human nonmoral rights such as the legal rights of humans or from nonhuman moral rights such as animal (moral) rights. In accordance with the objectives of this essay, we shall, for purposes of convenience, simply assume the understanding of "human rights" as referring to the moral rights of humans.

On the other hand, conventional rights are rights possessed by their bearers due to human agreements or conventions. The features necessary to have these rights are likewise due to human agreements or conventions. These rights are usually divided into the legal and contractual kinds. Legal rights are the rights that we acquire when we become citizens of a certain country or state. The constitution of a state provides for the qualities necessary to be its citizens and thus to be bearers of these rights. Contractual rights, on the other hand, are the rights that we acquire when we enter into an agreement or a contract with some other persons or institutions. The terms of the contract specify what these rights are. Contractual rights are either formal, when the rights of the parties of the contract, along with their correlative duties, are explicitly stated usually in some written document, or informal, if such rights and duties are merely implied. Typical examples of formal contractual rights are the rights of employees in a company and of the students in a school. Typical examples of informal contractual rights are the rights of individuals in friendly, familial, and romantic relationships.

Consider the issue on worker protection against COVID-19. Healthcare workers are the most vulnerable to COVID-19 infection, but essential workers are also at risk (Carlsten et al., 2021). Unacceptable working conditions have made certain worker populations more vulnerable, like the fish workers in Thailand (Marschke et al., 2021). To address this concern, certain countries like Indonesia, Cambodia, and Vietnam have implemented employment-related responses that made relevant impact on workers and unions (Ford & Ward, 2021). The Organisation for Economic Co-operation and Development (OECD) has also endorsed a social-policy response that protects workers by reducing exposure to COVID-19 in the workplace, among other things (OECD 2020). This issue essentially concerns the healthcare rights of an employee and the correlative duties of the employer, whether or not employers have the duty to reduce the employee's exposure to COVID-19, or if employees have the right to be protected against the virus. In this context, the employee's right to healthcare is considered a formal contractual right if such is explicitly written in his/her contract with his/her employer. However, in most instances, this right is informal, and so, its corollary duty is often deemed optional.

Legal and contractual rights are limited by and dependent on the legal and contractual systems they occur in. They are thus not the same for all humans. In contrast, moral or human rights are the same for all humans, which is what is meant in saying that moral rights are universal. Being universal, moral rights are over and above or, better yet, higher than legal and contractual rights. When making contracts, we usually make sure that they will be made legally, which means that contractual rights should ideally not violate legal rights. When provisions in their constitutions are drafted, lawmakers of countries usually make sure (as mandated by the United Nations) that such provisions will not violate human rights, which means that legal rights in turn should ideally not violate human rights. These ideal cases, of course, do not always happen as there have been contractual and legal rights that violate human rights. Examples are discriminatory laws that

give some people the legal right to discriminate against fellow citizens of their country. In any case, this makes moral rights the highest kind of rights.

Given these two general classifications of rights, let us now examine the nature of the right to healthcare. For purposes of convenience, we shall refer to this right simply as "RTHC." In terms of its relational nature, the RTHC is standardly regarded as a positive right along with the rights to education, work, information, social security, and others (Velasquez, 2014). This means that the right implies the positive duty of providing the right holder some healthcare provisions. The bearers of this positive duty will depend on the ontological nature of the right. If it is taken as a contractual right, then the duty bearers are one's partners in a contract. If it is taken as a legal right, then the duty bearers are the right holder's fellow citizens. If it is taken as a moral right, then duty bearers are one's fellow moral persons.

The RTHC thus occurs in both natural and conventional forms. As a contractual right, employees in certain companies, for instance, can enjoy this right as part of the contract they signed with these companies. An example is the right to certain healthcare resources (goods and services) provided by some private companies for their employees in addition to those covered by SSS (Social Security System). Some of these companies (including educational institutions) have their own health clinics, which provide basic healthcare services to their employees. Another is the right to certain healthcare resources guaranteed by or within the coverage of private health insurance plans. These insurance plans, usually in the form of HMO (health maintenance organization) plans, may be availed of individually or may form part of the benefits provided by private companies for their employees. As a legal right, a state, for instance, often provides its citizens as a matter of legal obligation a certain amount of either free or subsidized healthcare services. Examples include maternity and paternity leaves with pay, discounts in the cost of medical resources for senior citizens, and free or subsidized medical services by government hospitals, among others. Here in the Philippines, a government insurance plan called PhilHealth enables Filipino employees in both private and public companies to avail of healthcare services with financial subsidy from the government.

As a moral or human right, the right to healthcare (or the more general "right to health"—for our purposes, we shall regard the right to healthcare as a necessary component of the right to health) is one of the human rights identified in the UN Universal Declaration of Human Rights when it provides for the rights "to food, clothing, housing, and medical care" (Velasquez, 2014, p. 103; Wolff, 2012, pp. 84-85). Being one of the signatories to this declaration, the Philippines acknowledges and subscribes to this UN provision and is thus obliged (under international laws) to make provisions in this regard in its constitution. Thus, under the section "Health" in Article XIII of the 1987 Philippine Constitution, which deals with social justice and human rights, we can read,

> The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers. (Official Gazette of the Republic of the Philippines, 2021a)

As a further commitment of the Philippines to the UN provision, President Rodrigo Duterte signed into law Republic Act 11223 or the Universal Health Care Law. Under its General Objectives (Sec. 3), it is stated that the act seeks to "(a) Progressively realize universal health care in the country through a systematic approach and clear delineation of roles of key agencies and stakeholders towards better performance in the health systems; and to (b) Ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services, and protected against financial risk" (Official Gazette of the Republic of the Philippines, 2021b).

In Defense of the Moral View

Despite being recognized by the UN and countries that are signatories to the relevant UN provision, the existence of the moral RTHC, or more specifically the moral status of the RTHC, is being disputed by some. They argue that this right is never natural, being a mere creation of human conventions. One major reason for this view is the problem of clearly identifying the primary bearer of the correlative positive duty of the

RTHC. As Wolff (2012, p. 85) wrote, "In the case of the claimed 'human right to health' it is not obvious who the duty holder will be." The idea is that there can only be a duty if there is an identifiable bearer of this duty. For what is this duty for if no one is obliged to perform it? Wolff (2012, p. 86), nonetheless, hypothesized that if this duty would have a bearer, the two plausible candidates would be everyone and the government in which the right holders reside.

The idea that it would be everyone is based on the universality of moral rights. If moral rights are universal in that they are possessed by all humans in virtue of being moral persons, then it follows that their correlative moral duties are also universal. Pavel (2019, p. 506) put it as, "Indeed, the very idea of a human right requires that all agents, individuals included, are duty-bearers." Consequently, if the moral RTHC is a right of everyone, then everyone also bears its correlative moral duty. As Sreenivasan (2012, p. 244) remarked, "Everyone has a moral duty to preserve the health of each (other) human being." This would mean, therefore, that if every Filipino has the moral RTHC, then every human being in the world, Filipino and non-Filipino alike, has the moral duty to address the healthcare needs of every Filipino. Likewise, this would mean that each Filipino has the moral duty to address the healthcare needs of not only his/her fellow Filipinos but every non-Filipino as well.

On the other hand, the idea that it would be the government seems to arise from the consideration that the primary bearer of the alleged positive duty should be one in the best position to satisfy the demands of this duty. This is in respect of the point that for this duty to be real or legitimate, not only should there be a bearer of this duty, but this duty bearer, following the principle "ought implies can," should be capable of performing the duty. Again, it would be useless to assign a bearer to a duty, which cannot satisfy what the duty demands. But between human individuals and governments, it seems that governments are in a better position to satisfy the demands of this duty. Pavel (2019) explained this point as follows:

> The accounts outlined above have defended the idea that a right to healthcare gives rise to a claim against one's government for the provision of healthcare services, such as access to medical care, treatment for disease, disability support and end of life care. That governments are the main duty-bearers of a right to healthcare is far from a conceptual necessity. Indeed, the very idea of a human right requires that all agents, individuals included, are duty-bearers. But individuals cannot in most typical conditions provide healthcare goods and services to one another, since the provision of such goods requires specialized, professional knowledge, large resource investments and a well-developed infrastructure. (p. 506)

Simply, one cannot expect a Filipino living below the poverty line or who lives in slum areas and are unemployed to be the bearer of the moral obligation to address or supply the healthcare needs of Filipinos suffering due to the pandemic. He/she drastically needs assistance himself/herself to survive the challenges of the pandemic. Consequently, Pavel (2019, p. 507) contended that "[f]or here to be a human right to healthcare, governments must be able to provide those services that constitute their correlative duty." Such can be seen as embodied in the spirit of the Philippine law on Universal Health Care—the Philippine government takes upon itself the responsibility to address the moral RTHC of every Filipino. This, at the very least, ensures that the Filipino moral RTHC has an identifiable correlative duty bearer.

But those who object to the moral RTHC find both candidates for the bearer of the right's correlative duty, namely, every human being and the government, as problematic. For our purposes, we shall refer to their arguments as the *anti-universality argument* and the *anti-satisfiability argument*. According to the anti-universality argument, there is no way by which the RTHC can be universal because the very idea of everyone being the bearer of a right's correlative duty is absurd; hence, there is no moral RTHC. According to the anti-satisfiability argument, there is no way by which the demand of the moral RTHC's correlative duty can be satisfied, for even governments, which are most capable of satisfying this demand, are bound to fail. Hence, there is no moral RTHC. In what follows, we shall elaborate on these arguments and accordingly present our replies to each of them and to both of them taken together.

The anti-universality argument builds on the idea that for a right to truly exist, the bearer of its correlative duty must be clearly identifiable. As O'Neill (2005) explained,

> [T]he claim that rights must have counterpart obligations asserts the exceptionless logical point that where anyone is to have a right there must be identifiable others (either all others or specified others) with accurately corresponding obligations. From a normative view of rights, obligations and claimable rights are two perspectives on a single normative pattern: without the obligations there are no rights. (p. 431)

Sreenivasan (2012, p. 243) made the same point while contrasting positive rights from negative ones: "Positive claim-rights are meant to be less well-founded because in many cases it is unclear *who* bears the correlative duty (and hence unclear whether *anyone* does). If no one has the correlative duty, then (on the standard definition, anyhow) there is no right: no claim can be made."

Now, based on the universality of moral rights, the primary bearer of their correlative duties is everyone. In the case of the moral RTHC, this would thus mean that "[e]veryone has a moral duty to preserve the health of each (other) human being" (Sreenivasan, 2012, p. 244), which Sreenivasan (2012, p. 244) found absurd: "it is obscure, for many human beings, whether anybody—or any suitable body, anyhow—has a moral duty to preserve their health." He elaborated,

> It is highly implausible to contend that 'everyone' bears the duty correlative to a moral human claim-right to health. It seems clearly false, for instance, that individual inhabitants of Mozambique, to take Wolff's example, each have a moral duty to preserve the health of any given inhabitant of Brazil (let alone that of every Brazilian). The connection actually becomes preposterous if we ask, instead, whether inhabitants of Mozambique have any moral duty to preserve the health of the inhabitants of Switzerland. We may therefore reject (h55): Everyone has a moral duty to preserve the health of each (other) human being. (p. 244)

What makes it absurd is that we become accountable for everybody else's misfortunes brought about by their unsatisfied health needs even when not doing something wrong. As Pavel (2019, p. 501) explained, "when doing nothing wrong violates an alleged human right, the idea that the right in question is a *human* right needs to give way. The more general principle is this: *if duty-bearers can routinely violate a human right without doing anything wrong, the human right in question does not exist.*" There is something absurd indeed if we hold ourselves morally accountable for the deaths brought about by the pandemic when we, who ourselves are trying our best to survive the challenges of the pandemic, have not done something morally wrong to our fellowmen. Likewise the logical way out of this absurdity is indeed to think to that we actually do not bear this moral obligation to help everyone else meet their healthcare needs—or that there really is no such thing as the moral RTHC.

This point, however, assumes a certain view of what it means to have a moral duty—that we have to perform it at all times. This is not, however, the only meaningful way of conceiving it. As an alternative, we can see the framework of W.D. Ross (1930), which is given a modern version by Peter Vranas (2018), which explains the interplay among moral duties in terms of their relative degree of strength or incumbency (or obligatoriness). According to Ross and Vranas, if two or more of our moral duties happen to be in conflict, such that we can only do one of them, the stronger one overrides the weaker one(s).

Ross speaks of the distinction between our *prima facie* and *actual* duties, which Vranas refer to, respectively, as our *pro tanto* and *all-things-considered* duties. Our *prima facie/pro tanto* moral duties are the moral duties we feel obliged to do given initial considerations. Our actual/all-things-considered moral duties, on the other hand, are the moral duties we feel obliged more strongly to do after factoring all relevant considerations. Vranas (2018) gave the following illustration:

> You have a job at a military base. You have the evening off today, and you have promised to meet your sister at a restaurant for dinner at 7 p.m. At 4 p.m., as you are preparing to go home, your commanding officer unexpectedly orders you to stay in the base until tomorrow to work on an urgent and top-secret project. You are now prevented from communicating with the outside world, so you have no way to inform your sister if you stay in the base. You can still sneak out of the base if you want, but then you might be court-martialed. Now you have two

> incompatible obligations: an obligation to meet your sister, and an obligation to stay in the base. Both obligations are *pro tanto* (or, in an older terminology, *prima facie*), but your weaker obligation—namely, to meet your sister—is merely *pro tanto*. Your *all-things-considered* obligation is your *stronger* obligation—namely, to stay in the base. (p. 488)

Both Ross and Vranas point out that when our moral duties are overridden, they do not cease to be our moral duties. For Ross, this is evidenced by the fact that our nonperformance of the overridden duties brings about another *prima facie* duty—the duty of reparation. For Vranas, it is evidenced by the fact that we later on feel guilty that we did not perform them. As Vranas (2018, p. 488) explained—still in the context of the above illustration—"If you stay in the base, it is appropriate for you to feel regret for failing to meet your sister. This suggests that you still have the obligation to meet her: if you no longer had this obligation, why would it be appropriate for you to feel regret for failing to obey it?"

Given this framework, we can thus say that everyone has the *prima facie/pro tanto* moral duty to provide the healthcare needs of everyone else, but everyone does not have an actual/all-things-considered moral duty to do so. This addresses the worry that the universality of moral duties may be too demanding. Let us provide a simple illustration. As a further illustration, suppose Jose, a Filipino doctor residing in Manila whose wife grew up in Malaysia, happens to know upon watching the news on television that Malaysia is experiencing its worst COVID-19 surge with 205.1 cases per million people on weekly rolling average (Hunt, 2021). It does not seem absurd to think that Jose would initially feel obliged to offer his assistance. He may want to go to Malaysia and offer his medical assistance there. What he feels is his *pro tanto* moral duty to beneficence. But then, he also has other moral duties to attend to, foremost of which are his duties to his own patients in Manila (where there is likewise a considerable lack of health workers to attend to the increasing number of COVID-19 patients) and family (he has to ensure their safety against the virus). After considering these factors, Jose decides that his stronger moral duty, which becomes his actual moral duty, is to attend to his medical duties to his patients in Manila and to his family duties. Now, just because his duty to help Malaysian patients gives way to his duties to his Filipino patients and family does not mean that the former duty ceases to be a moral duty for Jose. For he still thinks that if only circumstances would allow it or would have been different, he would definitely go to Malaysia and offer his medical assistance.

The anti-satisfiability argument, on the other hand, claims that there is no way by which the demand of the moral RTHC's correlative duty can be satisfied. As Pavel (2019, p. 519) wrote, "The idea of mandatory behaviour carries the implication that the agent responsible (individual or institution) is capable, under normal circumstances, of discharging its duty." Thus, if the alleged duty cannot be carried out, following the ethical principle "ought implies can," then this duty does not exist. And again, if the duty does not exist, then the corresponding right that implies it does not exist as well (O'Neill, 2005, p. 431). Now, in this consideration, the ones in the best position to satisfy the demand of such a duty are governments. Thus, "Governments are typically considered the duty bearers" (Pavel, 2019, p. 500). But then, it is argued that however one conceives of how such duty can be satisfied by a government (such as satisfying a decent minimum of healthcare needs), it will not really work—governments cannot get the job done. Basically, for Pavel, this is due to the governments' lack of financial resources and institutional capacity.

What Pavel has pointed out seems to be the very questions raised about the Philippine law on universal healthcare (see, for instance, Punongbayan, 2019). Again, this law aims to improve the Philippine health system and ensure that all Filipinos would have equitable access to quality and affordable healthcare resources. Does the Philippine government have the institutional capacity and financial means to fully implement these objectives? Just consider how this law applies to the current pandemic. The first objective at the very least requires that no corruption should occur in the various ways of handling the situation, such as in the purchase of the vaccines and administration of such according to some prioritization guidelines. This is a daunting challenge given our political history. But the more challenging task is the second objective. It has been reported, for instance, that the government would need additional 25 billion pesos, on top of the estimated 82 billion pesos, to buy vaccines for all Filipinos (Mendez, 2021, p. 1). In addition to the vaccines, the government still has to contend with the tremendous loss of resources and opportunities, economic and

otherwise, Filipinos continue to experience as a result of the pandemic. Despite the valuable assistance from the private sector (in the forms of individual donations, community pantries, and work-from-home scheme of some companies, among others), the government aid in the forms of PhilHealth services and occasional "ayuda" (consisting of canned goods and rice, sometimes with some amount of money especially for the elders and public transport drivers) simply would not suffice.

We earlier noted, when explaining the difference between positive and negative rights, that the occurrence and scope of positive duties are capability relative. In terms of occurrence, a right only implies a positive duty when the right holder is incapable of securing for himself/herself the resources he/she needs to be able to exercise the right. In terms of scope, a right only implies a positive duty to the extent that the bearer of the positive duty is capable of satisfying the demand of the duty. This means that the extent of one's right is also determined by the capability of the bearer to satisfy the demand of the correlative positive duty. This, in fact, aligns well with the "ought implies can" principle. If we can only have a duty if we are capable of performing it, we are likewise obliged to perform this duty only to the extent that we are capable of performing it. The area or aspect of this duty that I cannot perform is thus beyond what I am obliged to do. Now, if I am able to perform the duty to the extent required by my capability to perform the duty, then I have satisfied the duty.

Governments would be remiss in their obligation to provide the healthcare needs of their citizens if what they have provided their citizens do not maximize what they are capable of providing for their citizens. But they cannot be said to be such just because they are unable to meet every healthcare need of their citizens. Rights are said to be tightly correlated with duties. If such are the only resources that a government is capable of providing for its citizens, that the citizens' right to demand for such resources is limited by that capability. If we understand the scope of rights and duties in this way, then it does not seem difficult to see why the duty imposed by the moral RTHC on individuals or institutions like governments can be satisfied.

The implication of this insight is that the fact that every healthcare need of each Filipino cannot be satisfied in this time of the pandemic does not immediately negate the moral status or universality of the RTHC as embodied in the Philippine Constitution or the Philippine Universal Health Care Law. For while this healthcare need may not be satisfied or fully satisfied, its satisfaction (or satisfaction to a certain degree) may be beyond the scope of what this right morally requires to be satisfied given the capability of the government as the duty bearer to do so. It is, of course, a different matter if the constraints of this capability result from the government's own doing, like when it mishandles its funds due to the corruption, opportunistic politicking, or poor decision-making of its officials. When this happens, the government can then be said to be remiss of its moral duty and thus is morally accountable (in the sense of deserving moral blame) for its consequences. But a duty bearer's failure to act on the demand of its duty does not mean the duty cannot be satisfied. The fact that the scope of this right (RTHC) is relative to the capability of the duty bearer to meet the demand of this right is guarantee enough that the moral duty can be satisfied. From the moral viewpoint, what is thus essential and imperative is for the government to ensure that it maximizes its institutional capacity and financial resources to achieve the noble objectives of the Universal Health Care Law especially in this time of the pandemic.

Finally, our reply to both arguments taken together is as follows. Taken as a positive right, the moral RTHC implies both negative duty of noninterference and positive duty of provision. It is clear that the two arguments only concern the correlative positive duty of the RTHC. Assuming that they do not see any problem with the right's correlative negative duty, then what these arguments are only entitled to conclude, granting their plausibility, is that the moral RTHC cannot be regarded as a positive right and can only be regarded as a negative right. They cannot conclude here that the moral RTHC is not a right at all. For them to argue that the RTHC is not a moral right at all, they also need to reject the negative duty implied by the right—which would be absurd.

It may be replied that the RHTC to be a right at all must be a positive right. It cannot take the form of a negative right, or there is no such thing as an RTHC regarded as a negative right. Thus, showing that the positive duty implied by the right is impossible (in terms of satisfying what it demands) is sufficient to show the impossibility of the right. But aside from the fact that there is no logical contradiction entailed by regarding the RTHC merely as a negative right

at least in some instances, the latter point likewise contradicts the capability relativity of the relational kinds of rights. Consequently, for someone who already has or is capable of securing for himself/herself the healthcare resource he/she needs, his/her right to this healthcare resource will only entail the negative duty that other people should not interfere if he/she decides to use this resource for his/her healthcare needs. In this case, his/her RTHC is merely negative. If, for instance, some Filipinos are already capable of securing their healthcare needs in this time of the pandemic using their own private resources, then their right to these resources will accordingly be merely negative in that they should be given the liberty to use such resources to advance their own well-being. This case does not seem to differ much from the case of the right to education. For states that can afford to provide free tuition fees for the education of their citizens, the right is a positive one, but for those states that cannot afford such, we cannot force them to regard the right as positive. Given their economic situation, the right can only be negative.

Conclusion

The pandemic has exposed the vulnerability of health systems around the world, and the consequences are dire especially to developing countries like the Philippines. A year after one of the world's longest lockdowns, the Philippines has reported 5,404 new cases and hospitals are again hitting full capacity (Madarang, 2021). Supply problems and public resistance have also compromised the Philippine government's vaccination program (Gomez, 2021). Now more than ever, it is increasingly clear that accessibility to quality healthcare is a necessity. We have argued in fact that it is more than that.

Aside from being an issue of justice, the current pandemic is likewise an issue of rights. This is evident in the way Emerlynne Gil, Amnesty International's Deputy Regional Director, for instance, frames her assessment of how the Philippine government has handled the crisis: "Over a year into the pandemic, the Philippine government's continued failure to ensure an adequate response is a serious human rights issue" (quoted in Amnesty International, 2021). The presupposition is that the Philippine government has a moral obligation to provide for the healthcare and related needs of its people as a way of adequately responding to the crisis. Now the extent to which the government is obliged to provide for these resources would largely depend on how we understand the nature of the right to healthcare and the scope of its correlative duty.

In this essay, we have shown that healthcare is fundamentally a moral right and, as such, implies both positive and negative duties. Respectively, these duties are the duty of provision or positive performance and the duty of noninterference. Following Velasquez (2018), we clarified that the duty of provision or positive performance is capability relative. This means that it only holds when the bearer of the right is capable of exercising it. Following W.D. Ross (1930) and Vranas (2018), we further qualified that said duty manifests in relative degree of incumbency, either as prima facie or pro tanto duty or as actual or all-things-considered duty, depending on the extent of the duty bearer's discernment of his or her obligations and other relevant considerations.

These qualifications allow us to respond to the objections against the view that healthcare is a moral right. First, we considered the anti-universality argument, which rejected moral RTHC on the premise that it would be absurd for everyone to be the bearer of the duty correlative to it. Hence, RTHC cannot be universal. To this we respond by invoking the relative degree of incumbency of the duty of provision, which implies that while everyone has prima facie or pro tanto duty to provide the healthcare needs of everyone else, not everyone has actual or an all-things-considered duty to do so. We also considered the anti-satisfiability argument, which rejects the moral RTHC on the premise that the demand of its correlative duty cannot be satisfied. To this, we respond by invoking the capability-relativity of the duty of provision, which implies that the extent of such duty is relative to one's capability to satisfy its demands. We also noted that even if both arguments are plausible, they still fail to reject moral RTHC since they only problematize its correlative positive duty, which, if successful, could only mean that moral RTHC is not a positive right and not that it is not a right at all.

The ethics of healthcare in the time of COVID-19 is a difficult issue but one that needs to be addressed in order to ground our responses to this public health crisis on a fundamental understanding of what we can demand as a matter of right and the duties of the government correlative to this right. In defending the

moral status of the right to healthcare, we strengthen the view that it is a matter of moral duty that we perform the various actions necessary in overcoming the challenges of the pandemic. We generally already have an idea what these actions are. Among others, they include those contained in the Implementing Rules and Regulations of the Universal Health Care Act, aligning our healthcare programs with WHO guidelines, improving regulation and transparency in the way government funds are used, fostering cooperative partnership between government and the private sectors willing to extend their assistance, and expediting the buying of vaccines and the vaccination of the people following the adopted prioritization scheme. In addition, we can benefit from the researches of scholars, like Timmis and Brüssow (2020), who cited contingency planning, benchmarking, and improving diagnostic, prophylaxis, and therapy capabilities as key to a successful realignment of crises responsiveness towards a more resilient healthcare system. Perhaps a decision framework that takes into account these key improvement areas and grounded on the moral insight on RTHC discussed in this paper will help the Philippine government discern the best strategy to make quality healthcare accessible to those who need it most. What we need is the moral resolve to perform these actions or implement these strategies, which we cannot have if we still have doubts on whether there really is such a thing as a moral right to healthcare or if it is not clear to us what it means for us and our government, through its constitution and laws, to recognize this moral right.

Decoration of Ownership

This report is our original work.

Conflict of Interest

None.

Ethical Clearance

This study was approved by our institution.

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