

RESPONSIBILITIES FOR THE PROVISION OF HEALTH CARE

Rabbis Elliot N. Dorff and Aaron L. Mackler

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Introduction

Providing health care in modern nations is a great and growing challenge. While health care in centuries past was both largely ineffective and inexpensive, in our time medicine can do remarkable things to save and enhance our lives, but all at a considerable cost. How shall we apportion that cost, and how should societies decide what to provide each citizen in the first place?

The provision of health care touches on values and responsibilities that are central to the Jewish tradition. Moreover, in the Jewish understanding, health care involves issues of justice and communal obligation relevant to all societies. While classical Jewish sources presume a context in which medicine was less expensive and less complicated than it is now, the Jewish tradition nevertheless offers important guidance for individual patients, family members, and health care providers in our day.

While traditional sources less directly address the responsibilities of societies in the provision of health care, halakhic guidance on these issues is needed as well. The Jewish

tradition understands the provision of needed health care to involve issues of justice and communal obligation that are relevant for all societies. Jews who are citizens of democracies accordingly have at least some degree of responsibility to concern themselves with the justice and well-being of these national societies, including the just and beneficent distribution of health care.

This paper presents three related *תשובות* on the responsibilities of individuals, health care providers, and communities for the provision of health care. These are preceded by an overview of Jewish understandings of medical care and human needs that will be relied on by each *תשובה*. The *תשובות* will provide limited but important guidance from our halakhic tradition. One limit relates to the need for prudential judgment, as well as compassion, in applying these guidelines to complex real life situations. Another limit reflects the scope of the paper. Additional questions that might profitably be addressed in future papers (by us or others) include: more specific guidelines for when better care should be chosen (by patients, health care providers, or society) despite increased cost, the role of rabbis as patient advocates in settings such as managed care, asset shifting to family members to become eligible for Medicaid, the right of physicians to strike, the priority to be accorded to research relative to current patient care, triage and the allocation of limited resources (such as organs for transplantation), and the selling of organs. Additional issues continue to develop. Despite these limitations, guidance from the tradition is both possible and important.

Traditional Views on Health Care and Human Needs

A. The Duty to Provide Medical Care

1. The theological and legal bases for medical intervention

Until the discovery of penicillin in 1938, physicians could do little to cure disease. Preventive medicine was better developed, although not uniformly practiced, but curative medicine was largely ineffective. When physicians could not do much to heal a sick patient, their services were easily attainable and relatively cheap. When the Talmud says, “The best of physicians should go to hell,”¹ it reflects the fact that patients seldom were cured by physicians, even though doctors held out that hope.

With the advent of antibiotics, other new drug therapies, and new diagnostic and surgical techniques, however, there has been an immense increase in the demand for medical care precisely as it has become much more expensive. This raises not only the “micro” questions of how physicians and patients should treat a given person’s disease, but also the “macro” questions of how we, as a society, should arrange for the medical care to be dis-

¹ M. Kiddushin 4:14 (82b). Exactly why “the best of physicians are destined for hell” is disputed. Rashi suggests several reasons: (1) Being unafraid of illness, they do not appropriately adjust the diet of the sick and feed them instead food for healthy people; (2) Again, because they do not fear illness and sometimes cure it, they are haughty before the Almighty; (3) Their treatment is sometimes fatal; and, finally, (4) On the other hand, by refusing treatment to the poor, they may indirectly cause their death. Hanokh Albeck, in his commentary to the Mishnah ([Tel Aviv: Dvir, 1958], vol. 3, p. 330), suggests that it is because they are not careful in their craft and thus cause sick people to die (similar to Rashi’s first and third explanations combined). Philip Blackman suggests in his commentary to the Mishnah ([New York: Judaica Press, 1963], vol. 3, p. 484, n. 27) that the subject of this curse is not doctors *per se*, but, “one who pretends to be a specialist and in consequence brings disaster to his patients.” The Soncino translation and commentary to the Talmud ([London: Soncino, 1936], Nashim, vol. 4, p. 423, n. 9, citing the *Jewish Chronicle* of 3 January 1935), says that “it is probable that it is not directed against healing as such, but against the ‘advanced’ views held by physicians in those days.”

tributed. On both levels, the ultimate question is the Kantian one: nobody has a duty to do that which humanly cannot be done, but once we gain the ability to do X, the moral question arises as to whether we should. On the macro level, this becomes the question of how much medical care should be provided to everyone in society as part of our collective duty to care for each other.

According to Jewish law, we have the clear duty to try to heal, and this duty devolves upon both the physician and the society. This, theologically, is somewhat surprising. After all, since God announces in the Bible that He will inflict illness for sin and, conversely, that He is our healer,² one might think that medicine is an improper human intervention in God's decision to inflict illness.

The Rabbis were aware of this line of reasoning, but they counteracted it by pointing out that God Himself authorizes us to heal. In fact, they maintain, God requires us to heal. They found that authorization and that imperative in various Biblical verses, including Exod. 21:19-20, according to which an assailant must insure that his victim is "thoroughly healed," and Deut. 22:2, "And you shall restore the lost property to him." The Talmud understands the Exodus verse as giving "permission for the physician to cure." On the basis of an extra letter in the Hebrew text of the Deuteronomy passage, the Talmud declares that that verse includes the obligation to restore another person's body as well as his or her property, and hence there is an obligation to come to the aid of someone in a life-threatening situation. On the basis of Lev. 19:16, "Nor shall you stand idly by the blood of your fellow," the Talmud expands the obligation to provide medical aid to encompass expenditure of financial resources for this purpose.³

In addition to these halakhic grounds for providing health care, there is an important theological underpinning. God is to be our model Whom we are to imitate. As the Talmud (Sotah 14a) teaches:

"Follow the Lord your God," (Deut. 13:5). What does that this mean? Is it possible for a mortal to follow God's presence? The verse means to teach us that we should follow the attributes of the Holy One, praised be He. As He clothes the naked, you should clothe the naked. The Bible teaches that the Holy One visited the sick; you should visit the sick.

We praise God in the Amidah: "You support the falling, heal the ailing, free the fettered."⁴ Accordingly, we are called upon to help others and provide health care to those in need.

While each Jew must come to the aid of a person in distress, and while the assailant has the direct duty to cure his victim, Jewish law recognized the expertise involved in medical care and thus here, as in other similar cases, the layman may hire the expert to carry out his obligations. Experts, in turn, have special obligations because of their expertise. Thus Joseph Karo (1488-1575) says:

The Torah gave permission to the physician to heal; moreover, this is a religious precept and is included in the category of sav-

² God inflicts illness for sin: Lev. 26:16; Deut. 28:22, 59-60. God as our healer: e.g., Exod. 15:26; Deut. 32:39; Isa. 19:22; 57:18-19; Jer. 30:17; 33:6; Hos. 6:1; Ps. 103:2-3; 107:20; Job 5:18.

³ B. Bava Kamma 85a; B. Sanhedrin 73a.

⁴ Translations from *Siddur Sim Shalom*, ed. Jules Harlow (New York: Rabbinical Assembly and United Synagogue, 1985), pp. 19, 107.

ing life, and if the physician withholds his services, it is considered as shedding blood.⁵

That the community shares in this responsibility together with the physician becomes clear from several sources. The Talmud, for example, describes ten services that a city must provide to make it fit for a Jewish scholar to live there, and the service of a physician is one of them:

A scholar (of Torah) should not reside in a city where (any of) the following ten things is missing: 1. A court of justice that (has the power to) impose flagellation and decree monetary penalties; 2. A *צדקה* fund collected by (at least) two people and distributed by (at least) three; 3. A synagogue; 4. Public baths; 5. A privy; 6. One who performs circumcisions (a *מרהל*); 7. A physician; 8. A scribe (who also functions as a notary); 9. A (kosher) butcher; 10. And a schoolmaster. Rabbi Akiba is quoted as including also several kinds of fruit (in the list) because they are beneficial to one's eyesight.⁶

Since each Jewish community needed a rabbi to interpret Jewish law and to teach the tradition, this list of requirements for having a rabbi effectively makes it every Jewish community's responsibility to furnish medical services. In the Middle Ages, Nahmanides (1194-1270) offers an additional rationale for this communal duty, basing it on the commandment in the Torah, "You shall love your neighbor as yourself," and reasoning that just as you would want medical care when you need it, so you need to provide it for others when they need it.⁷

2. *Prevention in preference to cure*

Illness is debilitating. In addition to any physical pain involved, sickness brings with it the frustration of not being able to pursue our normal tasks in life. We feel shaken in our sense of physical and psychological integrity, our sense of safety and security, and, indeed, in our sense of ourselves.

Illness is also degrading. When sick, we feel diminished as human beings. As much as we need to divorce ourselves from a common American evaluation of people in terms of their skills and accomplishments, recognizing instead the inherent value in every human being, when sick we inevitably feel that the divine aspect of power has been reduced in us. It also can be humiliating to have to be dependent on others for help in doing the everyday tasks of living. One feels like an infant.

These characteristics of illness make it preferable to prevent it in the first place than to cure it once it strikes. There are, of course, pragmatic considerations as well. It is still true today that "an ounce of prevention is worth a pound of cure," and sometimes, as is currently the case with regard to AIDS, we cannot cure a disease at all but we can prevent it. Historically, that was true for most diseases; for doctors were not able to cure very much, but their knowledge of preventive techniques was, in some ways, quite sophisticated. The fact that in practice we can prevent disease more easily and more economically than we can cure it, though, is not the whole of the story; we must prefer prevention to cure also in order to ward off the debilitating and degrading aspects of disease.

⁵ Joseph Karo, S.A. Yoreh De'ah 336:1.

⁶ B. Sanhedrin 17b.

⁷ Nahmanides, *Kitvei Haramban*, ed. Bernard Chavel (Jerusalem: Mosad Harav Kook, 1963), vol. 2, p. 43 (Hebrew). The verse from the Torah: Lev. 19:18.

B. Precedents and Analogies for the Provision of Health Care: Poverty and the Redemption of Captives

Halakhic sources are clear that members of the community are obligated to perform the mitzvah of *בקרר חולים*, visiting the sick. Even if our ancestors did not have many medications at hand to cure diseases, they knew better than we that cure depends crucially on the patient's will to live. Disease is inherently isolating and degrading. Those who visit the sick and engage them in adult conversations therefore contribute immeasurably to their recovery. This is especially crucial in our own time, when patients with serious illnesses are often treated not in the familiar surroundings of home, but rather in the strange, antiseptic environment of the hospital. Our communal responsibility for health care demands our time and caring. In addition to conversation and prayer, attending to spiritual needs of the sick individual, visitors are expected to care for the tangible needs of the patient as well.⁸

Some authorities also articulate a general expectation that the community as a whole will contribute to the healing of ill individuals.⁹ Traditional sources, though, have relatively little discussion of the extent of this responsibility. This is not surprising, as both the effectiveness and costs of medical treatments were much more limited in past centuries than they are today. Traditional sources, however, have more extensive discussion of the extent of the community's responsibility to provide for individuals in other contexts, of which two are especially relevant to health care: *צדקה*, support for the poor; and *פדיון שבוים*, redeeming captives.¹⁰

1. Poverty Legislation (*צדקה*)

Halakhah understands the responsibility of *צדקה*, literally meaning "justice," to entail enforceable obligations for the community and its members. Codifying traditions going back to the Talmud, the Shulhan Arukh states that "each individual is obligated to give *צדקה*. . . . If one gives less than is appropriate, the courts may administer lashes until he gives according to the assessment, and the courts may go to his property in his presence and take the amount that it is appropriate for him to give."¹¹

Halakhic authorities seek to specify the minimum levels of support required by *צדקה* from the perspectives of both giver and recipient. The general rule is that one pay a tenth of one's income (including acquired capital) for *צדקה*. Giving one fifth represents "choice" fulfillment of the obligation, and one should give, "according to the needs of the poor," even above one fifth of one's income, if one can afford to do so. Many authorities add that one must give at least one fifth when one can afford to do so without difficulty and there is pressing need, and one must give whatever is required in cases immediately involving the saving of life. In other cases, giving more than one fifth is generally seen as commendable, but not obligatory.¹²

⁸ S.A. Yoreh De'ah 335; Immanuel Jakobovits, *Jewish Medical Ethics*, 2d ed. (New York: Bloch, 1975), pp. 106-109. In addition, the Shulhan Arukh (Yoreh De'ah 249:16) indicates that the financial needs of the sick have at least equal claim on communal resources as other requirements of *צדקה*, and may have special priority.

⁹ See n. 7.

¹⁰ These issues are further discussed in Aaron L. Mackler, "Judaism, Justice, and Access to Health Care," *Kennedy Institute of Ethics Journal* 1 (1991): 143-161; and in Elliot N. Dorff, *Matters of Life and Death* (Philadelphia: Jewish Publication Society, 1998), ch. 12.

¹¹ S.A. Yoreh De'ah 248:1. The obligation of *צדקה* in Judaism is binding, analogous to the duty to pay income taxes in the United States.

¹² S.A. Yoreh De'ah 249:1. See Cyril Domb, *Maaser Kesafim* (Jerusalem: Feldheim/Association of Orthodox Jewish Scientists, 1980), pp. 34-38.

The limits on the redistribution of resources required by צדקה depend most importantly on the needs of the poor. The exact determination of needs is debatable, but a broad consensus does emerge from the tradition, centered on the idea of lack, or that which is missing. The Talmud sets parameters in its exegesis of the verse in Deuteronomy (15:8), “You shall surely open your hand to him, and shall surely lend him sufficient for his need/lack, according as he needs/lacks,” (די מחסרו אשר יחסר לו). The Talmud cites an earlier baraita: “Sufficient for his lack’ – you are commanded to support him, and you are not commanded to enrich him; ‘according as he lacks’ – even a horse on which to ride, and a servant to run in front of him.”¹³ As Maimonides paraphrases the guideline, “according to that which is lacking for the poor person, you are commanded to give him. . . . You are commanded to fill in for his lack, but you are not commanded to enrich him.”¹⁴ Note that צדקה, and by implication the distribution of health care, only requires meeting the needs of all members of society, not providing anything that would be of benefit. At the same time, as the second half of the baraita suggests, we must be prepared to construe these needs broadly.

The general standard against which lacks are evaluated is largely implicit. Traditional sources, though, do provide a list of paradigmatic cases:

If it is appropriate to give him bread, they give him bread; if dough, they give him dough. . . if to feed him, they feed him. If he is not married and wants to take a wife, they enable him to marry; they rent a house for him, and provide a bed and furnishings.¹⁵

A woman who wishes to be married is similarly provided with a dowry. Clothing and other basic needs are implicit. Moses Isserles notes that the provision of such needs is primarily the responsibility of the community.¹⁶ The basic requirement of צדקה is thus to provide food, clothing and shelter, and with these, the opportunity for family life.¹⁷ Yet even the meeting of other needs may be obligatory, as the baraita’s discussion of providing a horse at least rhetorically reminds us.¹⁸

Extrapolating from these general requirements would require the provision of a “decent minimum” of health care, sufficient to meet the needs of each member of the community. Such needs could generally be interpreted in a fairly basic and objective way, though special needs of individuals may in some cases be considered as well.

2. Redemption from Captivity (פדיון שבויים)

The redemption of captives, those captured by slave traders or unjustly held prisoner, provides a precedent even more closely analogous to at least some types of medical care. This category of acute needs is seen to take precedence even over general obligations of צדקה. Funds collected or allocated for any other purpose may be diverted to securing the release

¹³ B. Ketubbot 67b.

¹⁴ Moses Maimonides, M.T. Laws of Gifts to the Poor 7:3.

¹⁵ S.A. Yoreh De’ah 250:1.

¹⁶ Ibid.

¹⁷ The provision of universal education is a separate communal obligation. See S.A. Yoreh De’ah 245:7, 249:16; *Encyclopaedia Judaica*, s.v. “Education.”

¹⁸ The Talmud, and subsequently codes, understand the “lack” of a horse as relative to the previous condition of a once-wealthy recipient. Following this paradigm, special needs might be understood in terms of the previous status of an individual, current psychological needs, or expectations or felt needs. While this paper follows a relatively conservative interpretation of focusing on objective needs and a basic level of support, the provision of a horse serves as a rhetorical injunction to be sensitive to special needs of individuals, at least in exceptional cases.

of captives when necessary. Maimonides, for example, states that “the redemption of captives takes precedence over the support of the poor, and there is no greater obligatory precept than the redemption of captives.” He offers the explanation that, “a captive falls in the category of the hungry and the thirsty and the naked, and stands in danger of his life.”¹⁹ Health care shares these characteristics that justify the priority accorded to פְּדוּיֵן שְׂבוּיִים: both concern individuals who are suffering and may be in immediate danger. Further, both categories entail special needs that vary greatly among individuals. Jewish law and ethics understand the community to have a fundamental obligation to save lives whenever possible, diverting funds from other projects as required.²⁰

Part I: The Responsibility of Patients and Their Families

שאלה

To what extent are individual patients and their family members responsible for providing health care?

תשובה

Individuals bear some of the responsibility for maintaining their health. This begins with taking steps to prevent illness in the first place. While curative medicine in past centuries was not well developed, our ancestors knew a great deal about preventive medicine. Thus Maimonides (Mishneh Torah, Deot, 4:1ff.), for example, asserts a positive obligation “to avoid anything that is injurious to the body, and to conduct oneself in ways that promote health.” He already states the importance of proper diet, exercise, hygiene, and sleep. Conversely, he repeats the Talmud’s prohibition of abusing our bodies through unhealthy habits. In carrying out our primary duty to provide for our own health care, then, we in our time need to pay heed to those ancient prescriptions for keeping ourselves healthy so that we can carry out our God-given mission to help others and to fix the world.

When one needs the aid of health care professionals, the individual must bear at least some of the financial burden. Thus the Shulhan Arukh rules as follows:

If someone is taken captive and he has property but does not want to redeem himself, we redeem him (with the money that his property will bring) against his will.²¹

While this source speaks of redemption from captivity and not health care, the duty to redeem captives is based on the danger to their lives in captivity. As argued above, this rule about financing a person’s freedom is thus a reasonable source for determining whether an individual has a financial responsibility for his or her own health care as well, and the ruling makes it clear that one does.

In traditional Jewish sources, these requirements are described as the duties of a man toward his own health care, but a man’s responsibility to pay for the health care of his wife

¹⁹ M.T. Laws of Gifts to the Poor 8:10. See also S.A. Yoreh De’ah, 252:1.

²⁰ S.A. Yoreh De’ah 252:4; Talmud Bavli Gittin 45a. The standard case in the tradition is that in which payments for the captive’s release are necessary and will be effective in securing the captive’s freedom. Accordingly, the analogy would apply to medical care that is both necessary and effective.

²¹ S.A. Yoreh De’ah 252:11.

is even clearer, for among the obligations that a man assumes in marriage is the medical care of his wife.²² Similarly, for her redemption the Shulhan Arukh rules:

If a man and his wife are in captivity, his wife takes precedence over him. The court invades his property to redeem her. Even if he stands and shouts, “Do not redeem her from my property!” we do not listen to him.²³

Thus a man has a clear duty to provide medical care for his wife, especially, but not exclusively, when her life is threatened in captivity or, presumably, in some other way.

He has the same duty vis-à-vis his children and other relatives if they cannot care for themselves. Once again, the precedent for this comes from the laws of redemption from captivity:

A father must redeem his son if the father has money but the son does not. Gloss: And the same is true for one relative redeeming another, the closer relative comes first, for all of them may not enrich themselves and thrust [the redemption of] their relatives on the community.²⁴

In our own, more egalitarian society, these sources would presumably mean that spouses of either gender have responsibility for the health care of each other and of their children. In carrying out that responsibility, one may not preserve the family fortune and make the Jewish community or government pay for one's own health care or that of one's spouse or children, except to the extent that the government itself makes provision for all sick, elderly citizens in programs like Medicare without restrictions as to a person's income or estate. Absent such provisions in the law, one must provide for one's own health care and for that of one's relatives. One might do that by using one's own assets or through buying a health insurance policy, either privately or through one's employment. One may only, according to these sources, call on public aid when and if one qualifies for aid to the poor through programs like Medicaid.²⁵

²² M. Ketubbot 4:9; S.A. Even HaEzer 79.

²³ S.A. Yoreh De'ah 252:10; Even HaEzer 78. This is ultimately based on the Mishnah's insistence that a man redeem his wife from captivity before being able to divorce her; cf. M. Ketubbot 4:9.

²⁴ S.A. Yoreh De'ah 252:12.

²⁵ The individual also has a duty to contribute to the medical care of others. Although this generally is not spelled out in just those words, it is a clear implication of the understanding of the community's obligations seen above. Traditional sources obligate individuals to contribute to the needs of others through צדקה and פדיון שבויים. Moreover, the Rabbis, as we have seen, see the absence of health care as shedding blood. Since the physician alone cannot be expected to bear the costs of health care for those who cannot afford it, this duty devolves upon the community, and the costs of health care for the poor become part of the צדקה one must give, a strict and enforceable obligation. See the discussion above in section I; M.T. Laws of Gifts to the Poor 7:10; S.A. Yoreh De'ah 248:2. At the same time, there are limits on this obligation. The Shulhan Arukh and the Jewish tradition in general, acknowledge limits on the obligation to provide for the needs of others, at least in exceptional cases. In the most extreme case, one does not have to endanger one's own life in order to save the life of another. As seen above, each individual is generally not obligated to pay more than ten or twenty per cent of income toward the provision of the needs of the poor. While the obligation to provide all resources necessary to save lives generally supersedes all such limits, halakhic sources can envision cases in which not all lives can be saved, and offer various sets of priorities to consider in such extreme cases. S.A. Yoreh De'ah 252:5-12; see Shlomo Dichowsky, “Rescue and Treatment: Halakhic Scales of Priority” (Hebrew), *Dine Israel* 7 (1976): 45-66; Martin Goding, “Preventive vs. Curative Medicine,” *Journal of Medicine and Philosophy* 8 (1983): 276-279; Fred Rosner, *Modern Medicine and Jewish Ethics*, 2d ed. (Hoboken, N.J.: Ktav, and New York: Yeshiva University Press, 1991), pp. 375-390.

Patients who have no resources to pay for health care may accept public assistance to procure it. In fact, they must do so, for to refuse needed care is to endanger their lives which is, for Jewish law, tantamount to committing suicide. Still, the Shulhan Arukh strongly condemns those who use public funds for their health care when they do not need to do so, and it appreciates those who postpone calling upon the public purse for as long as possible:

Anyone who does not need to take from the צדקה fund and deceives the community and takes money will not die until he does indeed need צדקה from others. And whoever needs to take such that he cannot live unless he takes, for example, an elderly person or a sick person or a suffering person, but he forces himself not to take is like one who sheds blood (namely, his own) and he is liable for his own life, and his pain is only the product of sin and transgression. But anyone who needs to take (צדקה) but puts himself instead into a position of pain and pushes off the time (when he takes צדקה) and lives a life of pain so that he will not burden the community will not die until he sustains others, and about him Scripture says, "Blessed is the man who trusts in God."²⁶

Conversely, unless a given drug or medical procedure is so scarce that the government has put limits on who may obtain it even with their own money, individual patients who have the money to afford something that the government or their private plan does not provide may decide to use it to pay for the drug or procedure privately. Thus, the Shulhan Arukh, following earlier formulations of Jewish law, puts a limit on the amount of money a community may spend on redeeming any given captive in order to depress the market in captives and ultimately to deter kidnapping altogether, but even though that is a distinct social good, a given individual is free to spend as much of his own funds as he wishes to redeem himself or his relative:

We do not redeem captives for more than their worth out of considerations of fixing the world, so that the enemies will not dedicate themselves to take them captive. An individual, however, may redeem himself for as much as he would like.²⁷

This is unfair in one sense, but it is only the unfairness built into any capitalistic system, and Jewish sources do not require that Jews use socialism as their form of government or their rule for distributing and charging goods. In the provision of health care as in other areas, the Jewish tradition does not enforce a ceiling of the resources one may spend for one's own benefit, but rather seeks to establish a floor that, at a minimum, assures at least the basic needs for all.

Conclusion

Individuals and family members have the responsibility to care for their own health, and the primary responsibility to pay (directly or through insurance) for health care needed by themselves or by family members. When they cannot do so, they may and should avail themselves of publicly funded programs to acquire the health care they need. In any case, one should seek to prevent illness rather than wait to cure an illness that has already occurred.

²⁶ S.A. Yoreh De'ah 255:2.

²⁷ S.A. Yoreh De'ah 252:4.

Part II: The Responsibility of Physicians and Other Health Care Professionals

שאלה

To what extent are physicians and other health care providers responsible for providing health care?

תשובה

The same general principles would apply to the societal obligation for provision of health care. To begin with the physician, halakhic sources, as noted above, discuss in general terms the mandate for the individual physician to heal and for the individual patient to seek healing.²⁸ While physicians have very definite obligations towards their patients, they generally may expect to receive appropriate fees.

Nonetheless, Jewish medical writers through the ages have urged physicians to treat the poor without charge. The Talmud commends as an ideal the practice of Abba the therapeutic blood letter. He had his patients deposit their payments in a box so that those who could afford to pay could pay, while those who could not afford to do so could receive treatment without embarrassment. In some cases he would give a needy patient money for sustenance during recuperation.²⁹ In the nineteenth century, Rabbi Eleazar Flekeles ruled that free care of the poor was not only a virtue to be expected from a benevolent physician, but a halakhic obligation enforceable by a (religious) court.³⁰ While there are limits on the extent of such obligation in contemporary societies, as discussed below, the strong expectation that physicians will provide health care that is needed is clear.

While traditional sources focus on the responsibility of providing health care for the needy, in our own day these questions no longer affect the poor alone. Most people simply cannot pay for some of the new procedures, no matter how much money they have or can borrow. The size of the problem makes even conscientious and morally sensitive physicians think that any individual effort on their part to resolve this issue is useless. Moreover, the costs that they themselves assumed in gaining a modern medical education must somehow be repaid – to say nothing of malpractice insurance, overhead for their offices and for the hospitals in which they practice, staff, and the like. The question of paying for medical care in our society therefore becomes a critical issue.

Traditional Jewish communities that expected physicians to treat those in need without pay customarily offered tax benefits and other privileges in return. In some cases, the community would directly hire physicians to provide for the treatment of the poor and others. While unpaid treatment of the poor was the norm, the Portuguese-Jewish community in Hamburg in 1666 declined the offer of a physician to treat the poor with no charge, on grounds that “it is not fitting to engage someone without salary; for the payment will force the doctor to be [o]n time when called in by a patient.”³¹ Along the same lines, the Talmud asserts that a physician who heals for nothing is worth nothing.³²

²⁸ See above, section I; S.A. Yoreh De'ah 336; Rosner, 5-19; J. David Bleich, “The Obligation to Heal in the Judaic Tradition: A Comparative Analysis,” in *Jewish Bioethics*, eds. Fred Rosner and J. David Bleich (New York: Sanhedrin Press, 1979), pp. 1-44.

²⁹ B. Ta'anit 21b.

³⁰ Eleazar Flekeles, *Teshuvah Me'Ahavah* (Prague, 1820), p. 70, on S.A. Yoreh De'ah 336.

³¹ Jakobovits, pp. 224-228.

³² B. Bava Kamma 85a.

Still, the example of Abba, the bleeder, and the stipulation in the Shulhan Arukh that withholding medical care is akin to murdering someone both establish that in Jewish law physicians have a primary duty to provide medical care. This would make systems of managing care that discourage doctors from providing needed and effective care Jewishly illegitimate, or at least suspect. Capitation, for instance, gives doctors a sum of money for each patient per year regardless of the amount of care they provide; that makes it economically disadvantageous to doctors personally to treat patients extensively, for the more time they spend with a patient, the less they earn per patient. Such a system can only be reconciled with the fundamental Jewish duty of physicians to care for their patients if there is some way to offset this economic pressure that mitigates against treatment so as to guarantee that doctors will nevertheless provide good care. Modifications of the physicians' professional code of ethics or government regulation may be part of what is needed to spell out accepted standards of care, and, however the standards are established and announced, capitation would inevitably require more frequent peer review than now occurs. If such measures proved unsuccessful in counterbalancing the economic pressures of capitation so as to guarantee a reasonable level of care, Jewish principles would forbid capitation as a violation of the duty to provide needed medical care.³³

In addition, the underlying duty of physicians to provide care means that they bear at least some responsibility for making health care available to those who cannot afford their normal fees. This would impose on doctors the obligation to do some work at reduced rates or for free. Like other people, though, they have a right to earn a living, and so the community and the individual patient must also share a portion of the financial burden.

In times past, all medical procedures were administered by two types of personnel: the physician and the surgeon. It is only in recent times that other health care professions have arisen as separate entities. Thus classical Jewish sources do not speak about nurses, physician assistants, health care technicians, social workers concentrating in health care, etc. One would expect, though, that the sources discussed above governing physicians would apply, *mutatis mutandis*, to other health care personnel as well. That is, such personnel, on this analysis, would have the positive obligation to provide some *pro bono* and emergency services, but that obligation would be limited so that they can earn a fair living. The remainder of the cost must be provided by the community and individual patient.

³³ In the United States, a number of states have passed laws restricting financial incentives to physicians. For example, Texas prohibits financial incentives that serve as inducements to limit medically necessary care (Tracy F. Miller, "Managed Care Regulation: In the Laboratory of the States," *Journal of the American Medical Association* 278 [1997]: 1104). According to the Council on Ethical and Judicial Affairs of the American Medical Association, "financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care." Furthermore, "regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients." ("Ethics in Managed Care," *Journal of the American Medical Association* 273 (1995): 334-335). Before affiliating with a managed care plan, an individual physician has the responsibility to ascertain the implications for his or her being able to provide appropriate patient care (as Haavi Morreim, a secular ethicist who is generally sympathetic to managed care, notes [*Balancing Act: The New Medical Ethics of Medicine's New Economics* (Washington: Georgetown University Press, 1995), pp. 121-23]). A physician should be willing to make at least some degree of financial sacrifice in order to better care for patients. In some cases, some degree of compromise from the ideal might be required in order for a physician to be able to practice in a given area. Precise resolution of such dilemmas is beyond the scope of this paper. Note, though, that for the Council on Ethical and Judicial Affairs of the American Medical Association, "physicians should not participate in any plan that encourages or requires care at or below minimum professional standards" ("Ethics in Managed Care," pp. 334-35).

Conclusion

Physicians and other health care professionals must treat patients in case of emergency, and they have some responsibility more generally to make health care available to those who cannot afford their normal fees. At the same time, health care professionals legitimately may expect compensation for their efforts and expenses, and should be able to earn a living.

Part III: The Responsibility of the Community

שאלה

What is the extent of the community's responsibilities to provide health care? In contemporary countries such as the United States and Canada, to what extent are these responsibilities of the Jewish community? Of the general society?

תשובה

A. Responsibilities

As communities have grown larger and the provision of health care more expensive, the role of the community in assuring provision of needed care has become more central.³⁴ While accepting Flekeles's nineteenth-century ruling on the individual physician's obligation to provide care, the contemporary authority Rabbi Eliezer Yehudah Waldenberg notes problems in enforcement even within a traditional Jewish community today. The logical basis for the ruling, he observes, is that when an individual cannot afford to pay for medical care, the court, on behalf of the community, acquires the obligation for that person's healing. Because the court has responsibility for the health care of that individual, it has the power to force the physician to treat the individual. The community's responsibility for the care of that person logically falls on the physician more than anyone else, because of the physician's special knowledge and ability.³⁵

Waldenberg asserts that while a virtuous physician is expected to provide charitable free care for the poor, this can only be enforced as a legal responsibility in a community that has just one physician. In contemporary communities with more than one physician, possibilities for meeting the community's obligation to assure provision of health care include appropriating money from the general welfare (צדקה) fund, conducting a special financial appeal, and equitably apportioning cases to all physicians for treatment on a *pro bono* basis. The most praiseworthy option, however, is to establish a special fund for the payment of physician fees for treatment of the poor.³⁶

The central point of Waldenberg's analysis is consistent with the tradition's understanding of the importance of health care, and the general guidance provided by discussion of צדקה and פדיון שבויים. If an individual cannot afford to pay for needed health care, the obligation to provide for that care devolves on the community as a whole. The community may legitimately choose any of a variety of ways to meet this responsibility, so long as the responsibility is met in every case of need. While it is commendable for a physician to treat the poor with-

³⁴ Indeed, by the sixteenth century Isserles noted that the central locus for the provision of צדקה had shifted from individuals to the community (S.A. Yoreh De'ah 250:1).

³⁵ Eliezer Yehudah Waldenberg, *Ramat Rachel* (printed with vol. 5 of *Tzitz Eliezer*) (Jerusalem, 1985), responsum no. 24, p. 31.

³⁶ *Ibid.*, pp. 31-32.

out charge, and while a virtuous physician will do so routinely as part of his or her practice and always when an emergency arises, such treatment represents a halakhic obligation and requirement of justice only when the community has fairly designated the physician as responsible for fulfilling the community's obligation. Preferred ways to meet this communal responsibility for the care of the poor include a societal health payment program, perhaps analogous to Medicare or national health insurance, or direct government provision of medical care.

The standard for the amount of care to be assured is that of need. Patients are not entitled to, and society not obligated to provide, all care that is desired, all care that might offer some benefit, or all care that anyone else in the society receives. The community is obligated, however, to assure access to all care that is needed by a patient to lead a reasonably full life.³⁷ While identifying "needed" treatments will change with developing medical practice and vary among individual cases, in general it would be treatment that would be effective in sustaining life, curing disease, restoring health, or improving function.³⁸

Two areas of health care require special mention. First, in distribution of health care as in other areas, halakhah would understand health and health care to include mental as well as physical health.³⁹

Second, the community's responsibilities to provide health care are not limited to curative care; they include preventive care as well.⁴⁰ In the societies of times past, the preventive medical care that was available was relatively limited in cost, and so the need to allocate significant resources for such care does not seem to have arisen. Nevertheless, in our own time the provision of some preventive care, such as vaccination and prenatal care, is mandatory on two grounds. First, since prevention is often less expensive than cure, and since society is ultimately obligated to provide all curative care needed, communities should provide significant preventive care as a cost-effective way to meet that duty.⁴¹

³⁷ Traditional Jewish sources find concepts analogous to "need" relatively unproblematic, and devote little attention to specifying the levels of food, shelter, or medical care required by justice. The generally implicit standard of the codes at least roughly corresponds with the concept of "natural function" or "species-typical functioning," developed by Christopher Boorse and utilized by Norman Daniels in discussing allocation of health care (Daniels, *Just Health Care* [New York: Cambridge University Press, 1985], esp. pp. 26-32).

³⁸ Possible limits on the degree to which a particular society can afford to provide such care as balanced against its other obligations are discussed below.

³⁹ Rabbi Elliot N. Dorff, "The Jewish Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, eds. Ronald L. Numbers and Darrel W. Amundsen (New York: Macmillan, 1986), pp. 23-25; David M. Feldman, *Health and Medicine in the Jewish Tradition* (New York: Crossroad, 1986), p. 49; citing: B. Yoma 82a; Nahmanides, *Torat HaAdam*; Israel Meir Mizrahi, *Responsa Pri HaAretz, Yoreh De'ah* no. 2; Mordekhai Winkler, *Responsa Levushei Mordekhai*, Hoshen Mishpat no. 39; *Responsa Minhag Yitzhak*, vol. 1, no. 115; *Responsa Igrot Moshe*, Even HaEzer no. 65.

⁴⁰ See Martin Golding, "Preventive vs. Curative Medicine," *Journal of Medicine and Philosophy* 8 (1983): 269-86.

⁴¹ Louise Russell and others, however, note that the relative cost effectiveness of preventive and curative care varies greatly, and that many preventive measures cannot be justified solely on the basis of cost effectiveness. While preventing one person's disease is generally less expensive than curing disease that has occurred, large numbers of patients may need to be screened and treated for each case of disease prevented. Studies have found that screening for cervical cancer among low-income elderly women who had not been screened in many years can save money, for example, but that routinely screening women every year instead of every two years costs \$1.8 million for each year of life saved, far more than many curative interventions (Louise B. Russell, "The Role of Prevention in Health Reform," *New England Journal of Medicine* 329 [1993]: 352-354). See also Russell's "Some of the Tough Decisions Required by a National Health Plan," *Science* 246 (1989): 892-896; *Is Prevention Better Than Cure?* (Washington, DC: Brookings Institution, 1986), p. 110; David M. Eddy, "Cost-effectiveness Analysis: Is It Up to the Task?" *Journal of the American Medical Association* 267 (1992): 3346-3347. The extent of preventive care that should be considered appropriate or "needed" is an issue of ongoing debate in bioethics and health policy. Paul Menzel (*Medical Costs, Moral*

Moreover, since prevention avoids the degradation of illness, communities must provide preventive care for that theological and humanitarian consideration as well.

B. Limits

At the same time, there are some limits. The responsibility to provide for the redemption of captives may also be limited when the captive is responsible for his own predicament, though only in the most extreme cases. The *Shulhan Arukh* considers the case of one who sells himself into captivity, or is held prisoner as a result of defaulting on a loan. The community must pay to free the captive if this is the first or second time that he has brought about his own captivity, but the community need not make such payments after the third such occurrence. In case of immediate threat to the captive's life, though, even the captive responsible for his own captivity must be rescued.⁴² By analogy, those who make choices (in lifestyle or health care) that turn out to be unfortunate or irresponsible thereby attenuate their claims to the community's support, but do not forfeit all such claims. Individuals who do not purchase health insurance when they are able to do so fail to live up to their responsibilities. Still, they remain persons of infinite value, created in God's image. The community must continue to provide some care even for those responsible for their own misfortune, in this or other ways, especially in cases involving threats to life. Formulating an equitable public policy within these parameters is a complex challenge. Possible alternatives include universal national health insurance, and requirements for individuals to purchase catastrophic health insurance coverage.

A more general limitation is noted on the financial extent of the obligation to redeem captives. "One does not redeem captives for more than their monetary worth" as slaves. This provision dates back to the *Mishnah*, and the *Talmud* debates whether such a limit could be justified as protecting the community from onerous burdens or as "improving the world" (תיקון עולם) by avoiding incentives for future hostage taking. The *Shulhan Arukh*, following *Maimonides* and other codifiers, accepts only the latter justification.⁴³ Resources to help an individual with exceptional needs may be limited to generally accepted levels when this limitation is necessary to avoid endangering others. By analogy, it could be argued that a community's paying for extremely expensive experimental treatments, such as an artificial heart, might significantly weaken the health care system as a whole, thereby depriving future patients of needed care. In such cases, a community may be justified in limiting expenditures to the range reasonably expected by most patients.

Moreover, the community must use its resources wisely. The *Talmud* lists ten services that a community must provide, and in our own day, there are undoubtedly others which the non-Jewish government took care of in *Talmudic* and medieval times but which are vital to any society – services like defense, civil peace, and roads and bridges. The community must balance its commitments to health care against its responsibility to provide other services, whether those on the *Talmud's* list of ten or others that arise and are deemed necessary, and it must ensure that those who get public assistance for their health care deserve it.

Choices [New Haven: Yale University Press, 1983], p. 83), for example, argues that even granting that "people need to avoid suffering or dying does not mean that they need all the things which reduce the chances of suffering or dying." At the same time, even preventive measures that increase health care expenses may be warranted because they prevent suffering and support human dignity, as discussed in the text.

⁴² S.A. *Yoreh De'ah* 252:6.

⁴³ B. *Gittin* 45a; S.A. *Yoreh De'ah* 252:4.

Such limits should not be invoked too quickly, however. Very few interventions require such extraordinary expenditures that their provision would not only be burdensome for society, but would endanger the health care system. More basically, possible limits to intervention must always be weighed against the value of human life and healing, and the injunction that a physician who fails to provide needed care is considered as one who sheds blood. In the case of redemption of captives (פדיון שבויים), some authorities state that even excessive ransoms may (or must) be paid in cases of immediate danger to a hostage, despite the importance of saving future lives.⁴⁴

Similarly, while the Talmudic consideration of a limit on payments for the redemption of captives in order to avoid an onerous burden on the community has been accorded little weight by halakhic authorities, it might be argued that modern medical technology has revived the need for consideration of such limits on societal obligations, at least in extreme cases involving very expensive and questionably effective procedures. The relevance of such limits to contemporary nations such as the United States requires further consideration and empirical research. Given the relative affluence of such countries, though, much more could be done for the poorest and most disadvantaged without approaching the above limits on minimal obligations. In particular, these societies do not face the absolute poverty that would force them to allow otherwise preventable deaths by failing to provide adequate health care (or by failing to provide adequate food, clothing, or shelter). While there is some room for consideration of limits on expenditures, the strong presumption of the Jewish tradition is for provision of the resources necessary to preserve and save life.⁴⁵

C. Responsibilities of the Jewish and General Communities

The community has a responsibility to provide needed health care to all of its members. But what counts as a community – the United States as a whole, a synagogue, a metropolitan area’s general or Jewish population? And, however we define “community,” what are the obligations to those outside the community?

Jewish sources do not provide an unambiguous position. Our own best reading of them is that all members of the community, and in fact all humans, have equal intrinsic value before God.⁴⁶ From this point of view, I relate to each human person as a being of value whom I must respect. Yet I additionally stand in a variety of special relationships with some persons, such as family members and fellow citizens. These special relationships of care and commitment entail particular responsibilities in varying degrees. To take a contemporary example, it may be appropriate for United States citizens to accord some degree of priority to fellow citizens over the needy in other nations or even over those living here illegally.

Consistent with this view, halakhic sources picture the individual’s responsibilities as radiating in concentric circles, with responsibility most acute for those to whom one stands in closest relation. Accordingly, if an individual’s resources to meet the needs of others are limited, priority should be given to members of his or her household before others, and to inhabitants of one’s own city before those of other cities. While greatest

⁴⁴ See above, and S.A. Yoreh De’ah 252:4; 336.

⁴⁵ While full evaluation of arguments for rationing is beyond the scope of this paper, rationing that denies needed health care is a last resort, and at best premature given the lack of serious efforts to provide needed health care or to limit that which is unneeded.

⁴⁶ See Louis Finkelstein, “Human Equality in the Jewish Tradition,” in *Aspects of Human Equality*, ed. Lyman Bryson et al. (New York: Harper and Brothers, 1956), pp. 179-205. Finkelstein argues that all humans are equal in that they may serve and have obligations to God, and that all may have a share in the world to come.

resources should be devoted to those with whom one stands in closest relationship, however, one must offer some degree of support to those who are more distant as well.⁴⁷

Some degree of responsibility would extend to those beyond the community. Throughout most of Jewish history, Jews have formed independent or semi-autonomous communities; only in recent centuries have Jews been equal citizens in societies of nation-states. For most classical sources, then, the “community” refers to the Jewish community. Even from this vantage point, classical sources call on Jews to support the needy outside the Jewish community along with needy Jews, “for the sake of the paths of peace.”⁴⁸

In our own day, Jewish federation councils coordinate the fund-raising activities of the Jewish community, and so the federation may be seen as the communal agency that, according to the sources, should be responsible for providing for health care. Federations, however, do not have the taxing or police powers of pre-Enlightenment Jewish communities, and so federations are not completely parallel to the communal authorities of the past. In any case, the cost of health care today is far beyond the resources of federations to supply. Such costs are more appropriately borne by insurance companies and governments, as is indeed the case.

The real question, then, is whether federations should provide some support for Jewish hospitals as an expression of the Jewish communal duty to provide health care. Jewish communities in the early decades of the twentieth century sponsored hospitals in order to provide places where Jewish doctors could work, given that they were barred from practicing in many non-Jewish hospitals. When that form of anti-Semitism diminished in mid-century, Jewish federations continued to sponsor hospitals in order to provide kosher food and other Jewish amenities to Jewish patients, and also as the Jewish contribution to the general community’s health care. In our day, the cost of health care is far beyond the resources of the Jewish community, and there are many other important claims on the Jewish community’s resources in the areas of Jewish education and social services. Individual federations will need to judge whether any of the former grounds for Jewish support of hospitals still hold or whether there are new reasons for the Jewish community to support health care and, if so, how those resources should be balanced against the other needs of the community. In any case, because the federation is not the full equivalent of the communal governing authorities of the past, and because unmet health care costs far exceed those of the past, Jewish law would not require federations to support hospitals or other forms of health care, leaving it rather to the judgment of the federation to balance this communal activity against the others that would benefit the community. Ultimate responsibility for the meeting of health care needs is that of the nation’s government and health care system as a whole.

According to the Jewish model of צדקה and its application to the distribution of health care, the community has concrete responsibilities to provide all needed health care to all within the community. Responsibilities to those outside the community are less strictly enforceable, but still significant. By implication, national communities would have an obligation to provide all needed health care to those within the community: to all citizens without question, probably to all residing legally in the country, and perhaps even to those here

⁴⁷ This priority may be found in M.T. Laws of Gifts to the Poor 7:13; S.A. Yoreh De’ah 251:3. While these texts are unclear about whether there are exceptions to this order, R. Yehiel Michal Halevi Epstein argues that this order of priority is not absolute (Arukh Hashulhan, Yoreh De’ah 251:4).

⁴⁸ M. Gittin 5:8; B. Gittin 61a; M.T. Laws of Idolatry 10:5, Laws of Gifts to the Poor 7:7. The tradition sees Jews as having special responsibilities to support those within the community, but these responsibilities extend to others in the broader human community as well, albeit to a lesser degree.

illegally. After all, as Rabbi Eugene Borowitz observes, the Bible's creation story, depicting all of humanity as descendants of a common ancestor, suggests that "all human beings have familial obligations to one another."⁴⁹

One basic issue in current discussions of allocation of health care resources is whether contemporary nations are the types of communities that have obligations towards their members. Especially in the United States, the distribution of health care is often debated as if providing access to health care were a matter of charity and benevolence. Even on these grounds, it would seem that enlightened self-interest would provide a compelling reason for affording universal access to needed health care. A vision of the nation as a community would make a stronger claim. The Jewish position developed above would make a claim yet stronger, based upon our duty to pursue justice, and to love and care for our neighbor and, indeed, the stranger.

Specific claims of halakhah are not binding on secular nations, of course. Jewish understandings of justice should not (and could not) be imposed monolithically, but should contribute to a national dialogue in which diverse philosophical, religious, and other views would be represented. In the Jewish understanding developed in this paper, securing access to all health care that is needed represents a matter of foundational justice. And whatever the differences between traditional Jewish societies and contemporary countries such as the United States and Canada, all societies are appropriately responsible for the achievement of foundational justice. Jews who are citizens of democratic societies have at least some degree of responsibility to support general institutions that will assure the provision of needed care, through lobbying, social action, and other means.

From the time of the Bible, Judaism has understood social justice as both morally obligatory and crucial to national security. And since that time, Jews have been urged to seek the peace and well-being (shalom) of the nations in which they live.⁵⁰ If such counsel was given even for the Babylonia of Jeremiah's time, the responsibility of Jewish citizens of contemporary nations, in which Jews are full and free citizens, to lobby for sufficient health care for all citizens (and possibly all residents) is much stronger.⁵¹

Conclusions

Jewish law requires that people be provided with needed health care, at least a "decent minimum" that preserves life and meets other basic needs, including some amount of preventive care. The responsibility to assure this provision is shared among individuals and families, physicians and other health care providers, and the community.

The community bears ultimate responsibility to assure provision of needed health care for individuals who cannot afford it, as a matter of justice as well as a specific halakhic obligation. The "community" that bears that responsibility in our day is the national society, through its government, health care institutions, insurance companies, and private enterprise. Jewish citizens should support (by lobbying and other means) general societal

⁴⁹ Eugene B. Borowitz, *Exploring Jewish Ethics* (Detroit: Wayne State University Press, 1990), p. 99. See also M. Sanhedrin 4:5; Simon Greenberg, *A Jewish Philosophy and Pattern of Life* (New York: Jewish Theological Seminary of America, 1981), esp. pp. 219-221.

⁵⁰ Jer. 29:7.

⁵¹ As Abraham Joshua Heschel wrote in another context: "In regard to the cruelties committed in the name of a free society, some are guilty, while all are responsible. I did not feel guilty as an individual American. . .but I feel deeply responsible. 'Thou shalt not stand idly by the blood of thy neighbor' (Lev. 19:15). This is not a recommendation but an imperative, a supreme commandment" (*Moral Grandeur and Spiritual Audacity*, ed. Susannah Heschel [New York: Farrar, Straus and Giroux, 1996], p. 225).

institutions that will fulfill this responsibility. The Jewish community, though its federations, synagogues, and other institutions, must assess whether and to what extent it should support hospitals and other forms of health care. It should balance that purpose against its commitment to other important Jewish needs, such as Jewish education and social services, in light of contemporary patterns of funding health care.

The guarantee of provision of needed health care does not extend to all treatment that is desired, or even all that might provide some benefit. Even needed treatment might be limited when it is so extraordinarily expensive that its provision would deprive other patients of needed care. Still, possible limits to interventions must be weighed against the value of human life and healing, and the injunction that a physician who fails to provide needed health care is considered as one who sheds blood.

Summary of Conclusions

1. Jewish law requires that people be provided with needed health care, at least a “decent minimum” that preserves life and meets other basic needs, including some amount of preventive care. The responsibility to assure this provision is shared among individuals and families, physicians and other health care providers, and the community.

2. Individuals have the responsibility to care for their own health, and the primary responsibility to pay (directly or through insurance) for health care needed by themselves or by family members. When they cannot do so, they may and should avail themselves of publicly funded programs to acquire the health care they need. In any case, one should seek to prevent illness rather than wait to cure an illness that has already occurred.

3. Physicians and other health care professionals must treat patients in case of emergency, and they have some responsibility more generally to make health care available to those who cannot afford their normal fees. At the same time, health care professionals legitimately may expect compensation for their efforts and expenses, and should be able to earn a living.

4. The community bears ultimate responsibility to assure provision of needed health care for individuals who cannot afford it, as a matter of justice as well as a specific halakhic obligation. The “community” that bears that responsibility in our day is the national society, through its government, health care institutions, insurance companies, and private enterprise. Jewish citizens should support (by lobbying and other means) general societal institutions that will fulfill this responsibility. The Jewish community, though its federations, synagogues, and other institutions, must assess whether and to what extent it should support hospitals and other forms of health care. It should balance that purpose against its commitment to other important Jewish needs, such as Jewish education and social services, in light of contemporary patterns of funding health care.

5. The guarantee of provision of needed health care does not extend to all treatment that is desired, or even all that might provide some benefit. Even needed treatment might be limited when it is so extraordinarily expensive that its provision would deprive other patients of needed care. Still, possible limits to interventions must be weighed against the value of human life and healing, and the injunction that a physician who fails to provide needed health care is considered as one who sheds blood.