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Solidarity, Responsibility, and Freedom: Health Care Reform in the United States at the Millennium

by

Peter William McDonald

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APPROVED, THESIS COMMITTEE:

Dr. Gerald McKenny, Chair
Professor, Theology

Dr. John M. Stroup
Professor, Religious Studies

Dr. H. Tristram Engelhardt
Professor, Philosophy

Dr. Edith Wyschogrod
Professor, Religious Studies

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ABSTRACT

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The current crisis in the distribution of health care resources in the U.S. derives largely from insufficient access to health care, on the one hand, and inadequate control of rising costs, on the other hand. The response to the problem of insufficient access should not be the recognition of a moral right to health care but rather the establishment of a legal right to health care for all. In turn, the contours of this legal right can be the means to create the needed cost controls. To this end, they should include a laundry list of covered condition-treatment pairs, which would be informed by the measuring stick of quality-adjusted-life-years, and which would be the product of input from the public, the medical profession, and the Congress. The resultant structure of universal coverage, under a system of explicit rationing, would include a morally mandated second tier. Universal coverage, explicit rationing, and a second tier are the indispensable building blocks of meaningful health care reform in the U.S.
To my mother
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Submitted by
Peter William McDonald

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Part One of Three

1. General Orientation

The central purpose of Part One is essentially two-fold:
1) It will establish the philosophical underpinnings of our general thrust in favor of universal health care coverage, explicit rationing and a second tier.
2) It will argue forcefully that there is no moral right to health care, that there is a moral right to have access to medical care in a second tier, that it would be morally permissible to institute a system of universal health care coverage in the United States, and that it would be morally permissible to incorporate explicit rationing into such a system. Much of the detail concerning universal health care coverage and explicit rationing will be discussed in Parts Two and Three, which will show that they are morally preferable as well as morally permissible, if not morally mandatory. Thus, the goal in Part One is to fashion a scaffolding sufficiently strong to support the argument of Parts Two and Three.

The effort in Part One will be notably more abstract than that of the following two parts. It is here that matters of definition and clarification will be heaviest. We will begin by clarifying the concept of a "right" and will relate rights to their important correlate, that of "duty." From there, we will attempt to locate rights within the moral firmament in general. Here the struggle between the "right" and the "good" will emerge, and will be a recurrent theme throughout this thesis. The important distinction between the "right to health" and the "right to health care" will be foreshadowed by the critical distinction between "positive" and "negative" rights, the latter being central to much of our perspective. Rights will be examined in relation to various moral foundations and to the moral systems built upon them. Here, as elsewhere, much light can be shed through the
examination of competing views. This will serve to articulate the moral "system" which is to be carried forward to Parts Two and Three. For instance, the foundation of various "rights" will be seen as rather different under libertarian and consequentialist perspectives, respectively. The main basis for any purported moral right to health care continues to be medical need, while medical benefit, merit, and good behavior, as well as combinations of these, play a lesser role. The perspective offered here calling for a legal right to health care will assign a smaller role to medical need and a larger role to medical benefit as well as bringing cost considerations into the equation. The discussion of rights will be followed by their position within major moral and political perspectives, including our own more limited perspective.

Consideration of these perspectives will be for the purpose of locating our own perspective within the moral and political landscape. Pursuant to this end, we need not offer a complete, full-blown moral and political theory. It will be sufficient to trace our position, in outline with some detail, to substantiate the major elements of the particular positions actually taken in support of the thesis. The theoretical underpinnings will be a balance between a deontological core sufficiently spare to allow for it to be bounded by layers of moral permissibility where consequentialist considerations can be brought to bear. Such an approach is likely to render a less dogmatic tone and it will provide a degree of flexibility indispensable
to meaningful comprehensive reform. A thoroughgoing "consequentialist" or "libertarian" perspective, for example, can be vulnerable to certain counterexamples, as we shall see. Similarly, more egalitarian perspectives, such as those of Veatch, Rawls, and Daniels, are also vulnerable to attack, especially where health care is concerned. The core of the present theory can be fairly subsumed under "deontology," "respect for persons," or even "libertarianism." However, the rights thus recognized under this view will be far less numerous and less extensive than is often the case for such theories. This will serve to carve out a somewhat greater area for the "morally permissible," measurably adding a certain flexibility to our approach. Such an area will prove indispensable when universal health care coverage and explicit rationing are considered. In such areas as these two, if one is not morally free to balance benefits and burdens, or to privilege the "good" where the "right" seems to be indeterminate, then one cannot seriously engage them as viable moral options. Importantly, our implicit limitation here of "deontology," "respect for persons," or "libertarianism" applies as well to "egalitarian" and "liberal" perspectives. For the latter as well as the former, when taken in their pure forms, the "right" tends to loom too large to allow for the requisite balancing and weighing where universal health care coverage and explicit rationing are concerned. What then of a consequentialist dimension which, after all, is effectively the principal one we are proposing for the
consideration of these two areas? We will show how the major shortcomings of that perspective as a moral system manifest themselves here in Part One, where we seek to construct a moral scaffolding sufficiently strong to support, while also limiting, our positions on universal health care coverage and explicit rationing in Parts Two and Three, respectively.

All of this will become sufficiently clear in greater detail as this work unfolds. Suffice it to say here that we fashion a moral and political theory only to the extent needed to construct a strong foundation for the claims we are making about the health care reforms we are advocating. Although this position of necessity extends to some degree beyond health care concerns, at the same time, many important issues in health care (e.g., abortion, euthanasia, or genetic engineering) are not even implicitly addressed. Our subject matter is the allocation of health care resources in the United States. The goal here is to suggest in a general way, with some detail, the shape that meaningful reform should take. In our view, a strategic admixture of the morally mandatory and the morally permissible will be required for our advocacy to be maximally effective. Concomitant to this strategic bifurcation is that between the individual and society. What will emerge from this vortex of competing values and perspectives is a particular vision of health care reform in the United States.
II. Moral and Legal Rights

In addressing the threshold question about whether there is a moral right to health care, a number of preliminary matters must be initially clarified. We need to identify what a "right" is in the first place. Rights derive from claims made on the basis of justice or of law, with such claims being said to be moral to the extent that they are in conformity with justice. Rights based in law can range from the codification of moral rights, the recognition of which is morally mandated independently of any concomitant legal enactment on the one hand, to the creation of a legal right borne entirely of the perceived need for a convention in certain circumstances on the other hand. A widely recognized example of the former is the right to "free speech" and a representative example of the latter is the designation of the right lane in jurisdictions of the United States as the mandated path of two-way travel for motorists. While the former would constitute a subsistent moral right in any case, the latter would have moral force purely on the basis of its legal status. Rights thus may be in accord with justice or law or both and, accordingly, can be classified as being "inherent moral" claims of right or as claims based on conformity with explicit law or custom--legal rights. We will refer to these claims as "moral rights" and "legal rights," respectively. The distinction is an important one. Since moral rights derive from moral principles which are closely connected to justice and are deemed to have some objectively valid basis, they are
typically placed above legal rights which are grounded in convention. While that which is grounded in convention is by definition subject to change, moral rights are often considered inalienable, or at least legitimately dislodged only under carefully outlined circumstances.

Not only might the elimination of a moral right be virtually proscribed, but any substantial abridgement may be perceived as a violation of such a right. One may look to a right such as "free speech" for an illustration of such a right where attempted abridgement is somewhat likely to be viewed by many as a morally impermissible encroachment; even though such a right is constitutionally recognized in this country, many consider it a moral right which has been constitutionally or legally reinforced. Issues arising in the wake of an attempted abridgement of a moral right point to another characteristic of such rights. Because of their perceived lofty status and their heavily "principled" non-conventional basis as well as their more general content, such rights do not possess the relatively sharp definitional edges typically accorded to legal rights. Inherent moral rights often lack the precision endemic to legal rights. Accordingly, a consensus may often be lacking for even basic content as well as extension where moral rights are concerned. As we shall see, the proponents of any purported moral right to health care are unlikely to be able to avoid the vagaries of such "untidiness"; it comes with the territory. Thus, we may place certain ambiguities of basic content and a lack of sharp definitional
edges alongside the aforementioned relative "inalienability" as characteristics of moral rights. Throughout our discussion of "rights," the distinction between moral rights and legal rights should be firmly kept in mind. We now move from the "abstract definition" phase of our examination of "rights," in effect their "skeleton," to the "definition in use" phase where we will put some "flesh" on those bones.

III. Rights and Duties

The most important and frequently discussed correlate of rights is the concept of "duty." A duty is an action or forbearance required by one's position and may constitute a moral or legal obligation. Intuitively, if a right exists in one or more persons, there arises a corresponding duty or duties owed to these persons on the part of or by other persons. As we shall see below, this correspondence is far from a perfect one, yet it can be useful in helping us better to understand what rights are. In addition, it will be useful to consider duties to be either "perfect" or "imperfect." Perfect duties are those which must be discharged with regard to a particular party or parties. The party to whom the duty is owed is identifiable and there is also usually some specificity as to a time frame and a situs of performance. If A borrows a sum of money from B, say $100, A has a duty to repay it to B or to B's designate at the time and place indicated. Imperfect duties or obligations, on the other hand, are not
nearly as specific. They are not owed to an identifiable person and
the obligor is thus accorded a good deal of leeway as to the
specifics of discharging the duty. Among the duties not owed to a
particular person are those arising out of beneficence. Obligations
of charity, for instance, if and to the extent that they are recognized
as obligations, are owed to potential beneficiaries only in a general,
non-specific way as to particular obligees, time, or place.

Even a commentator who has notably decried the increasing
emphasis in recent years on right-based ethical frameworks, which
has produced a corresponding de-emphasis on obligation-based
ethical frameworks, has not argued that a representative imperfect
obligation such as this implies a corresponding right (O’Neill 1990,
Chapter 5); indeed the libertarian view that only liberty rights can be
matched by truly universal obligations is affirmed in this non-
libertarian account. Another obligation might have a specific obligee,
such as one to whom financial support is owed, but just how and
when this obligation is to be discharged is somewhat left to the
discretion of the obligor. This is properly considered a perfect
obligation, in spite of the "flexibility" involved, since the obligee is
identifiable. It is clear from the foregoing that, while imperfect duties
do not have rights which "correspond" to them, perfect duties are
more likely to reflect such a correspondence. A closer look at
perfect duties shows, however, that the correspondence between
such duties and their related rights is itself rather "imperfect." This will serve further to illuminate the overall sense of "rights."

Rights do imply duties but duties do not necessarily imply rights, or so the "truism" goes. In fact, while the latter is true, the former is not always the case either. For a right and a duty to imply each other, they must have the same content in a reciprocal way. In the previous instance of a loan of $100, the duty to pay the sum clearly corresponds to the right to be paid that sum, and so it often is with rights and duties. However, as David Lyons has pointed out, the relation between what he calls "active" rights and "passive" duties typically does not reflect the requisite reciprocity (Lyons 1970, pages 50-54). He compares the example of a sum of money owed with that of a person's right to free speech and the duty of others not to interfere with the exercise of that right. He points out that people other than the relevant authorities have a duty not to interfere with the speaker even if the speaker does not have the right to speak (for lack of an appropriate permit perhaps), and thus the duty could not imply the right in such an instance. He further reminds us that the right to speak is only one of an indefinite number of "rights" we are generally free to exercise strictly where ceteris paribus others have a duty not to interfere which is not implied by such a right. Lyons does allow that passive rights and active duties typically do fit the pattern of mutual implication. Where one has a duty to do something specific for another, a right to receive that act or service
does seem to be implied by such a duty. If a right to health care were to be recognized, whether as a moral right or as a legal right, such a right would be passive and any corresponding duty would be construed as active; it seems to fit the passive-active "mix" seen by Lyons to involve mutual entailment. On this view, the right to health care would imply a duty on the part of others to provide such care and vice versa. Whether one would accept this mutual implication may turn more on the nature of the alleged obligation since, if one acknowledges such a right, there would seem to be a corresponding (perfect) obligation.

In a 1983 report, *Securing Access to Health Care*, the President's Commission for the Study of Ethical Problems in Medicine argued in favor of a moral obligation on the part of Americans to provide access to adequate health care, yet it stopped short of arguing for a corresponding "right" to such access. Stating that such a right would "make impossible demands on society's resources" (*President's Commission for the Study of Ethical Problems in Medicine* 1983, page 10), the President's Commission appeared reluctant to claim that such an entitlement should be recognized. The closer one looks, however, the more the "real" position of that body tends to be obscured. The President's Commission went on to say, "The Commission has sought to frame the issues in terms of the special nature of health care and of society's moral obligation to achieve equity, without taking a position
on whether the term obligation should be read as entailing a moral right" (*Ibid.*, page 32). It also stated, perhaps with some inconsistency, the following:

\[\ldots\] to say that society has a moral obligation to do something is to say that it ought morally to do that thing and that failure to do it makes society liable to serious moral criticism. This does not, however, mean there is a corresponding right. For example, a person may have a moral obligation to help those in need, even though the needy cannot, strictly speaking, demand that person's aid as something they are due. (*Ibid.*, page 34)

Clearly, there is some hesitation here. While one commentator concluded that the President's Commission had argued for a relatively weak, beneficence-based rather than justice-based societal obligation to assure adequate access to health care for all Americans (*Fleck 1989*, pages 167, 174), another commentator took the report of the President's Commission somewhat less at face value. In a 1991 article, Baruch Brody contended that the real position of the President's Commission, given its insistence on the moral obligation to provide health care to those who need it but cannot pay for it themselves, obliged it to acknowledge the existence of a correlative right to health care (*Brody 1991*, page 117). Declaring the analogy to the moral obligation of individuals to help the needy if they can reasonably do so to be misplaced, he argued that society as a whole could have (in effect) a perfect obligation to
the medically indigent; while an individual could not be "pinned down" in this manner as to the applicable moral obligation, society here would not be in a position to "satisfy" its obligation by helping some but not others among the medically indigent. It does seem legitimate to declare the class of potential beneficiaries to be specifically identifiable, given the far larger class of potential obligors available to satisfy the avowed obligation. Certainly this raises the stakes somewhat, politically not the least. Indeed Brody attributed the apparently flawed reasoning of the President's Commission to political expediency and not to any deficiencies of reasoning. Be that as it may, the relation between rights and duties can be a complex one, as the instance illustrates.

This is a tightrope we will also have to walk. We will be disavowing the recognition of a moral right to health care while arguing that the United States should adopt universal health care coverage which would bestow an important legal entitlement on millions of people. Such advocacy will require a particularly nuanced relation between the right which emerges and the correlative duty which mutually support each other. The route to this conceptual end state, however, is picketed thick with the underbrush and overgrowth of centuries of ethical and political discourse. Perhaps none of the major elements of the edifice we seek to construct will themselves be historically unique, but we seek to fashion a distinctive amalgamation of existing elements. Pursuant to this end, we will be
examining some of the moral bases for rights and their relation to various moral systems.

IV. The Right and the Good

Any claim concerning a moral "right" will of necessity reflect the basic tensions out of which such a right purportedly emerges. These inherent tensions run the gamut of moral discourse. Perhaps foremost is the tension between the "right" and the "good." The distinction between the right and the good, and the conceptual tensions to be found between them underlie much of moral discourse, even where something else may be the explicit concern. Neither the right nor the good can be truly separated from each other in any treatment of either. Virtually all moral schemes will envelop each of the concepts, however begrudgingly, whether it is Robert Nozick at one extreme calling for police protection from common funds or modern consequentialists who realize some notion of rights is indispensable to a stable moral order at another extreme. Rights are essentially claims which must be accorded a measure of respect by other individuals and thus by society at large. Characteristics properly attributed to rights include a demand for recognition and a certain permanence or stability which can range in degree from the absolute to the merely presumptive and which in some instances is asserted in opposition to those of others or society at large. These characteristics are akin to carving out a
certain moral space and can be gauged in relation to their strength to resist extinction or even change, and their potential conflict with the right-claims of others or of their government. The dynamic notion of rights is well shown in the definition of a right given by H. L. A. Hart as that which "belongs to that branch of morality which is specifically concerned to determine when one person's freedom may be limited by the freedom of another and to determine what actions may appropriately be made the subject of coercive rules" (Hart 1955, page 177). The limits are thus drawn, legitimately or otherwise, by coercion or the demand that a person shall do or not do some action. Such a definition could be applied equally well to moral rights or legal rights, even though it was rendered in reference to the latter. The inherently dynamic character of rights is aptly conveyed here even if there is a passive side to them as well. We now move to a consideration of the nature and changeability of rights as they involve more direct struggle between the right and the good.

The changeability of rights varies with regard to both the importance or dignity of the right itself and the moral perspective from which it is being viewed. A legal right of relatively modest importance, such as the right to hold a license to hunt or fish on state-owned lands, could more easily and with less moral "freight" be modified or extinguished than a purported moral right such as the right to "free speech." Similarly, while a consequentialist perspective might well hold all moral rights, regardless of their importance, to be
defeasible, at least in principle and for sufficient reason, a libertarian perspective may well be sharply opposed to any change in even a middle-level legal right such as the right to freely mortgage one's home beyond a first mortgage. In a sense, the threshold issue with regard to such changes is which rights can be subject to a balancing process at all. And then, concerning those rights which are deemed subject to such a balancing process, the issue is essentially whether the importance of the right is strong enough to resist changing or extinguishing it for the sake of the perceived common good. In such contexts, the right and the good are weighed against each other.

The "good" may be considered objective or subjective and may be viewed as either inherently or instrumentally good. A subjective good is any state of affairs or end state, or any object, for which a preference or desire is held by any individual or group. An objective good, on the other hand, encompasses the same range of states of affairs or end states, or objects, deemed to be desirable or to be preferred independently of whether they are beheld as such by anyone. The good is more overtly tied to our wants and our welfare than is the right. It is thus more encompassing, more variable, and more flexible in its applications than is the right, which tends to be applied in a more limited and less flexible way.

Although only a pure consequentialist perspective, or perhaps a non-consequentialist natural law perspective as well, would in theory see the right entirely in terms of the good, the good is
otherwise at least implicitly involved in determining the right for a wide range of moral perspectives. Having said this, few would seriously doubt that claims recognized as rights, even including those considered to be among the most important, are generally less secure from a consequentialist perspective. This is recognized whether one is faced with a pure version of consequentialism or is dealing with one of its various modified forms. Stated in a nutshell, the fear is that many if not all or nearly all rights are intrinsically weakened by the constant threat of the imposition of some balancing process, given changed circumstances, that could formally change or eliminate any given right.

In an early paper, John Rawls forcefully argued against the facile acceptance of the view that rights could not be secure under a consequentialist regime (Rawls 1955). Rawls specifically discusses the keeping of promises, an important area where consequentialist ethics is frequently declared to be lacking. His main thrust here, however, which goes well beyond the practices under discussion, is his distinction between justifying a practice and justifying an act falling under that practice. He clarifies this distinction by contrasting what he calls a "practice" view of rules with a "summary" view of rules. The summary view, which obscures the distinction between justifying a practice and justifying an act falling under that practice, characterizes rules as being summaries of past decisions which are logically prior to those rules. Such a view suggests a "case by "case" approach to
rules with the cases determining the rule; at some almost mythical point, the relevant cases to that point are "crystalized" into the rule. In an important sense, of course, a "rule" could barely be said to exist at that juncture; a rule, after all, is supposed to be a guide to action and the guidance here would be exceedingly thin.

Even under a system like the old English system of common law, which was quite possibly the closest historical example of a "case by case" approach, the orbit or penumbra of the more seminal cases was seen to explicitly emerge so that lead or paradigm cases could shed light on future cases. In this context, a precedent is carved out which provides guidance in similar cases. Thus various areas of the law give rise to a core of legal content to which only a limited number of cases truly contribute. Legal shorthand on this order lends a cohesiveness and a continuity which could not be achieved under anything like a true "case by case" basis. The evolution of a set of rules which in England came to be known as "the common law" is mirrored by Rawls' "practice" view of rules, the corrective to the "summary" view of rules. Relying on the aforementioned distinction between justifying a practice and justifying a particular action falling under it, Rawls argues for a view where the rules define the practice rather than vice versa. It is an alternative where one realizes that what is required is the establishment of a practice, the specification of a new form of activity; and from this one sees that a practice necessarily involves the abdication
of full liberty to act on utilitarian and prudential grounds... rules cannot be taken as simply describing how those engaged in the practice in fact behave... it is essential to the notion of a practice that the rules are publicly known and understood as definitive... rules define a practice and are themselves the subject of the utilitarian principle. (Rawls 1955, page 24)

We are in substantial agreement with Rawls in his analysis of these aspects of consequentialism and its relation to rules of conduct. His position can easily be viewed as giving it its "due," in spite of the fact that he is no longer a consequentialist, with much of his verbal ammunition in his magnum opus, A Theory of Justice (Rawls 1971) being pointedly directed at that school of thought. His views in "Two Concepts of Rules" should be kept in mind throughout much that follows since they are an important rejection of a persistent caricatured portrait of consequentialism. Clearly few comprehensive moral schemes, excepting those which are staunchly libertarian, can avoid a fairly substantial consideration of consequences and, therefore, it would seem incumbent to treat such matters in a judicious way. This certainly includes the present perspective and some of the positions we will be taking as we attempt to blend the morally proscribed, the morally prescribed, the morally permissible, and the morally preferable. We continue here with "rights" and their general standing from a consequentialist perspective, mindful that Rawls has at least shown the absence of a necessary incompatibility.
Despite this, a substantial conflict between the right and the good is often unavoidable.

R. B. Brandt, a thoroughgoing consequentialist, argues that that perspective is not necessarily incompatible with rights, but does concede it cannot recognize absolute rights (Brandt 1992, page 196). He disagrees with David Lyons, who claimed a basic incompatibility between consequentialism and rights on grounds that one can always ask whether overriding a right will actually maximize utility (Lyons 1980, page 19). Brandt notes that, while virtually all rules have exceptions, this state of affairs hardly negates the basic thrust of the rules themselves; indeed it can be seen as defining them instead. He argues that the state has a strong obligation not to override rights except where extreme demands on welfare warrant such action and that this is especially true of rule utilitarianism. Consequentialists can embrace both acts and moral systems as desirable if they maximize expected utility; preserving a system at considerable "cost" would thus often be justifiable. Brandt sums up his position in part by calling for "... the moral code the acceptance of which promises to maximize utility, and not compromise, except in extreme circumstances, in order to do what in a particular situation will maximize utility, where so doing conflicts with the utility-maximizing code" (Brandt 1992, page 212). Combining the insights of Rawls and Brandt, we reject the notion that any justifiable moral system could lightly jettison or substantially modify existing legitimate rights.
Marginal additions to the general welfare do not provide sufficient grounds for such modifications, even under a consequentialist regime. The recognition of rights does, however, represent a balancing of sorts in many instances. Moral values such as autonomy and paternalism tend to pull in opposite directions and cannot be simultaneously embraced in full. Rather, depending on what is at stake, certain moral considerations will be deemed to outweigh competing moral considerations. Rights represent a constraint on the discretion of others which, to a greater or lesser degree, may lead to less than optimal results in the short run. This statement would be challenged by few. The long run is another matter. Here the various perspectives are at odds in a more meaningful way. A central paradox is that rights themselves are often justified in part by an appeal to human welfare. Rights typically provide a fairly clear benefit in the eye of their advocates. Whether we are referring to a right to speak, a right not to be taxed, a right to have an abortion, or the right to engage in a foreign war, supporters will tend to point at least in part to the advantages which would result from their recognition. Now it is true that some rights may be advocated and defended largely from a perspective emphasizing autonomy or self-respect; the appeal may well not be couched in terms of overt advantages to society and may instead be couched more in terms of that which morally accrues to a moral agent qua moral agent. Rights in this respect are more likely to be viewed as moral rights, therefore as being of first order
importance and possibly even completely inalienable in character. Even here, however, it may be held in some sense to be "better" for the would-be holder of the right to have such a right than not to have it. None of this is to imply there has to be even a covert appeal in terms of self-interest or of particular consequences for the welfare of the individual or of society. Concomitantly, the further away we move from such unusually staunch right-claims the more overt will likely be the appeal to self-interest or to particular consequences.

Continuing in our quest to clarify the nature of rights by examining the relation between the right and the good, certain other alleged shortcomings of positions inspired largely by the good (consequentialism mainly) need to be looked at. We have already discussed the general hostility to rights widely said to be engendered by heavy reliance on the good; there is a basis for such criticism but, as our discussion showed, this can easily be overdone. A major criticism of consequentialism in its emphasis on the good involves "rights" in a notably different way. Distributive rights, or rights to a "fair" share of the more important tangible goods of society are claims seldom explicitly recognized by a consequentialist perspective. Such "rights" tend to be overlooked in the quest for a maximum aggregate level or average level of good for a given society. While only various strains of egalitarianism tend to advocate equal or approximately equal shares of these goods, other perspectives, most notably liberalism and its contractualist variants, do take seriously the relative
fairness of distribution while leaving strict equality in this area to the egalitarians. However, this would seem to make fairness in this area a *balancing* process analogous to that so often occurring between at least "non-fundamental" rights in general and the prospective welfare of competing considerations or other would-be rights. For the process to be otherwise, a society would have to adopt either a very highly planned (i.e., rather totalitarian) scheme of things or an ambitious redistribution agenda which might easily amount to the same thing; to term such a society "egalitarian" would do virtually nothing to change a recipe for stagnation coupled with a high cost in human freedom.

While this extreme outlook need not detain us here, this balancing inherent in reckoning distributive shares will resurface in an important way in our discussion of rights in health care; in that context, some commentators (e.g., Robert Veatch and Peter Singer) have advocated a thoroughgoing egalitarianism in (American) health care while stopping short of such a regime in overall terms. At bottom, for the most part, the struggle for distributive rights and the opposing proponents of some gauge of overall or average welfare pits the argument for some minimum entitlement against the argument for a greater long-term benefit accruing to society as a whole and even perhaps a greater long-term benefit for the class of people denied the benefit; the leading exception to this is the libertarian perspective, which would deny the very validity of such a balancing process even
as the form of a threshold question. Thus, while a staunchly egalitarian or libertarian perspective would, for essentially opposite reasons, consider distributive rights not to be rightly a part of the balancing of interests which is typical of the political process, the various liberal and (to a somewhat lesser degree) consequentialist perspectives will view such balancing as justifiable. This justifiability derives in no small measure from the absence of a canonical minimum which is to be embraced. A canonical level would exist only from a purely egalitarian perspective because, while the amount of each share would be relative to the level of wealth in a given society, the shares would be required to be at least approximately equal.

A strong parallel between these general perspectives and those to be taken regarding health care is apparent. However, some commentators have singled out health care as a strategic social good which calls for special treatment, whether such treatment takes the form of equal shares or some particular moral minimum which must be made available to all. At certain points in this endeavor, we will be concerned with the peregrinations of the search for a "decent minimum" which would meet the moral requirements of the beholder. What we wish to call attention to here is the general conflict which is endemic to distributive rights (the right) and the welfare interests of others and of society as a whole (the good).

Much of the discussion to this point has touched on "moral rights" but such rights have not been separately examined in relation to the
right and the good. Moral rights are critical to our analysis, and our specific positions with regard to them are an indispensable part of the foundation for the reforms we are advocating. Moral rights are those claimed to exist and to be morally binding on all other individuals and on organized social units such as governments. Such rights are binding on all from a moral standpoint even as against the conscientious moral sense of others and the lawful declarations of government. These rights serve as the catalyst for a distinct class of moral conflicts. Where recognized, moral rights represent a more pure example of "the" right because their recognition is not contingent upon approval nor can it be set aside for any but catastrophic circumstances, if at all. Before identifying and defining our own concept of moral rights as well as the specific inherent moral rights we recognize, we will look at an area which can illuminate in a special way aspects of their nature.

This area may be characterized as follows: The area where an act or failure to act could be, at the same time, "morally wrong" while the moral agent had a "right" so to act or, at the same time, "morally right" while the moral agent had no "right" to so act. One might here distinguish between what Bernard Williams calls the right of "principle" and what he terms the ought of "what to do." The former refers to what is more or less the generally binding received view while the latter refers more to what is being more immediately urged by one's (more or less principled) instincts (see Williams 1965, pgs. 121-122).
To identify the two oughts is to commit oneself to the superiority of the former; to distinguish the two is to acknowledge a legitimate moral choice where one can act "morally" in choosing either of two (or more) options. What Williams is referring to in "Ethical Consistency" are situations where imperfect duties "conflict" in the sense that, within a given time frame, one or some can be met but not all; as Williams points out (Ibid., page 118), the multiplicity of "oughts" here cannot be assimilated without contradiction to the dictum "ought implies can." For example, one ought to take care of one's sick mother but one also ought to save a drowning person if this can be done at no appreciable risk or cost; in such a situation, one could have a "right" to stay with one's mother even when, at no appreciable risk to the mother, one could have been saving the drowning person at no appreciable risk or cost and thus may be said to have acted "wrongly." Changing the facts, one could be fairly said to have done what is morally right while having had no "right" so to act where one saves the drowning person after having previously promised one's mother one would not leave for any reason. A variant of this scenario can occur where there is a (tragic) conflict between one's "moral" and "natural" inclinations. If one's mother were terminally ill and dying, one could easily be imagined to be strongly insisting on extraordinary care involving use of advanced technology which is scarce and could best be used elsewhere from a medical standpoint; it is even easier to imagine if this extraordinary care is fully covered
by insurance (or one is independently wealthy). Similar situations are easily conceived which are at the same time quite realistic.

Having said all this, what can be further said about moral rights and the distinction between the "right" and the "good"? To begin with, one can say that the word "the" is too strong by far in all three instances (i.e., the distinction, the right, the good). The foregoing discussion does show at least implicitly that the right and the good may be distinguished or contrasted in opposition to each other in at least the following situations: 1) Where both represent claims of separate moral rights; 2) where both represent claims of separate legal rights; and 3) where one represents a claim of a moral right and the other a claim of a legal right. Not only can the right and the good be distinguished in a number of ways, but it is also apparent that the definitions (in use) of the two can overlap to such an extent that they can be difficult to distinguish in a given instance.

In all three of these conflicts of "rights," the "good" can readily be seen close to the surface. Even where legal rights appear to conflict, which will prevail may easily boil down to which it is "better" to favor. Both divorcing parents may have an "equal" right to custody but the "best interests" (i.e., best consequences) of the child is the basis for deciding. A clash of legal and alleged moral rights, whether perceived as a legal or a moral question, may involve weighing the importance of a free conscience weighing the effect of acts of legal disobedience, and weighing the long- and the short-term social effects of various
types of conduct. Similarly, a clash of moral (imperfect) duties, as we saw directly above, may easily involve a weighing of attendant good and bad consequences within the framework of two or more "right" choices.

The good may thus be involved in determining the right, although this will not be the case for strict deontological theories. Perhaps it is less obvious how the right may be involved in determining the good. After all, although rights typically imply duties, duties often do not imply rights, as was apparent from our treatment of imperfect duties. However, under virtually any species of rule utilitarianism, the good which controls is itself based in part on the desirability of recognizing certain rights. Thus, while rights are recognized because they secure the good and not vice versa, they can be effectively incorporated into the good. Rawls' arguments in "Two Concepts of Rules" show that the good of a social institution may easily be determined in part by the recognition of rights. Thus we can see the potential influence of the right on the determination of the good. The degree of overlap and cross-fertilization between the two terms is surely greater than the respective histories of the usage of terms might suggest. Those "histories" probably suggest greater contrast because they tend to reflect well-drawn conceptual battle lines of an often hypothetical character (e.g., certain well-worn arguments against consequentialism addressed by Rawls in "Two Concepts of Rules").
Another reason for the exaggerated contrast is that much may depend on the strategy of the advocate. The tendency is to take the "high" road and to depict one's opponents as taking the "low" road. This may point to a "principled" stand against an "unprincipled" or "less principled" stand. On the other hand, this may mean some amalgamation of the right and the good; after all, it is better to have both the right and the good on one's side rather than to have only one of the two on one's side. Even as thoroughgoing a consequentialist as John Stuart Mill saw no fundamental conflict in the "final rules" between his utility-based moral system and the notions of "right" which had grounded other moral systems. On the other hand, the "great divide" is more in evidence when a thoroughgoing libertarianism (e.g., Nozick's) is on display. Perhaps a major reason, if not the major reason, the right and the good are often welded if not bonded together is that moral rights are a fundamental element of most moral systems. Even under schemes where such rights are less than absolute, they often can only be dislodged for the gravest (and often very hypothetical) of reasons; even where they are not explicitly recognized at all, this hardly means such rights will be non-existent in fact.

We now turn to a more explicit and detailed examination of rights. Our perspective on moral rights will serve to provide an important foundational element of our position and will lead us into a consideration of positive and negative rights. This will prepare us to
more definitively address rights in relation to health care. We do not leave the right and the good behind at this point; rather they merely fade into the background for now, ever ready to appear and re-appear as a leitmotif.

V. Moral Rights

In arguing for the recognition of moral rights, we must strive for: a reasonably well-defined scope and a persuasive basis for such rights.

Our position can be viewed both in terms of a single basic right "expandable" into others and in terms of a "set" of rights "reducible" to a single basic right. Taking an approach analogous to that of Plato in *The Republic* in his discussion of "justice," that of tackling "justice writ large" at the social level first and then proceeding to the individual level, we begin with the minimal conditions for human society. The immediate task is to identify those aspects of our social nature which must be satisfied if we are to live in a state of cooperative "society" rather than a non-cooperative "state of nature."

We seek to isolate that which distinguishes human society from any other kind, a set of minimal conditions which are the basis for cooperation. We do not explicitly refer to a state of nature in this connection, in spite of its permanent place as an important concept in the history of political philosophy (Hobbes, Locke, Rousseau and others). Thus we are not concerned with the fact that such a state
has not been confirmed as a historical fact. Instead our focus is to identify the elements of human society which are indispensable to it. In so doing, we will isolate the basis for moral rights.

Our status as moral agents lies at the very core of that basis. Since all depends on our expectations, what might those expectations be? Given expectations which would enable us to look to the future and given our status as moral agents, the only basis capable of delivering such a state of affairs, whatever the details, is that of "contract." Moral agents must mutually agree to act in such a way that those who are party to the agreement will be able to plan for a future which will be better than the present, at least in terms of being more secure and, hopefully, in terms of a human flourishing commensurate with a wide range of human activities. A more constricted Hobbesian-style view would emphasize security with little concern for the rights retained (or thus attained) against society by its individual members; a more expansive Lockean-style view would emphasize property rights as the just fruits of human industry among those rights retained against society, in addition to including the requisite security in general against attacks on one's person or property. Pervading any such arrangement at its very core is the contractual arrangement itself. While the details could doubtless vary a great deal, we submit the minimal conditions for human society are the following: 1) A social system providing a basic level of physical security concerning one's person and one's general freedom to be at
large; 2) a social system which imposes sanctions in response to more serious forms of deception; 3) a social system which recognizes at least some form of property and which provides for sanctions for some offenses against property. We do not hereby enter into debate with those who would endeavor to produce historical counterexamples which might apply at least in part. These conditions not only are generally applicable but become more so as social complexity increases. Each of these is to be broadly construed. Hence some restriction on gratuitous violence is called for, some general level of liberty is to be respected, some limits of personal deception are to be prescribed, and some form of property is to be observed. Even under a system where all property is effectively communal, some forms of individual conduct are likely to be proscribed and even prescribed where such property is concerned.

All this is to say that one cannot prepare for a secure tomorrow if freedom and physical security are not to be enjoyed, that one cannot truly achieve the (mutual) benefits available from agreements with others unless a system of contracts recognizes them as binding and penalizes related failure and deceptions, and that one generally cannot properly enjoy the fruits of one's labors if the ownership of property is not recognized in some form with sanctions provided for offenses against property. These three general areas, where individual rights must be recognized if there is to be human society, can be seen to roughly correspond to the three areas into which law
may be broken down; these are respectively, torts, contracts, and property. In this account, we have leaned on the seminal work of H. L. A. Hart.

In his *Concept of Law*, Hart sought to define and describe "law" while clarifying the relation between law and morality. Viewing legal systems as a blend of "primary" rules and "secondary" rules, Hart described the former as rules under which "human beings are required to do or abstain from certain actions, whether they wish to or not" (*Hart 1961*, page 81) and the latter as "... provid[ing] that human beings may by doing or saying certain things introduce new rules. ... [r]ules of the first type impose duties; rules of the second type confer powers, public or private" (*Ibid.*). Rules of the second type may introduce rules of the first type but, strictly speaking, rules of the first type are "primary" and can exist without the benefit of those which are "secondary." Importantly, Hart concedes that a society can subsist purely on the basis of primary rules, provided that: 1) "... the rules must contain in some form restrictions on the free use of violence, theft, and deception ..."; and 2) "those who accept the rules and those who reject the rules except where fear of social pressure induces them to conform ... the latter cannot be more than a minority. ..." (*Ibid.*, pages 91-92).

Hart's second provision for a society to subsist purely on the basis of primary rules is concomitant to the first provision and is suggestive of the social consensus needed for these "primary rules"
to go into effect at a given time and place. The two provisions thus weld together the elements of "minimum content" for society and an actual social "acceptance" thereof, respectively. In our analysis, we will combine the minimum content for human society with the social contract needed to realize both their effective enforcement and their particular delimitations under a given regime. The delimitation of property rights will be especially salient since it is requisite to the moral authority of the sovereign to levy taxes, taxes which will be needed to fund a public tier of health care in this instance.

The minimal conditions for human society form an acceptable, if not compelling, basis for the recognition of moral rights. As we indicated above, the basic set of moral rights, though not framed in detail, can perhaps be boiled down to a single moral right which, conversely and more importantly, is a means of deriving the other two. The primacy of the first right, concerning non-interference and the general right to be at large, is clear in that contracting with others and acquiring property are specific fruits to be derived from the exercise of that right. This first right is also the strongest and hence the most inalienable among them because of this relation. Thus people can agree through binding overall social arrangements to various restrictions or limitations on their property rights or their commercial and domestic relations which they are less free to do where their personal freedoms are concerned in a more general way. Some of the best examples would include the following: 1) Agreeing
to become a slave for some consideration; 2) agreeing to forego the
police protection afforded to all; 3) agreeing to prohibitions on one's
(non-criminal) associations with others or one's movements in
general. We do not necessarily refer to the complete inalienability of
the first right but at least to less alienability in relation to those
derivable from it.

Again we turn to H. L. A. Hart for some illumination. In *The
Concept of Law*, he was not primarily concerned with natural or
inherent moral rights, although the connection between law and
morals was an important theme. In a felicitously titled article, "Are
There Any Natural Rights?," written six years before *The Concept of
Law*, Hart declared that, if there were any such rights, one above all
would so qualify. This right may be characterized as the equal right
of all to be free, "right" being defined in general as that contained by
conceptual boundaries where one person's freedom may be limited by
the freedom of another (*Hart 1955, page 177*). This equal "right" to
be free entails forbearance on the part of others from the use of
coercion and the liberty to do anything which does not coerce or
injure others, with the proviso that the distinction between the "liberty"
of coercion and the liberty of competition tends to break down under
conditions of extreme scarcity (*Ibid., page 175*). Hart also
distinguishes "having a right to" and "being at liberty to" to further
clarify the foundational right. The former refers to rights which imply
corresponding duties. Such rights are not part of this foundational

right; rather the latter, which has no implied corresponding duty, is the foundational right itself. This foundational right in turn is paradigmatically subsumed under his aforementioned definition of a right, being that which is limited by the corresponding freedom of others. This foundational right would be not only the most important right but would also have the greatest scope of any right. Under relatively normal social conditions, such a right would enable all to pursue their own respective versions of enlightened self-interest; only within realms which are legitimately competitive would one find significant opposition to one's actions. Of course, various protocols would be needed to regulate the areas of legitimate competition, from the search for land to the search for a spouse, etc.

This brings us to the cusp of our discussion of positive and negative rights, which appears in the next section. Before leaving this section, however, we need to further delineate the characteristics we attribute to moral rights and to locate them more firmly within our overall position. The moral right(s) we have identified has per se only a moral force. Without an arrangement encompassing mutual consent, it would be largely unenforced, a practical nullity. Under such an arrangement, however, legal recognition transforms this right into a living and breathing entity which takes its place among other legal rights.

Even as a legal right, this moral right is traditionally given constitutional or otherwise elevated legal status. This points to
limitations on the changeability of such a right. Not only is the holder restricted as to alienability, but legal changes in its contours are also more restricted and are procedurally more difficult to effect. This is not to say that, at least in theory, the system cannot substantially alter or even completely abrogate this right. But this is truly more of a theoretical possibility, especially under current conditions here in the United States. To eliminate or substantially diminish this right would be to challenge the very foundation of cooperative society.

The moral right lacks the relatively sharp definitional edges which legal rights often have. This is because the right is incomparably broad while its contours intersect other legal rights at any number of points. It is like a huge island which nonetheless has a jagged periphery with many edges. Limits are more easily imposed on more ordinary legal rights which do not have such a broad scope. While commentators as diverse as Rawls and Nozick have subscribed to the primacy of the general right to liberty, a view which is concomitant with a thin theory of the good at the public level, others have dissented from such a strong emphasis on liberty. Embracing a more robust theory of the good, O'Neill and Raz have both called for less emphasis on individual rights, albeit from somewhat different perspectives. The former has sought in the main to have both universal and special imperfect obligations move closer to center stage without arguing directly against liberty rights (O'Neill 1990, Chapter 5). Raz has engaged in more of a frontal attack on the
received view of "liberty" itself. A self-styled advocate of
perfectionism, he flatly states, "The importance of liberal rights is in
their service to the public good" (Raz 1986, page 256). Rejecting
what he calls "the presumption of liberty" and the related "single
principle of freedom," Raz views "freedom" in contradistinction with
"autonomy." For him, it is the actual degree of autonomy we possess
which determines the value of our "freedom" in the abstract sense.
This state of affairs in turn is a product of how consonant our
ambitions and goals are with the actual opportunities open to us.

On this view, personal autonomy is not a strictly individual matter.
Institutional context becomes part of the matrix which determines the
autonomy of a given individual. As we will see below in our discussion
of the authority of government and the duty to obey its laws, Raz
unhesitatingly mixes, as he does here, the more formal and enduring
aspects of morality in the public sphere with the corresponding private
circumstances of given individuals. An unusually robust theory of the
public good, indeed a species of perfectionism, is being advocated
here. The actual level of reference at this point in Raz's account is
largely institutional, while it is more nominally about fundamental rights
in freedom-autonomy. The corrective to such a state of affairs clearly
would be with the appropriate legislative authority which would be
formulating a measured response to current conditions, and which
could not be fairly said to be according legal recognition to a
fundamental moral right. Perhaps our contention in the last clause can be used as a line of demarcation between our respective points of view. Raz states, "According to the account proposed above, every legal right is a legally recognized pre-existing moral right" (Raz 1989, page 253). He clearly takes a far broader view of moral rights than we do and his account does not accord our primary moral right the lofty status which we have. This may well be due to our heavy emphasis on the pivotal distinction between positive and negative rights, a distinction of far less importance in Raz's scheme. We now turn to this discussion which plays a central role in both our denial of a moral right to health care and our affirmation of a moral right to pursue health care in a second tier.

VI. Positive and Negative Rights

The distinction between positive and negative rights has been an important one in recent moral discourse and it is one which must be clarified. Key aspects of our position rely on this distinction for much of their impetus. The same will also hold (not always expressly) for many of the commentators we discuss, sometimes in a way which is unfavorable to their positions. "Positive" and "negative" rights are an integral part of the moral lexicon for both moral rights and for legal rights. As we will see below, the distinction between positive and negative rights is not always a hard and fast one but, for the most part, it has considerable significance. A parallel to the "analytic-
"synthetic" distinction comes to mind; this important longstanding
distinction has long since become somewhat blurred in relation to its
historical zenith, yet few would deny it remains useful and significant.
In the area of positive and negative rights, a distinction rendered early
on by Isaiah Berlin (and others), notably challenged by Norman
Daniels, retains much of its former clout though, again, qualifications-
reservations have crept into the picture.

In a classic analysis (Berlin 1969), Berlin drew several distinctions
in the hope of clarifying the concept of "liberty." Negative freedom is
defined as ". . . the area within which a man can act unobstructed by
others" (Berlin 1969, page 122). This is characterized as a freedom
"from" whereas positive freedom is characterized as a freedom "to."

We should note here the somewhat parallel distinction between
rights "to" and rights "in." The former delineates the right to do
certain things or the right to (an interest in) property while the latter
encompasses the right involved in actually doing a certain thing or in
utilizing in some way (an item of) property. The concept of "positive
freedom" set forth here sounds far less sharp-edged, beginning as
the desire to be one's own master, and developing into the idea that
one should be under the direction of the "real me," or "the rational
me," which would, if fully developed, choose a particular end (Ibid.
pages 131, 132). Berlin's notion of negative freedom remains part of
the "received view" while his notion of positive freedom seems
overtly political and overly hazy in its moral content, to wit: "It is one thing to say that I may be coerced for my own good which I am too blind to see... indeed it may enlarge the scope of my liberty. It is another to say that if it is my good, then [the real] I am not being coerced..." (Ibid., page 134). Further elaboration which gives the area of control as the concern where negative freedom is involved and the source of control where positive freedom is involved does not seem to shed much further light. This may be because Berlin's language of "freedom" has become in no small part a vocabulary of "rights" and the "translation" has been more transparent on the negative side than on the other side.

Perhaps no one has made more of the concept of negative rights than has Robert Nozick. In his seminal work, Anarchy, State, and Utopia (Nozick 1974), Nozick importantly distinguished freedom as a side constraint and freedom as a value, something Kant (among others) neglected to do. We will discuss below the way Nozick turned negative rights into the lynchpin of his magnum opus. In opposing consequentialism, he affirmed that the rights of others determine the constraints upon one's actions. This echoes Hart's "fundamental natural right" and is clearly in the same mold as Berlin's notion of negative freedom. However, although Nozick did not address the role positive rights should play in moral theory, his stand on negative rights is so robust as to rule out any effective role for positive rights.

Another commentator of note adopting the view that all moral rights
are negative rights is Bernard Gert. Seeing morality as more concerned with minimizing evil than maximizing good, he states: "Moral rules do not tell one to promote good, or even to prevent evil, but to avoid causing evil. It is not an accident that all moral rules are, or can be, stated as prohibitions" (Gert 1988, page 70).

An author who did speak extensively to positive as well as negative rights was Charles Fried (see Fried 1978, chapter 5). Viewing negative rights as something flowing from an individual and positive rights as something flowing to an individual, he tied positive rights to two major aspects which retain currency: 1) The tying of positive rights to one's fair share of scarce goods; and 2) the tying of positive rights to one's right to protection in certain areas. Affirming the moral importance of positive rights, Fried asserted that basic needs (food, clothing, shelter, education, and health care) relate to the fundamental concept of a person and thus demand recognition as moral rights. Adopting the position that property rights, somewhat like promises, are potentially overrideable in the moral sphere, he emphatically rejected the view (a la Nozick) that only negative rights can enjoy the status of moral rights. As we will see below, for various authors there is usually a rather direct relation between how strongly one advocates positive rights and the extent to which one argues for limitations on the scope of property rights; the challenge we have set for ourselves is to deny positive moral rights while arguing that sovereign taxation to finance a public tier of health care is morally
permissible and morally preferable in the United States. Although Fried contributed significantly to the discourse on positive and negative rights, tying positive rights as he did both to one's fair share of scarce goods and to one's right to protection in certain areas, some of his commentary illustrates the difficulty of distinguishing positive and negative rights in particular instances. We will briefly examine positions taken by him in a 1976 article (Fried 1976, pages 29-34) along with some criticisms of those positions made three years later by Daniels (Daniels 1979, pages 174-191).

Fried sought to compare aspects of the widely recognized right to free speech with the less widely recognized right to equal access to health care, hoping to show that recognizing the right to equal access to health care does not imply recognizing the right to equality of health. He begins by pointing out the confusion inherent in concluding that one's right to "free speech" implies equal access to the media so that one can be effective in exercising that right; this "confusion" shows the failure to distinguish the negative right to free speech so widely recognized in one form or another from the "positive" right to free speech associated with access to the mass media. Fried then compares this fairly obvious confusion with the "same" confusion involved in arguing a right of equal access to health care implies some guarantee of equality of health. As Daniels points out, this miscasts the relation between these concepts in a number of ways, the most important of these being that
the appropriate free speech analogue to guaranteeing equality of access to health care would be the means of disseminating their views. But this is just what Fried denies an equal right to free speech involves. One problem here is that Fried construes freedom of speech as a negative liberty. In contrast, the right to equal access to health care requires a positive contribution of others to our health maintenance. (Daniels 1979, page 176---emphasis in original)

Daniels goes on to note that, if the right to health care is considered strictly parallel to the negative right to free speech, one could still be denied access to health care if one could not pay for such care. This goes to the crux of the matter. The right to free speech does not imply equal access to the mass media. If one is unable to pay for such access, those who own the various mass media outlets may justly refuse such access. Admittedly, collateral issues may well arise if the refusal were on some other grounds besides inability to pay for the services rendered, but they need not concern us here. The distinction between the right to free speech and the right to "equal" access to the mass media derives largely from the fundamental distinction between negative and positive rights. The former requires for the most part the forbearance of others while the latter represents a claim for the "free use" of the assets of others. Let us look at another side of the latter. The right to equal access to the mass media can be viewed in its negative aspects as well. If
the state, some private group, or an individual were to deny or forbid such access to a person or organization without a clear justification, this denial would violate a fundamental moral right. But what sort of right would this be? We agreed with Daniels' denial of the existence of any moral right to access to the mass media, yet we are affirming another sense of a moral right to access to the mass media. Of course, we could refer to the two "rights" by different terms but it may be equally feasible to view this as a right-claim with markedly different aspects which may be labeled "positive" and "negative," respectively. We make no claim either way as to whether all right-claims can be reasonably viewed as having both aspects; rather we claim at this point only that it is reasonable to view the right to free speech, and undoubtedly many others as well, as possessing this duality. In this instance, the right-claims, which can be construed as more than one right-claim, are sufficiently close in content to also be reasonably viewed as different aspects of a "right-claim" constellation.

Clearly the right to free speech can be helpfully approached in this bifurcated way. The right to free speech, which few would contend is merely a right-claim, simply requires that others not unreasonably interfere with its expression. This includes individuals, groups of individuals, organizations, and the government. What would constitute a reasonable interference must be left partially open but could well envelop such things as tortious shouting, slanderous utterings, pornographic materials, incitations to immediate violence
and the like. We label this as the "negative" side because the primary element appears in the form of a mandatory forbearance. The positive side, labeled as another aspect of the right to free speech, represents the right to a degree of protection from the government against unreasonable interference with that right by other parties. The right to access to the mass media, in turn, would itself have both a positive side, which would involve the right to actual use of the resources of the mass media, and a negative side which can be construed as an equal right to use, which would be normally contingent on the ability to pay, among other requirements, which others may not interfere with.

Thus, it may actually be more helpful to employ at least two separate bifurcations where free speech is concerned. The right to free speech itself, clearly a negative right, may be said to have two sides, its most widely recognized negative side and a positive side, suggested by Fried, relating to the protection (where required) of such a right. If a large crowd is threatening to prevent a speech we have a moral right to give, human and other resources may well be needed to assure that we will be able to speak. Our right to speak may not be effective unless resources apart from ours can be brought to bear on the situation. The contrast between the positive and negative aspects of the right to free speech is readily apparent even at this basic level. While the negative right may only be contingent upon not being slanderous, etc., the positive right may be contingent
on a number of things such as jurisdiction, citizenship, etc. These differences are substantial, even though we would agree the right to free speech might be far less effective without such available protection. In turn, in addition to this bifurcation of the right to free speech (narrowly construed), we have a larger division to be noted between the right to free speech and the right to have access to the means of disseminating such views, including the mass media. Here we have the positive right-claim and the negative right to access. The former would be a claim against the resources of others while the latter would be the right to be free from unreasonable interference with such access. What emerges from the analysis is a constellation of four "rights," two "negative" and two "positive." We have used the example of free speech at some length because it is among the best understood and widely discussed rights of all. A similar analysis of the "right to health care" is central to our project in Part One.

The literature in medical ethics roughly divides the "right to health care" into the "right to health" and the "right to health care," although some ambiguity is to be found. In the article discussed immediately above, which was entitled "Rights to Health Care and Distributive Justice: Programmatic Worries," Daniels elected to use the term "health care" broadly, thereby consolidating the "right to health care" and the "right to health." His purpose was to show that the line between positive and negative rights, where health care is concerned, is not as clear-cut as others may suppose. We are in agreement with
this apparent purpose of his but we have elected to increase rather than decrease the number of "rights" involved in the hope of making certain distinctions more clear. We prefer to separate or distinguish the right to health and the right to health care. Although nearly all that is health care has an impact on health, much that has an impact on health is not health care. Daniels is well aware of this but would counter that, as long as the "right to health" is not construed as an equal right to health itself, but to equally benefiting from or getting equal access to a broad range of actions which include preventive measures such as pollution controls as well as medical care, respectively, the terms may be harmlessly assimilated (Daniels 1979, pages 175-176). Be that as it may, we will divide the constellation of rights here into the negative and positive aspects of both the right to health and the right to health care, respectively, as we did above with the right to free speech and the right of access to the mass media. The positive aspect of the right to health care is the major concern for our purposes and, hopefully, the others will serve to place it in sharper focus. In Part Two, we will examine some of the ways this particular right-claim can be construed in terms of its application to the provision of health care.

Taking the right to health first, the negative aspect is relatively unimportant in the immediate context. Clearly, others are under a moral duty to avoid deliberately (or carelessly) acting in such a way as to injure the health of others. This could well be considered part of
the most fundamental inherent moral right which we embraced above, essentially the general proscription on the unreasonable interference of others with our actions in general. The positive aspect of the right to health would be the affirmative requirement on the part of governmental authority to meet at least some appropriate minimum standard in the general safeguarding of our environment as it relates to health. Here it may be helpful to divide the various aspects of the environment into those which are man-made and those which are not man-made. In general, one could more easily argue in favor of a government intervention where man-made environmental conditions are involved because of the clear causal connection to human agency.

Unavoidably, however, this is a question of degree. Virtually all of the effluent of modern industry has either a neutral or at least a slightly harmful potential direct or indirect effect on human health. Certain risks must be considered acceptable; just as we must accept some auto fatalities which safer cars could prevent, given that virtually any car could be made safer, if we are to allow them at all, so too a balance must be struck here. While society may well decide that a legal right to compensation arises from some or possibly all damage "caused" by the locus of the relevant balance in effect at a given time, to argue for a moral right here where legal activities are involved is to take on an extremely heavy burden. The certification of scientific "experts," the relevant scientific measurements, and the
determination of appropriate human thresholds is ineliminably a matter of the give and take of the political process to a large degree. In all instances, the government would have the obligation and the right to balance the damage done to the environment by various (presumably) legal activities and the social as well as the economic gains derived from such activity against any such right-claim. Because the right-claim to have the government intervene on behalf of such claimants is properly subject to such a balancing process, it could be overridden in such a process by any number of considerations, and thus it does not rise to the level of a moral right, in spite of its potential importance. If such is the case regarding man-made environmental conditions, it is all the more apparently the case where non-man-made conditions are concerned; here the government would have to balance the potential harm against alternative uses of its scarce resources. We would agree with Daniels that this aspect of human health is important, that it should be factored into health care policy, and that it does compel us to look more closely at the widely-received divide between positive and negative rights. We will address below Daniels' attempt to place the right-claim to health care (in our narrower sense) within a Rawlsian schema.

In so doing, we will make substantial use of the distinctions drawn here between the many aspects of positive and negative rights, respectively. As we have seen, while Berlin has contributed heavily to our understanding of negative rights and Fried has done so
with regard to positive rights, Daniels has galvanized us to look more deeply into these categories in ways which will prove decisive for our analysis. Others have recognized the distinction and, at least in a begrudging way, have accorded a certain priority to the negative rights correlative to negative duties. Rawls revealingly states:

The distinction between positive and negative duties is intuitively clear in many cases, but often gives way. I shall not put any stress upon it. The distinction is important only in connection with the priority problem, since it seems plausible to hold that, when the distinction is clear, negative duties have more weight than positive ones. But I shall not pursue this question here. (Rawls 1971, page 114)

Nagel refers to "exclusive" and "non-exclusive" instead of negative and positive rights, respectively, the former being "... rights which exclude others from directly interfering with their enjoyment or exercise..." while the latter are characterized as "... positive welfare rights--rights to subsistence, medical care, a minimum wage. ... They belong to the subject of socioeconomic equality discussed earlier" (Nagel 1991, page 139, emphasis supplied). He notes the exercise of exclusive rights by one person cannot be inconsistent with their exercise by another person(s) and that such rights can be governed by procedural justice alone.

Another commentator recognizing a relatively clear line of demarcation in this area is O'Neill. Despite her disapproval of the
recent emphasis on moral rights at the "expense" of moral obligations, she too draws a clear line in fleshing out this distinction:

The supposed disanalogy between universal liberty and welfare rights is not then bogus: the two are generally asymmetric. For example, when a liberty right is violated, then, whether or not specific institutions have been established, there are determinate others to whom the violation might be imputed. . . . But when supposed universal rights to goods, services, or welfare are not met, and no institutions for distributing or allocating special obligations have (yet) been established, there is systematic unclarity about whether one can speak of violators, and not just contingent uncertainty about who they might be. (O'Neill 1990, page 132)

The main point being made here, beside the general salience of the distinction between the two, is that positive rights always exist relative to a given institutional structure, a characteristic which does not always hold for negative rights. An important difference between positive and negative rights is underscored here which would seem at least implicitly to place the latter on a higher moral plane, inasmuch as the latter requires far less entanglement with the actual institutional arrangements of a given society while the former, on the other hand, are to be spelled out according to a particular social response geared to specific circumstances.
While negative rights (and the corresponding duties) have been generally more uniformly delineated than have positive rights, the former are better understood as the latter become more transparent. In spite of Daniels' forceful attempt to diminish the significance of the distinction between the two, our account has shown that a more fine-grained analysis can largely preserve its importance. Daniels nonetheless in particular has been a catalyst for us in a most positive way. We now transport the schema developed here to health care and the right claim to that care, having effectively begun the task in this section by separately treating the "right to health" in its negative and positive aspects, respectively. In the next section, the negative and positive dimensions of the "right to health care" will be examined with a view to answering two questions which are central to our thesis: 1) Is there a moral right to health care? 2) Is there a moral right to access health care?

VII. The Right to Health Care /

The Right to Access a Second Tier

We now turn to the right to health care in both its positive and negative aspects. The right to health care which is the most controversial is the positive right-claim of those with medical needs. Let us first consider the negative aspects of this right. This latter right is basically the claim that one has a moral right to seek and pursue medical care, hoping to enter into mutually satisfactory
arrangements with care providers, without undue interference from other individuals, organizations, or the government. As stated above with regard to the purely negative aspects of the right to health and the right to free speech, this right may be fairly considered a part of the most fundamental inherent moral right of all, the general proscription on the unreasonable interference of others with our actions in general. In terms of medical care, this amounts to free access to a second or non-public tier of medical care.

Although few would deny the purely negative aspect of the many branches of the most fundamental inherent moral right, when we come to health care, such denials are much more frequent. Typically, these denials or conditional "affirmations" are linked to a strong endorsement of the positive aspect of the right to health care, whether or not a moral right is systematically asserted. Daniels' position, which does not include the outright denial of a morally mandated access to a second tier, would make the moral permissibility of a second tier contingent on its not being an undue hindrance to the first tier. This rather stunted second tier is described thusly: "My account is compatible with (but does not imply) a multi-tiered health-care system. The basic tier would include health care services that meet important health-care needs, defined by reference to their effects on opportunity. Other tiers would include services that meet less important health-care needs or other
preferences" (Daniels 1981, page 175, emphasis supplied). A similar view is expressed by Robert Veatch. He states:

... there are potential problems for an egalitarian if the relatively well-off are permitted to buy a second ... tier of care. As long as what is being bought is conceptualized as a luxury, there is no problem in principle with permitting such purchases with discretionary funds. But the problem will arise if these funds are used by the relatively well-off to tie up scarce, irreplaceable resources needed for the medically worst off. ... Egalitarian justice would not automatically oppose a second tier of health care, but it would be skeptical and seek assurance that permitting a second tier would not jeopardize the prior right of those who are not getting the decent minimum. (Veatch 1994 in Chapman 1994, pages 116-117)

Clearly, perspectives such as these can be barely said to allow a second tier, given the extreme conditions of justifiability required for it. Our view is almost diametrically opposed to the structured and reluctant second tier thus envisioned. Access to a second tier is part of the fundamental moral right. While it may be less important than the right to be free from coercive violence or the right to pursue the basic necessities of life (roughly food, clothing, and shelter), there would be few, if any, others which could be placed "ahead" of this inherent moral right. The connection between the negative and the positive aspects of the right to health care is readily apparent in
analyses such as those of Daniels and Veatch. Our position will utilize the critical distinction between positive and negative rights. Let us examine first, by way of continuing with our discussion of the moral right of access to a second tier, the views of a leading commentator which firmly support our position.

In a 1992 article, H. Tristram Engelhardt Jr. proclaimed the moral unavoidability of a two tier system of health care delivery (Engelhardt 1992, pages 196-207). Contrasting those who would attempt to broaden the scope of basic coverage to the less fortunate with those who would achieve more parity by restricting access to a second tier, he labeled the former "egalitarians of altruism" and the latter as "egalitarians of jealousy." Denying the existence of a canonical or generally justifiable moral vision which could guide us in selecting an approach to distributing health care resources, Engelhardt calls for the distribution of those resources according to the "principle of mutual agreement." This principle would allow communal provisions for a first tier, not as a matter of moral right, but as a consequence of a certain consensus which might be found; the same principle is said to mandate a free and open sphere beyond any such public sphere where health care seekers and providers can come to terms.

Engelhardt concludes:

The existence of a substantial private-tier health care represents a recognition of the limited authority of secular societies. After it has been decided how to dispense public funds for communal
resources in creating a limited social insurance against health losses, people should be free to purchase additional health care according to their inclinations and resources. A private health care tier, that is supported by private insurance, is important—not because of what it accomplishes, but because it acknowledges the limits of community authority and the diversity of individual moral sentiments and wishes. ([Ibid.], page 205)

Left unsaid in this analysis, but a clear inference to be drawn from it, is that if a first tier were to be a moral mandate, any accompanying second tier would very likely thereby fall well short of the moral mandate for a robust second tier. In our view, it is critical to realize that, if a first tier is morally mandated, then it must have a certain potentially destructive moral priority over any second tier which might be permitted. The converse, however, does not follow if a second tier is morally mandated. This is due largely to the difference between positive and negative rights. A morally mandated first tier represents a prior moral claim on the resources of a health care system, requiring that access to a second tier be restricted or even denied altogether if "surplus" medical resources are not left over after publicly prescribed health care "needs" have been met. From this, it follows that the sort of "interference" with the smooth functioning of the first tier which is decried by Daniels and Veatch among others would be sufficient to warrant severe restrictions on the
related second tier. Since the moral mandate of a robust second tier does not represent a moral claim on the resources of a health care system, but rather merely affirms the moral right freely to pursue mutually satisfactory arrangements with health care providers for the delivery of health care, a second tier would not represent a "morally prior" claim in any threatening sense. Neither the moral capacity nor the practical ability of a given society to institute a first tier of health care delivery need be significantly compromised by the embrace of a moral right to have access to a second tier. We have shown at the very least that the legitimate denial of our claim of a moral right to have access to a second tier depends upon the establishment of a positive moral right to health care. While to deny the moral mandate of both a first and a second tier would not be a contradiction, to deny the moral mandate of the latter after denying that of the former would be to introduce questions of coherence at the least. Thus, the centrality of the question whether there is a moral right to health care is squarely before us.

We noted in discussing the positive aspects of various right-claims (the "right to free speech," the "right of access to the mass media," and the "right to health") that each represents a claim against the property or assets of others, whether they be private parties or governments, whether they be a claim for protection or for the actual use of such property or assets. As we have seen, it is much harder to argue in favor of a positive right which involves the use of property
or assets and not "merely" a claim for some sort of protection. Indeed, the positive side of the right to access to the mass media was seen to involve the virtual "commandeering" of property. Undoubtedly some feel that health care carries a particular urgency and therefore warrants a stronger claim as well, regardless of the consequences. It is to this claim that we now turn.

Medical care undoubtedly occupies a special place in human affairs. The need for medical care is probably as basic as any of our material needs, excepting those relating to food, clothing, and shelter. If the right to medical care is to be recognized as a moral right, it must be recognized as such on the basis of medical needs. However, if one argues for this moral right, one must also be committed to the position that there is a moral right to some share of food-clothing-shelter, given the greater priority of the latter on the scale of human needs, if one is to be consistent. Thus, a commitment to some form of minimum income guarantee or its equivalent comes with the territory here. In addition, while health care is very high on the list of human needs, it is not necessarily right behind food, clothing, and shelter. Education comes to mind as a need which could challenge health care for position on the list. Daniels in particular has viewed the two needs as largely parallel to each other. There may be other needs which could be interposed as well. However, while the list of needs which must be included among moral rights if the right to health care is so recognized might be
difficult to circumscribe, this is not our only objection to the recognition of this right. Rather the intrinsic nature of the positive side of the moral right to health care also renders it an unsuitable candidate for this status. As we will see below, the sheer weight of this purported right makes it suspect. We will firmly conclude the right to health care should not be recognized as a moral right.

The central characteristic of positive rights is the claim they represent against the property or assets of other parties. The term "positive" in this context points to the requirement of a positive contribution of resources as opposed to the forbearance which is the cornerstone of negative rights. The demands of justice here are distributive and not retributive in nature. The right-claims asserted lend themselves to a divisibility and a quantification essentially foreign to negative rights. Similarly, these claims fall into "competition" with each other, given the ineliminable scarcity of all material resources, while negative rights do not similarly compete with each other and cannot be viewed as "contradictory" to each other. And, while some of the rights we have labeled as positive (e.g., the positive aspect of the right to free speech) may possess these attributes to different degrees, the positive aspect of the right to health care is paradigmatic of such rights. This is because such a right manifests in the most explicit way the single most defining characteristic of positive rights: the basing of such rights on one's fair share of scarce goods. In this, we echo Fried in spite of his concomitant affirmation of such rights
based on need, importantly including health care itself. Even if one argues on some other basis for the recognition of such a right, e.g., the right to have fair access to the various opportunities in life (see Daniels 1981, pages 146-179), the support for the right must involve one's fair distributive share of scarce goods which is need-based. To couch this in terms at one step removed is only to say that the failure to satisfy certain medical needs would compromise the right-claimant in such a serious way that such failure would be a violation of a moral right, however described.

Unsatisfied medical needs per se are certainly an unfortunate turn of events. The question, however, is whether such a state of affairs is unfair as well and thus bespeaks of a serious moral wrong. To suggest as we are that the normal operation of our proposed health care system virtually guarantees that some will suffer serious medical consequences due to the limited medical resources they can rightfully command, while others will avoid the same consequences because of the relatively greater medical resources they can rightfully command, is to countenance the unfortunate but, rather than a denial of moral rights, it is an affirmation of them coupled with the recognition of resultant limits of the purely moral sphere. The recognition of a morally-mandated first tier is to encroach impermissibly on the moral mandate of a second tier. The recognition of a morally-mandated second tier is to limit the morally permissible scope of any related first tier. The recognition of both a moral right to
a first tier and access to a second tier is again incompatible if not quite contradictory.

The relationship between these two claims, i.e., that there is no moral right to health care while there is a moral right to access health care in a second tier, is the focal point of our thesis. We have already argued that the latter is a discrete segment of the fundamental moral right while the former is not such, largely on the basis of the distinction between positive and negative rights. Yet the incompatibility of the joint conclusion that the former is a moral right, while the latter is pre-empted to the extent required by recognition of the former or denied the status of a moral right altogether, may be intuitively easier to comprehend. If a first tier is morally mandated, the operant institutional structure must satisfy the applicable standard, whether it is a minimum level for all or equal expenditures for all with a minimum level or "equal health" for all. Unless or until this standard has been met, second tier resources must not be utilized or must be otherwise curbed to the extent that such utilization would or reasonably could jeopardize meeting the standard for the first tier. The right to access medical care in a second tier would be, to a greater or lesser degree, held hostage in each fiscal year to the contingencies of the first tier, being itself a contingent right at most. Thus the moral right to access medical care, whether nominally recognized or not, would be in principle a mere shell of a moral right, if that. It is hardly an objection to say things might "work out." No
commentator we know of has had the temerity to label this a fundamental moral right while concomitantly affirming such a right to health care itself. This is strong circumstantial evidence at least of a basic incompatibility between the two moral right-claims. This incompatibility, on the other hand, will require us, in arguing below for the moral permissibility of a universal first tier, to delimit that tier to the extent necessary to uphold the moral right to access medical care in a second tier.

Since the right to access to a second tier has been established herein as essentially an extension of the fundamental moral right, it is the moral right-claim to health care which cannot stand. It also cannot stand in its own right, considerations of a second tier aside. Arguments for such a right tend to be need-based, include a corresponding moral duty, and are often motivated by either egalitarian or "redistributarian" concerns or both. The egalitarian and redistributarian perspectives overlap quite a bit, although egalitarian and redistributarian perspectives need not be need-based. This having been said, the clear effect of the realization of such views would be to shift health care resources away from those with relatively fewer health care needs toward those with relatively greater health care needs. This effect is certainly the case if one concedes that generally those with relatively greater resources have relatively fewer health problems. Veatch states the basis for egalitarianism is an assumption or set of assumptions: 1) All deserve an equal share
of available resources; 2) natural resources are available for common appropriation without strings attached; and 3) people have a moral responsibility to use available resources to effect a more equal distribution of resources (Veatch 1991, page 85). While such a strict egalitarianism is conceptually at odds with a needs-based approach, the morally mandated redistribution would still have the above-mentioned effect of shifting health care resources toward those relatively with greater health care needs.

John Moskop has captured most saliently the considerable difficulty in deriving the moral right-claim to health care. Honing in on the unwieldiness of such a right as a "moral right," he examined the attempts of both Green (Green 1976 and Green 1983) and Daniels (Daniels 1981) to substantially equalize the allocation of health care resources under a Rawlsian framework. He criticized Green's inclusion of a moral right to health care under "primary social goods" as opening the door to a proliferation of principles designed to satisfy other basic needs and criticized Daniels' inclusion of a right to health care, which is just short of being a fundamental right, under Rawls' principle of "fair equality of opportunity," as necessitating a balance of support against other competing institutions, a consideration clearly outside the "veil of ignorance" which is best considered at a legislative stage of deliberation. Moskop does express concern about Nozick's position that such a right-claim should be rejected (absent consent)
even at the legislative level, however. He fairly summarizes his position:

The difficulties we have encountered in deriving a human right to health care from even a theory as sympathetic as Rawls' theory of justice make the task of justifying a basic human right to health care appear more and more difficult. Instead I would suggest . . . that the provision of health care is best understood not as a universal human right, but as a social ideal which may inspire the creation of specific legal rights. (Moskop 1983, page 336, emphasis supplied)

Rawls himself did not argue for such a right in A Theory of Justice. (In his 1999 book, The Law of Peoples, Rawls does support a right to "basic health care" for all citizens, but no argument is offered in favor of such a right.) This is of overwhelming significance for at least two reasons: 1) Rawls is the most influential political philosopher of our time. 2) Rawls' views have sometimes been used, most notably by Daniels, as a basis for justifying a moral right to health care. Rawls' relevant central general conception is stated by him as follows: "All societal primary goods--liberty and opportunity, income and wealth, and the basis of self-respect--are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored" (Rawls 1971, page 303), having earlier assigned health to the lower status of a natural good: ". . . the chief primary goods at the disposition of society are
rights and liberties, powers and opportunities, income and wealth. . . . These are the social primary goods. Other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure, they are not directly under its control" (Ibid., page 62).

Some eleven years later, Rawls seemed acutely aware of the unique problems posed by the highly skewed distribution of health care needs. He defended his exclusion of health from social primary goods by declaring its status as a natural good rendered it a more suitable topic in the give and take of a legislative context than the more lofty deliberations of those in the Rawlsian "original position." He states:

I begin by considering what might seem to be an objection to the use of primary goods in a well-ordered society. It may be said that when we take the two principles of justice in their simplest form, so that income and wealth is the only primary good with which the difference principle is concerned, this principle cannot be reasonable or just. This can be shown, one might argue, by two examples: special medical and health needs. . . . It is best to make an initial concession in the case of special health and medical needs. I put this difficult problem aside in this paper and assume that all citizens have physical and psychological capacities within a certain normal range. I do this because the first problem of justice concerns the relations
between citizens who are normally active and fully cooperating members of society over a complete life. Perhaps the social resources to be devoted to the normal health and medical needs of such citizens can be decided at the legislative stage in the light of existing social conditions and reasonable expectations of the frequency of illness and accident. (*Rawls 1982*, pages 167-168)

Four conclusions can be drawn from this. Firstly, Rawls' exclusion of those with significant health care problems clearly does not render them less a part of the polity; rather it is simply Rawls' way of recognizing that not everyone can participate in deliberations entered into from the original position, not only as a matter of human logistics, but because many would not or could not participate for any number of reasons, including it would seem even those of median intelligence who lack the capacity for such matters. Secondly, health care is broadly parallel to education for Rawls as it is for other commentators, notably Daniels. Educational and health care needs are highly skewed throughout the population in a way that our more evenly distributed minimum needs for food, clothing, and shelter are not, and thus do not lend themselves to the formulation of some readily determinable minimum level and thus, in Rawls' scheme, the latter needs are to be factored into the institutional structures itself while health and education, with neither being a primary social good, are not so included. Thirdly, the distributive shares of the societal
product allocable to health care needs through public law and policy is to be determined by the legislative process and not at the level of the basic structure. This is an implicit admission that the give and take of the bargaining process, the endless balancing and re-balancing endemic to the legislative function, is more suitable as a vehicle for decision than the loftier and more permanent decrees which are both logically and temporily prior. The degree of balancing and compromise which is normal and beneficial is far greater at this relatively lower moral level of deliberation because they are more suitable to the subject matter at hand, such as health care needs and education.

Fourthly, and most tellingly, the right-claim to health care, important though it may be on virtually all accounts, does not attain the level of a moral right. Certainly Rawls saw a clear line of demarcation between income and wealth (i.e., for practical purposes, food-clothing-shelter), on the one hand, and health care (as well as education), on the other hand. This is true in spite of his emphatic renunciation of economics and social welfare as the sole basis for assessing these two areas (Rawls 1971, pages 101, 107). Despite language assimilating natural talents and their differing amenability to education to the common pool of assets, they are not directly "subject to" his difference principle as are income and wealth. Thus, health needs are removed from that orbit in his scheme of things. Even though Rawls has said far less about health care than education, it
seems fair to attempt to determine why, given their rough parallel. In education, while Rawls favored extra help for the educationally deprived, he undoubtedly accepted limits on such interventions. In health care, the incredible advances in modern medicine have made the delimitation of boundaries increasingly difficult. People can more readily accept limited educability than they can limited health care interventions. The potential for spending far greater sums on even a single patient, to say nothing of various medical groupings, is almost unimaginably greater in medicine than in education.

Indeed the notion of a potential "bottomless pit" is hardly inappropriate at one end of the spectrum. To apply the difference principle in this area, i.e., to maintain that unequal distributions must inure to the benefit of the least advantaged, is to stretch even such a history-making concept beyond its useful capacity. Rawls' effective embrace of a minimum income concept barely scratches the surface of the problems bedeviling the distribution of health care resources in the United States. This is to say nothing truly negative about Rawls' system in regard to health care. If anything, we applaud an approach which is at least implicitly aware of the uniquely intractable character of much of this area, and that is aware of the unsuitability of a prefabricated set of instructional requirements to deal with it. At least in a strong indirect way, Rawls' perspective reinforces our position that no moral right to health care should be recognized.
We conclude this section by summing up our reasons for denying the right-claim to health care the status of a moral right. The foregoing account yields the following (not sharply defined) characteristics for moral rights: 1) Alienability--they are relatively inalienable in that, if not unchangeable, they are procedurally and practically more difficult to alter than purely legal rights; in addition moral rights are notably more difficult to voluntarily alienate or extinguish than purely legal rights which are more often "waiveable." 2) Non-competitive--they are far less likely than purely legal rights to be in direct conflict with other rights; stated more positively, they are more completely compatible with these rights. 3) Independence--they are not nearly as dependent as are purely legal rights on a given institutional structure for their configuration; this is the case even though moral rights may well depend on a given institutional structure as do purely legal rights for their effective recognition. Other characteristics could be listed as well, e.g. that of being the subject of a wider range of reasonable agreement than purely legal rights, but this will tend to be more peripheral and more difficult to defend. What is critical here is that the moral right-claim to health care does not meet these criteria, criteria our analysis has shown the moral right-claim to access a second tier of health care does meet.

The moral right-claim to health care falls well short in all these respects. Our list does effectively exclude positive rights, but a consensus of commentators would give negative rights a priority over
positive rights, whether or not they would recognize any positive rights as moral rights. In addition, if such a positive moral right-claim were recognized, as we have argued, any canonical list of moral rights would have to include a number of others which might well prove unwieldly for such a project. While we do not agree with Rawls' effective inclusion of a minimum standard of living as a basic moral right, his position at least has the virtue of including the positive right least likely to compromise the endeavor of compiling such a list. We do not concede this point to Rawls but, arguendo if we did, it would not per se implode our list. However, such a result would obtain if the moral-right claim to health care were included. In any event, our account shows this claim to be wanting and, accordingly, it must be rejected. As our thesis unfolds, the denial of this moral right-claim will become increasingly important to the project. The contours of the legal right to health care we are advocating are both indispensable to our proposal and incompatible with the moral right-claim to health care. Before we conclude the main text of Part One with a section addressing the moral permissibility of such a legal right, we must flesh out further the conceptual scaffolding of our project so that it may bear the considerable weight assigned to it.
VIII. Linking the Nucleus and the Orbits

of Our Conceptual Scaffolding:

The Mandatory, the Permissible, and the Preferable

To this point, we have taken two definite stands. We have maintained, virtually without qualification, that there is no moral right to health care and that there is a moral right to have access to a second tier of health care. We believe this has been satisfactorily shown. However, we still must complete the philosophical scaffolding needed to support our reform proposals for the United States health care system. In addition to these two elements of that structure, we must also show the moral permissibility of universal health care coverage and of explicit rationing within such a system. In so doing, we shift from the morally mandatory to the morally permissible. Here the burden of proof is accordingly less stringent. A course of action or policy can be fairly viewed as morally permissible if, and only if, it does not breach or unreasonably delimit any moral right, and it is morally preferable as well if the prospective benefits of such course can reasonably be expected to outweigh any associated negative effects or burdens. Since the formulation of a complete moral and political theory is not required for our purposes, this affords a greater degree of flexibility than would otherwise be the case. It is sufficient if we can provide adequate justification for the precepts we are actually advancing.
Our stance in outline is essentially deontological at its core, where a very modest range of moral rights has been recognized and substantiated. This constitutes the mandatory or deontological aspect of our position. The core envelops, in addition to a denial of a moral right to health care and an affirmation of the moral right to pursue health care in a second tier, a defense of the moral permissibility of a public tier of health care which encompasses a system of explicit rationing. We support the moral preferability of such a public program on grounds that it will substantially improve the general health of the United States population without violating the moral rights of any individual. In this fashion, we combine a largely deontological core with a moral periphery which opts for a significant incremental balance of benefits over burdens in the proposed allocation of medical resources while observing the moral constraints which remain operative.

The core remains inviolable as before but, as we venture away from it toward various possibilities for a general improvement of the health care system, the balancing, the measurement, the weighing, and the judging involved assume a more pragmatic, and expedient tone.

Thus, we propose a blueprint, which is consistent yet not thoroughgoing, which is essentially deontological yet short on deontological commitment, which is long on balancing myriad considerations, but which nonetheless violates no moral proscriptions.
Our claims are not offered as proofs or demonstrations, but are reasonable positions which are consistent and which include plausible projections at least as reasonable as those which might be opposed, most particularly states of affairs which approximate the status quo. We do not check conceptual rigor at the door at this point of our quest. Rather we must change conceptual gears as the public sphere looms progressively larger in the questions presented and the private sphere correspondingly contracts. The search here is for a morally preferable option(s), which is (are) to be first shown to be morally permissible. The "good" which derives from consequences, now moves to center stage, not in supplanting the "right," but in supplementing it.

Whether one of two hypothetical acts, which act results in demonstrably better consequences than the other, both acts being "right" and therefore morally permissible in the context, could be more "just" or "right" than the other could certainly be disputed but that it would be "better" seems largely beyond cavil. Further, if a community has the option of spending a given sum of its commonly-held assets on an orphanage or increased welfare benefits, for example, the related debate could well be spirited and even acrimonious but, if the relevant citizenry believed overwhelmingly that one of the two options would have somewhat more beneficial consequences for the community as a whole, few would insist that that option was not likely the "better" or "morally preferable" of the two. Admittedly, since the
variety of consequences can be numerous and the debateability of what they will actually be can be extensive, to say nothing of the likely absence of a canonical view of the good in a given case, what is morally preferable where questions of the common good are concerned will often be reduced, as a practical matter, largely to a political question. Nonetheless, even where judgments with moral implications have an irreducibly relative aspect, some alternatives will be morally better than others. Indeed, more than a few moral questions turn on which is the (morally) lesser or least of evils. So the choices of which we speak here are not so much about right and wrong as they are about the good and how it should be pursued. There are, of course, considerations which in general render judgments about particular conceptions of the good more suspect than in the past.

Since MacIntyre's *After Virtue* appeared (*MacIntyre 1981*), the absence of a true moral consensus in this country has come to be increasingly recognized. We do not celebrate this state of affairs, but it does have ramifications which must be reckoned with. As a result of this regrettable but all too real incommensurability, the perspective of particular moral communities takes on added importance. The barriers between universality and particular moral communities must be minimized if our society is to be sufficiently responsive. It has been recognized at least since the time of Hegel, but often forgotten today, that morality requires situatedness within a moral community
(McKenny 1993, page 512). This places a higher premium on autonomy, consensus, and concomitant procedural safeguards rather than on a governing conceptual apparatus presupposing common ends. There can be a fundamental tension inherent in a greater emphasis on autonomy, but here one must distinguish the particular communities within a larger society and the larger society itself. Within a particular community, a greater emphasis on individual autonomy may well serve to undermine the moral cohesiveness of the community. However, within the larger society consisting of a number of particular communities, greater emphasis on autonomy can help to ensure the moral integrity of particular communities. If a choice is viewed as one of autonomous action, then members of two differing moral communities could respond in different ways under this single principle recognizing the moral agency of each community to the extent practicable.

Having said all this, we must advocate a particularized conception of the good at this juncture if our goals are to be set forth. In calling for a public system of universal health care coverage in the United States, embracing a legal right to health care, we favor a major change in the administration and distribution of health care resources. Effective medical care is a good on any account, but by appealing for what we consider a morally preferable new system, we assume the mantle of consequentialism to that extent. Much as we saw above concerning how thoroughgoing or complete our
deontological core is required to be, our consequentialist call for a
comprehensive public tier of health care need not be particularly far
ranging or finely grained. Although the structure of the system
projected in Parts Two and Three is conspicuously marked throughout
by various rules and criteria designed to gauge the preferability of
available options, we need not decide here whether this represents a
variant of rule utilitarianism or whether, as Smart suggests (Smart
and Williams 1988, pages 11-12), all such purported systems collapse
into a form of act utilitarianism. Certainly to the extent a form of "act"
utilitarianism evaluates actions as well as consequences a bridge is
constructed between "act" utilitarianism and "rule" utilitarianism, since
"types"of acts and more "indirect" consequences would thus come to
play a correspondingly larger role. On the other hand, it does seem
clear our medical benefit criterion in light of relevant costs is decidedly
more non-hedonistic than hedonistic. Such a criterion is more on the
order of negative utilitarianism, where the primary concern is the
minimization of suffering and not necessarily the maximization or
aggregation of pleasure, happiness, preference, satisfaction, etc.

Our use of a consequentialist framework in outlining a system of
universal coverage does require us to spell out and defend our
allocation criterion. This will be done in some detail in Part Three,
while the general possibilities for overall improvements in United
States health care are discussed in Part Two. This criterion, by
measuring the quantity of medical benefit per intervention on a cost
per unit basis (known as Quality Adjusted Life Years), is a means for taking into account medical needs, medical risk, medical benefit, and cost. We are advocating this criterion as our consequentialist measure by virtue of which public-tier resources are to be distributed. To that extent, our system is consequentialist, again within a deontologically permissible sphere, but only in that allocational aspect. This permissibility itself in terms of the political process and its effect on property rights through the medium of taxation, will be shown immediately below. Before leaving our use of consequentialist criteria, a few further characterizations should be mentioned.

We are advocating a system geared toward the average level of benefit rather than any aggregate or total measure. This rough measure in turn is subject to a number of qualifications which do not apply within a purely consequentialist framework. Most importantly, no moral (or legal) rights may be violated in the process. Also, while we are outlining an allocational structure, this structure may be modified and implemented in various (unforeseeable) ways through the political process, which in our view should not be held hostage to consequentialist sensibilities. In addition, as will become clear in our detailed analysis in Part Three, certain limitations upon our consequentialist criterion, largely in the name of "fairness", have been allowed for so that certain projected results will reflect a better "balance." Thus, while our central criterion is the main focus of our allocational schema, it does not mirror a purely consequentialist
approach. Rather it is a criterion informed by an ethical cauldron somewhat richer in its elements and influences.

IX. Moral Permissibility of

Universal Coverage and Rationing

The moral permissibility of a public tier in the United States turns largely on the operant conception of property rights and its relation to that polity. The appropriate starting point is an account of property rights in relation to the moral order which is being outlined. We have placed property rights, along with the right to be free from gratuitous (tortious) interference and the right to freely pursue mutually satisfactory arrangements (contracts) with others, as constituting an integral part of a comprehensive moral right. In so doing, we have conceded that such a right in all its manifestations is largely unenforceable, and thus more of an ideal than a reality, absent a polity which in principle and in fact recognizes it. We have so conceded largely to avoid becoming involved too directly in a discussion of the "state of nature," a state of affairs which is not a historical fact. At the same time, we have contended that this fundamental moral right must be effectively recognized in some form if a given society is to be viable. Other right-claims such as the right to a minimum income, to a minimal level of education, and to some basic level of health care were all found to be less fundamental and to be lacking in the characteristics needed to be recognized as moral
rights. Much of the analysis turned on our relatively fine grained distinction between "positive" and "negative" rights. We showed the positive side of the equation to have negative elements and vice versa. This analysis must now be focused on property rights. Here too the relevant complexities will have to be laid bare if a cogent perspective is to emerge.

The negative side of property rights itself may be seen as having both a negative and a positive aspect. We have a moral right to be free to seek property by any means which is both moral and legal. Concomitantly, we have a right to be free from unreasonable interference with this right from whatever source. This does not mean, any more than it did with regard to our most general liberty right, that external restrictions are morally proscribed. The free pursuit of property may be restrained and regulated within reasonable bounds without such restrictions being violative of that right. To a large extent, how far this may go will depend on the relevant historical backdrop and social conditions. The positive aspect of the right to freely pursue property may require some state intervention to prevent undue interference with that right if it is to be duly recognized. In general, these are the negative and positive aspects of the negative side of the right to freely pursue property.

The positive side of property rights also may be seen to have both a negative and a positive aspect. While the negative side of property rights is a constant source of controversy and conflict, this is
even more the case where the positive side of property rights is concerned. The positive aspect of the positive side of property is less controversial than its negative aspect. It consists mainly of affirmative duties on the part of government to prevent and prosecute offenses against property. These offenses, which are generally criminal as well as civil in nature, include theft, conversion, damage including vandalism and destruction, and wrongful interference with the right to alienate or hypothecate one's property. Given the general recognition of property rights, there is relatively little here that is inherently controversial. The negative aspect of the positive side of property rights is, however, another matter. Here the corresponding duty is not to interfere with property rights. While few would disagree with the duty to avoid theft, conversion, vandalism, etc., there is another dimension here which raises relatively unchanging issues. The duty here of non-interference applies to all parties other than the property owner, including the government. Of course, the representatives of any government which is legitimate and not corrupt would readily agree not to engage in such acts. However, when the government chooses to "interfere" with property rights, a different vocabulary emerges, that of "eminent domain," "just taking," "taxation," and "escheat," etc. For our purposes, it is the power to tax which most squarely presents the moral issue whether the exercise of that power is a morally permissible exercise of state power. Questions of government legitimacy and observance of
applicable procedures may be assumed to have been answered in the affirmative here, reducing the matter to a clash between the property rights of the individual and the taxing power of government.

At one extreme is the view, trumpeted by Marx and others while being largely put into practice in a number of countries in the past century, that the state can legitimately outlaw private ownership of the means of production and, at least in principle, private ownership of other forms of property, the state being in effect empowered to recognize property rights as it sees fit. At the other extreme, represented most strikingly in recent years by Nozick, explicit consent of the property owner is needed for a legitimate divestiture to occur, save for the level of taxation needed to meet the minimal protective functions of the state. Since we are defending the position that taxation to fund a variety of public functions, including health care, is morally legitimate, we must come to terms with his position in the process of showing the moral permissibility of a first tier. Current views on income redistribution range from the virtual prohibition defended by Nozick to the openly permissive views of egalitarians like Veatch or a moderate egalitarian such as Rawls. Our perspective will emerge as an intermediate one, seeking to avoid both the virtual absoluteness of property rights in Nozick’s view and the more communal conception of property rights typified by the egalitarian view.
Nozick begins his account in *Anarchy, State, and Utopia* with self-ownership and entitlement, not with need or even with desert. Placing property rights on a par with life and liberty, he would restrict the proper role of that state to protecting the citizens against force, fraud, and theft, and to the enforcing of contracts. Under such a vision, negative rights as side constraints are of paramount importance while positive rights are to be recognized by agreement only. The state is characterized as being analogous to a night watchman who moves into action only when something on that watch appears to have gone wrong, as essentially a non-interventionist entity properly intervening only under a range of limited functions. The principles governing property are those of acquisition and transfer, subject to what has become known as the "Lockean Proviso." Locke had justified the appropriation of property subject to the condition that the appropriator leave "enough and as good" for others to come. Nozick interprets this restriction to proscribe making anyone's condition worse by such appropriations which effectively prevent others from doing so as well (*Nozick 1974, pages 176-177*). This amounts to a shift from prejudicing the "appropriation" of others to prejudicing the "use" of others, with even the "use" of others being satisfied if at least some new form of opportunity can serve as a counterbalance to opportunities otherwise diminished by the appropriation itself. These qualifications are of interest partly
because they echo, however faintly, some of the views of Rawls in his formulation of his difference principle.

In *A Theory of Justice*, Rawls asserted that income and wealth were to be distributed equally, an egalitarian conception, "... unless an unequal distribution ... is to the advantage of the least favored" (Rawls 1971, page 303). Casting aside the notion of desert in the distribution of social primary goods (wealth and income included), Rawls attributes difference in personal abilities and disposition to accidents of nature and social circumstance. Accordingly, he states: "We see then that the difference principle represents in effect, an agreement to regard the distribution of natural talents as a common asset and to share in the benefits of this distribution whatever it turns out to be" (*Ibid.*, page 101). So, while Nozick would see taxation beyond the barest minimum as a morally impermissible usurpation of state power, Rawls would require justification for all inequalities of wealth and income in such a way as to invite redistribution through taxation whenever such inequalities are not otherwise mitigated in the required way. Property rights are thus far less secure under Rawls' formulations than under those of Nozick. The latter views property rights as virtually absolute, despite token disclaimers about initially tainted acquisitions. The former, on the other hand, brings a penchant for positive rights which could, potentially at least, compromise property rights in a fairly basic way.
A view which is more moderate on property rights, which we do not necessarily endorse in its particulars, has been advanced by Brody. In a pair of articles written some ten years apart, he rejected the notion of a moral right to health care because the concomitant obligation cannot be substantiated (Brody 1991, page 117), whether one argues for such a right on the basis of need, marginal utility, or that such a right would form part of the basis to exercise all other rights (Brody 1981, page 154). Having rejected a moral right to health care, Brody argues that, not only are redistributive social programs not necessarily in conflict with the notion that people have a right to what they earn but, since even the libertarian arguments base the grounding of property rights on the labor involved, the initial value of natural resources independent of the value added by labor is properly viewed as belonging to the public domain. He argues further that, while it is more efficient to allow people to attain exclusive property rights over natural resources, a valid social claim should be interposed for this initial resource value. He concludes that if a society is sufficiently wealthy, this sector of the public domain could then be used to provide health care to the medically indigent.

Our task here is actually two-fold. In addition to that of showing the exercise of the power to tax can be morally permissible, we must also delineate in some way the moral limits on that exercise. Even Nozick, as staunch a defender of property rights as could be found, has conceded the legitimacy of taxation for certain limited protective
purposes. Indeed, a failure to concede as much is tantamount to a moral recipe for anarchy in virtually all but the smallest and most isolated societies. At least to this extent, a clear consensus emerges. However, to morally justify the comprehensive powers of taxation routinely exercised by developed nations in modern times, only an argument based on *effective* consent can truly hope to succeed if property rights are to be viewed as morally binding, at least once they have been effectively recognized by the state. Some might find an irony here, given that (explicit) consent is sometimes interposed as an indispensable moral basis for taxation *a la* Nozick. In addition to the rights to possess, use, and destroy one's property, one may alienate or hypothecate that property. Although the paradigmatic example of the latter is that of an outright transfer for consideration, one may be deemed to consent to such changes in numerous other ways. For example, in general, if a person benefits from the actions of another concerning that person's property, even without explicit consent, as when a boat or car is rescued and stored, indeed effectively salvaged, a claim against the property can arise if compensation is not rendered. The form of consent involved in taxation, while importantly different, represents a shift from a largely individual level to a purely social level. This particular form of consent, in turn, is inextricably tied to a more general consent which applies between an individual and the state. To simplify matters, and because it is the state under discussion, we refer here to the United States.
While this issue does compel one to consider the nature of the compact between an individual and the state, if one adopts a rather expansive view of the individual consent involved, as we do, this will at the same time diminish through effective pre-emption the importance of "pre-existing" property rights. In allowing for greater potential scope of the compact involved, we concomitantly allow for a correspondingly lesser role for the "inalienable." Given the obviously problematic status of any alleged "state of nature," the related focus on alienability assumes correspondingly greater importance. The right to be at large without undue interference and the right to enter into voluntary arrangements with others without undue interference are in a sense more basic than the right to own property without undue interference in that they are less alienable. In addition, as important as property rights undoubtedly are, one must be at large and free to make arrangements with others if property ownership is to come to fruition.

One can more easily question one's capacity to alienate one's ability to be at large, which could be viewed as at least a partial selling of oneself into a state of slavery or "unfreeness," to alienate one's capacity to enter into voluntary arrangements with others, which could be viewed as at least a partial abridgement of one's freedom to associate, than one's capacity to agree to allow a common authority to raise and maintain a common fund for the common good through the power of taxation. Although we have deemed it more salient to
carve out a single fundamental moral right in three parts rather than three such rights, some gradation concerning alienability should be recognized. Property is alienable virtually by definition. This is hardly true for the right to be at large and the right to enter into voluntary arrangements with others, even though such rights cannot themselves be without limits and the exercise of the right to make arrangements with others can easily limit the arrangements one is then free to enter into. We need not decide precisely to what degree property rights may be alienated through taxation (or conceivably by government decree) by a legitimate government, only whether actual and projected levels of taxation in the United States are morally permissible. These levels are by no means modest, though in general the burden is less than in other developed countries. Again, by stressing the determinative role of voluntary alienation, we have obviated the need for an extended discussion of pre-existing property rights. Thus, we need not take a position on the proper interpretation of the Lockean Proviso, e.g. whether Nozick's shift in interpretative emphasis from prejudicing the acquisition of others to prejudicing the use of others should be followed (Nozick 1974, pages 176-177). Similarly, recent discussions of "self-ownership" and pre-existing property rights need not detain us. These discussions do raise deep questions about the relationship between property and autonomy as well as that between freedom and equality (see especially Cohen 1995, Chapters 3, 4, 9 and 10), as well as others about the relevance
of owner intentions, the strength of any forfeiture rules which might apply, and the extent of trespasser parasitism which should be accepted (see Arneson 1991, pages 36-54), but such discussions are largely superseded to the extent that voluntary alienation applies.

One who has written extensively on the subject of voluntary alienation is Joseph Raz. Although we are in substantial disagreement with his position, he has raised important points which represent a vigorous attempt to limit the scope and degree of obeisance which applies here. We will examine the likely consequences of these views in supporting our own conclusions. Although most of Raz's views on this and related subjects are put forth in his best known book, *The Morality of Freedom* (Raz 1986), other of his works have touched on them as well, especially *The Authority of Law* (Raz 1979), *Ethics in the Public Domain* (Raz 1989), and *Practical Reason and Norms* (Raz 1990).

While Raz was insistent in his separation of issues concerning the authority of the state, the scope of its authority, the obligation to support just institutions, and the obligation to obey the law, his justification of the authority of the state forms the core of his views. It is there that his views on the other related issues are foreshadowed. He justifies the authority of the state on the basis of three closely related theses: the "normal justification" thesis, the "dependence" thesis, and the "pre-emption" thesis, the last being derived from the first two (Raz 1986, Chapter 3). The normal justification thesis
applies to those functions which a state is better able than the individual to comply with, in terms of reasons applying to the individual, but which functions make no difference as to what ought to be done. The dependence thesis refers to the need of the individual to have the state assume these functions so that they may be more ably handled. Raz does allow that many of the conventions which must be established in a modern state do not carry independent moral weight. Once the foundations can be identified and the concomitant dependence and trust of the individual attaches, the pre-emption thesis comes into effect, serving as a means for replacing reasons with directives (rules), directives which serve to mediate between deeper level considerations and concrete decisions. To this point, the thrust of Raz's position is not necessarily controversial, even though a rather thin theory of state authority is implied. Then, after rightly underscoring the self-proclaimed authority of the state to be virtually unlimited, given the changeability of all constitutions, he articulates a position denying political authority is an "all or nothing" proposition, denying also that there is a general obligation to obey on the part of the individual.

The nature of the "consent" involved is the fulcrum upon which the discussion turns. Raz divides consent arguments for authority into those which appeal to enlightened self-interest, citing Hobbes and Locke, and those which see consent as all encompassing, citing Rousseau and virtually all governments. Placing himself in the former
camp, he argues (implied or express) consent is binding only insofar as it reinforces independent obligations to obey. Those obligations in turn must improve one's "compliance with reason," hearkening back to the now fully mobilized normal justification thesis. This "compliance with reason" is taken seriously enough by Raz for him to conclude that government may have greater authority over some individuals than others. Surprisingly, he states: "One person has wide and reliable knowledge of cars, as well as an unimpeachable moral character. He may have no reason to acknowledge the authority of the government over him regarding the road worthiness of his car" (Raz 1986, page 78) and goes on to compound the confusion this would engender:

I have concentrated attention on the undramatic failures of laws which are not unjust or immoral authoritatively to bind everyone to whom they are meant to apply. In doing so I do not of course mean to deny that sometimes immoral or unjust laws are not authoritatively binding. Remember that sometimes immoral or unjust laws may be authoritatively binding, at least on some people. (Ibid.)

What implications these views might have for a legally valid tax system is anyone's guess, but they would almost surely be negative and acceptable to a very limited constituency. It is one thing to argue in favor of certain limits to state power over the individual, but quite
another to fragment the moral exercise of state power into numberless pieces in this fashion.

To a far lesser degree, Nozick is also guilty of espousing a certain fragmentation of "consent" to state power. While he would require express consent to taxation for myriad purposes other than minimal protective functions of the state, taxation for the protective functions is viewed as morally legitimate with or without express consent. Nozick and Raz represent two rather different perspectives where individual consent to state power is concerned. While the former concedes minimal taxing power to the state and thus maximizes property rights of the individual, the latter concedes far more taxing power to the state but in a way that the exercise of that power may or may not be moral in application to a given individual. However, both of them limit the moral taxing power of the state in unacceptable ways. This prompts the question: what would be acceptable ways to limit this taxing power?

The greatest safeguard which could be constructed to prevent this state power from illegitimately encroaching upon the fundamental rights of the governed is the political process itself. At stake here potentially is the de facto status, not only of property rights, but of the right to be at large and the right to make arrangements with others. The dilemma here is one of the profoundest importance for a polity and its denizens, here the United States and its residents. On the one hand, the scope of consent is in theory open ended as Raz has
pointed out, given that the network of public institutions in place has the capacity to change the network itself. On the other hand, certain levels of taxation, even if exacted entirely according to prescribed procedures, could be deemed to encroach impermissibly upon fundamental property rights initially, then as levels go still higher, to encroach upon the right to make arrangements with others and, in the end, even the right to be at large. Yet the consent itself must be deemed general, the only acceptable formal limitations being those validly in effect at a given time. The major alternatives to this view, represented by Nozick and Raz respectively, would either illegitimize various longstanding functions of the United States state or would render its actual administration a virtual impossibility.

Although no analogy in this area is likely to be completely convincing, the analogy of an agency or joint venture comes to mind. Under such an arrangement, other parties may act in one's name. Although a compact, implicit or otherwise, governs the relationship between the (say) two parties, if the acting party proceeds in an outwardly reasonable way, even though such actions go beyond the scope of the compact, the actions of the acting party can bind all parties. Procedures exist to sort out such matters and so it is with regard to the state. The point beyond which the compact is broken may be very difficult to pinpoint while, in the meantime, the following of procedures at least establishes prima facie validity. This difficulty is especially strong where levels of taxation are concerned. However,
given reasonably open and democratic procedures, and the clear tendency of people to be alert to pocketbook issues, the danger of encroachment on fundamental property rights would appear to be an acceptable one. The danger of an encroachment on the other fundamental rights, including the derivative right to access medical care in a second tier, would be a notably less and more remote possibility. In the meantime, we are not morally free to accept the countless benefits we derive from taxation while declaring them to be immoral and perhaps refusing to pay them as well, nor are we morally free to decide on a case-by-case basis which levies are moral and ought to be obeyed.

The foregoing signals our adoption of an historical, non-idealized conception of the compact between the state and the individual. In our judgment, while ahistorical idealized perspectives on this relation can and have added greatly to related discussions, they suffer from flaws endemic to their genus. The goal of such perspectives, at least in part, is to "improve upon" actual existent polities and the social configurations they represent. To this end, Rawls posits his veil of ignorance and, in so doing, fragmentizes the participants in ways which cast a giant shadow over the "deliberations" and prefigures their "results." The muted form of rational self-interest which thus emerges more resembles the deliberations of a homogeneous committee which has agreed upon an agenda beforehand than the actual deliberations for which they stand proxy. In attempting to
improve upon actual compacts, Rawls declines to accept two factors virtually universal to actual deliberations: 1) Participants, and by extension others who will be similarly affected before long, realize the end result must be either an acceptance of a consensus, however derived, or a return to a historically previous state which holds potentially greater uncertainty for virtually all parties. 2) Participants, and by extension others who will be similarly affected before long, bring to the occasion certain advantages, material and otherwise, which will tend to be reinforced under the new regime (the fact that some advantages could be reduced will tend to be negated by their enhanced security).

Gauthier, another major social contract advocate, is perhaps even more explicit than Rawls in his rejection of these actual factors (Gauthier 1986, especially Chapters I and VII). He begins by recognizing the first factor in a backhanded way, referring to the necessary condition that a compact can offer an improvement in the position of all over a "state of nature." He then imposes preconditions on these deliberations, stating: "If persons are willing to comply with the agreement . . . then they must find initially acceptable what each brings to the table. And if what some bring to the table includes the fruits of prior interaction forced on their fellows, then this initial acceptability will be lacking" (Ibid., page 15). An ex post facto requirement of the "rationality of compliance" apparently enables those considering themselves to have been coerced by the actual
bargaining and resultant agreement to morally refuse compliance (*Ibid.*, page 91). On this view, "consent" is not consent which binds if the author's conditions are not met.

How all this would be sorted out by Gauthier or Rawls or other ahistorical contractarians in the immediate instance of the legitimacy of the United States tax system in general, and as it bears, and would bear, on the financing of a public tier of health care, is hard to say. For the present at least, the moral legitimacy of the government and its longstanding system of taxation seem secure, based on the effective consent of the governed. Even as staunch a libertarian as Engelhardt has recognized the possibility of a morally permissible public tier of health care, as part of a two-tiered system (*Engelhardt 1995*, pages 355-368). The major moral requirement for him is the consent of those involved growing out of fair procedures respecting the freedom of the participants. Although he does not recognize a moral right to health care, as we also do not, he does recognize that a legal right to health care can be a morally permissible option: "The character of [legal] rights to health care delivery will depend on the moral vision of a particular community or the result of the negotiations among moral communities as occurs when a nation fashions its health care system" (*Ibid.*, page 367). In addition, his account views the two respective tiers as quite compatible and certainly not as being inherently contradictory. He does not declare a specific point beyond which an extremely robust first tier might impermissibly interfere with
the rights of those in a second tier, as indeed we have not done, but such a point would certainly not be reached under the reforms we are advocating.

A first tier is indeed morally permissible. We set aside until Part Two the further question of whether it would be advisable or desirable for a public tier providing universal coverage to be adopted in the United States at this time. Such an enactment would be a morally legitimate use of common funds derived through the valid consent of the governed, provided that the moral right to pursue health care in a second tier remains. In Part Two, we will discuss restrictions, limitations, regulations, etc., legitimate and otherwise, which may affect a second tier. A two-tiered system is thus morally mandated where the second tier is concerned and permissible where the first tier is concerned; a first tier is not only not morally mandated on its own intrinsic merits; we have shown as well that, if a first tier were to be viewed as morally mandatory, such a conclusion would be fundamentally incompatible with, if not actually contradictory to, the moral mandate for a second tier. The second tier is thus the greater moral priority, but not in an inherently destructive way. If this is honored, the scope remaining for a first tier, as we shall see below, is considerable and is properly considered one of our most important public initiatives for the new century. We will so argue in Part Two. However, for a universal system to be workable, important cost constraints will be needed. We will argue in Part Three
for a public tier which incorporates a system of rationing as an indispensable feature. Since there is no moral right to health care, any limitations imposed by a system of rationing on the first tier are overwhelmingly likely to be morally permissible; whether they are morally desirable will also be discussed in Part Three. The moral limitations on such a system of rationing are of two types: 1) They must not constitute in operation unreasonable restrictions on the moral right to pursue health care in a second tier. 2) They must not be imposed in a manner which violates the legal rights granted to those in the first tier. Clearly there is ample moral space for a first tier which incorporates rationing.

X. Concluding Remarks

Our philosophical scaffolding is now in place and this enables us to proceed with Parts Two and Three where we will show the moral preferability of a system of universal coverage and of the incorporation of a system of rationing concomitant to such coverage, respectively. Thus far, we have laid the following groundwork: 1) The establishment of a moral right to pursue health care in a second tier; 2) the establishment of the moral permissibility of a system of universal health care coverage in the United States, provided such a system does not unreasonably restrict or infringe upon the moral right to pursue health care in a second tier; 3) the establishment of the moral permissibility of a system of rationing
concomitant to such a system of universal health care coverage, provided that such a system does not unreasonably restrict or infringe upon the moral right to pursue health care in a second tier; and 4) the establishment of the proposition that there is no moral right to health care. This fourth proposition, while it appears wholly negative on its face, is a catalyst for our project in a number of ways. It is closely related to the first proposition, the two reflecting in a somewhat symmetrical way the two major sides of the "right" to health care; it helps to pave the way for the third proposition, which partially follows from it; it is all but necessary for an adequate understanding of what a system of universal health care coverage could be and preferably should be, revealing as it does both the limitations and the potential of a legal right. In an un compelling yet encompassing way, it clarifies and delimits our subject matter and, as we will see below, can even render it surpassingly transparent.
Part Two
of Three

I. General Orientation

Our main goal in Part Two is to show that a system of universal health care coverage in the United States would be morally preferable to the present "system." Important subsidiary goals include the following: 1. To reveal some of the more important deficiencies presently operant. 2. To propose a system of universal health care coverage which can substantially lessen these deficiencies. 3. To pinpoint the more important features which such a system should have. 4. To show the need for substantial and pervasive cost control features which such a system must have to be successful. Accomplishing these goals will require a number of supporting elements. In addition to showing the need for reform, we will have to examine alternative proposals. These will include not only comprehensive proposals such as the Clinton Plan and the Oregon Plan, but will also envelop alternatives concerned mainly with insurance reform, the
achievement of affordable subscription rates, and more effective utilization of medical resources. Although we will discuss the need for, and the effective operation of, a schema of explicit rationing in Part Three, we will establish in Part Two the need for systematic cost controls.

A brief historical sketch may be a helpful starting point. Until the 1980's, a "fee for service" system was dominant in the United States. Under such an arrangement, a contract to provide insurance for medical risks to health is entered into between various insurance companies, on the one hand, and Government, individuals, families, and organizations (mostly employers), on the other hand. As with any other type of insurance contract, the protection extended is spelled out in the contract itself. A number of the provisions are quite specific (e.g., injuries sustained in a war or visual impairment requiring corrective lenses might be excluded while injuries to natural teeth and the expenses of pregnancy might be included), while others are rather general. As we will see, important moral issues arise under both types of provisions. But the underlying tendency of the traditional fee for service arrangement is best captured by its general provisions, most particularly that of "medical necessity" or of costs which are "reasonable." How such general terms are interpreted depends upon the medical backdrop against which they must be given meaning. At that time, and even to a
substantial degree today, what was medically necessary was very broadly and aggressively construed to include virtually all medical interventions ordered or executed by physicians. Those covered by insurance enjoyed a care equally available to nearly all with their choice of physician in an environment where concern for cost remained firmly in the background. To enjoy all this, either need or benefit sufficed as a ticket for the full ride. The duties of physicians were correspondingly robust; an economics-blind, unitary, state of the art standard of care was firmly in place. As one commentator has put it: "... a retrospective fee-for-service reimbursement system encouraged health care providers to do as much as possible, as expensively as possible, for every patient. And yet, when viewed objectively instead of historically, that sort of arrangement appears quite extraordinary" (Morreim 1992, page 162).

This rather idyllic state of affairs was the result of circumstances which could not remain intact indefinitely. The confluence of economic interest between the three parties, patient-provider-insurer, was, in effect, a game played according to a temporary set of rules. Normally, if one party(s) to a contract benefits disproportionately from an arrangement, a concomitant detriment inures to the other party. Here a "conspiracy" of interest between physician and patient was a bond conceived in a clinical encounter, tempered by a
cornucopia of available services and procedures, and cemented by the conspiratorial silence of the insurer. Normally, in a constellation of economic relations, someone must "pay the freight" at some juncture and therefore can be expected to question costs which might be excessive under the circumstances. Why, then, the relative silence of the insurer in this scenario? Two reasons stand out: 1. Much as with taxes, increases in insurance rates are spread over larger numbers of subscribers, thus rendering the impact on a given subscriber rather small. 2. Technological advances and greater patient autonomy, perhaps the most important changes in the delivery of medical care in recent years and which have given rise to steadily increasing costs in the past thirty years or so, began at relatively low levels and it took many years of incremental change for rising costs to become a major concern. These factors tended to insulate patients, physicians, and insurers from the cost side of the health care equation. Although relative insensitivity to cost is not unknown in American industry, other examples that come to mind, such as cost-plus Government contracts and certain agricultural programs, have been so designed for various political reasons.

Gradually the dynamics of health care came to change. A relatively carefree outlook gave way to a more balanced view where costs no longer remained in the background. A disparate
confluence of factors has produced this change. In addition to the unceasing pace of technological innovation and increasing patient autonomy, a generally high level of inflation within the industry, beyond the historically high level in general, a general long-term low growth plateau for the economy, geometrically higher recoveries for successful malpractice claims, the somewhat limited success of attempts to measure empirical results, and the growing recognition that Enlightenment-driven hopes for a canonical perspective cannot be realized have all contributed to this evolution. In addition, Government programs have greatly added to patient demand for medical services. Since 1965, Medicare and Medicaid have been introduced, the former benefitting those aged sixty-five and older and the latter benefitting those below a certain level of means. Beginning rather modestly, these public or first tier programs have grown at an astonishing rate in more recent years. In fact, Federal and state governments now account for close to half of health care expenditures while the pressures for increased expenditures continue as before. We will examine these public programs in more detail below and will find them deficient in both access (Medicaid) and control of costs (Medicare and Medicaid).
II. The Problem in General

The horns of the dilemma confronting the system of health care in the United States at present are the insufficient access to the system and the failure of the system to control rising costs. No attempt to reform the system in a significant way could be successful without addressing these two ingrained problems. The task is especially difficult because the two problems effectively point in somewhat opposite directions. To "correct" the access problem would necessarily involve making health care available to millions of additional people and this, presumptively at least, points to higher overall costs. Our main goal is to broaden access to include all citizens and residents in a first or public tier, leaving aside more fine-grained questions of eligibility involving undocumented individuals, certain people of alien status, etc. At the same time, a change of such magnitude requires a correspondingly greater emphasis on cost control if the broadening of access is not to be unduly burdensome. Although accurate figures would be difficult for anyone to predict, we will suggest that the significantly larger number of additional people covered, perhaps some forty million people, as well as the impact of increases in life expectancy and concomitant demographic trends which both point to an aging population, can be offset at least in part by significant economies of scale, by
various cost control measures and by limitations on provided coverage.

In a 1993 article, "Reforming the Health Care System: The Universal Dilemma," Uwe Reinhardt took note of this central dilemma facing the health care system and identified a number of the salient factors which are part of the equation. Locating health care somewhere on the spectrum between private consumption and public good, he noted that forty-four percent of health care spending in the United States is publicly financed (Reinhardt 1993, page 24). Other facts of importance noted by him include thirty-seven million uninsured individuals, fourteen percent of Gross National Product represented by health care, and overall hospital occupancy rates of only sixty to seventy percent. A critical distinction drawn by Reinhardt is that between "socialized medicine" and "socialized insurance." Under the former, health care is both financed and delivered by the Government (as in England) while, under the latter, health care is financed but not delivered by the Government (as in Canada). As Reinhardt points out, American criticisms of foreign health care systems often ignore the distinction (Ibid., page 23). A social insurance system may be referred to as a "single payer" system but such should not be confused with a "single fund" system, under which all funds, whether derived from public or private sources, go into a single fund which in turn disburses all
payments for medical care. We will be calling for a multi-payer system for our first tier where the Government would pay over half of all payments and the balance would be paid by employers and their employees. Socialized medicine is clearly not a viable option in this country at the present time. Although the example of the British Health Service is an instructive one to which we will refer in Part Three, especially in regard to rationing, socialized medicine is unacceptable for both moral and political reasons. Socialized medicine is incompatible with the moral requirement of a robust second tier and would not be acceptable to the great majority of Americans in any event. In fact, the tendency of people in the United States to confuse socialized medicine with a single payer system, and with universal coverage as well, would make it that much more difficult to put into place our scheme of universal coverage funded by a multi-payer system.

We will consider and endorse below Beauchamp's proposal for a single fund, while we reject his proposal for a "decent minimum" as the appropriate measuring stick for a first tier.

Reinhardt also addressed the second horn of the United States health care dilemma, that of the need to control costs. He notes that attempts to control costs do so by constraining either the demand for, or the supply of, health care. Virtually any health care system will utilize both means to keep costs in check, but the United States in general has addressed costs on
the demand side while other developed countries have generally attacked the problem on the supply side. Restrictions on demand are mainly restrictions on purchasing power in one way or another. The primary engine is ability to pay and is usually connected to the private sector. Here, as in a number of other areas, demand is reflected by a combination of ability to pay and a choice among a multiplicity of items. The choice aspect should be duly acknowledged. Many choices in health care represent choices between non-health care options and health care options as well as those between health care options. What one individual or family considers an "essential" addition to some designated basic or standard package of care may be far from "essential" to other individuals or families. The range of choice and the decisions made concerning these choices are very important for the second tier of our proposal. Beyond the coverage universally available in the first tier, any coverage selected in the second tier is optional. Available for purchase would likely be options for, e.g., additional hospital days for pregnancies, initial or additional tests for certain conditions, coverage for infertility treatments and procedures, second and third opinions, and elective cosmetic surgery. The significance of personal choice in certain matters can hardly be overestimated. Indeed the primary justification for actual limits on the health care available to a given individual or family in the
second tier is that that individual or family has freely chosen which additional procedures and treatments will be available. In a different way, this type of justification also applies to limits on the health care available in the first tier. There the choice is that of society as a whole made through its representatives for each member of society.

Controlling costs by limiting the supply of medical care can involve a number of means. This is typically done through extensive central planning and is far more common in Europe than elsewhere. Here the actual supply of beds, of available technology, and even of physicians can be limited by centrally directed policies. Global budgets encompassing all relevant expenditures are often an integral part of such systematic attempts to control supply. In the alternative, only some of these elements may be so limited. Global budgets, those encompassing hospital beds-technology-physicians, would be per se incompatible with our requirements for a second tier if they applied to total medical expenditures but could be structured to apply to the first tier only. If this could be accomplished, such restrictions on the first tier would be morally acceptable as long as they were also consistent with the overall level of care guaranteed by the system. Viewed purely as a technical tool, global budgets could certainly be effective in containing costs. They could be effectively used in connection
with a variety of arrangements. These include various forms of "managed care" such as health maintenance organizations (H.M.O.'s), preferred provider organizations (P.P.O.'s), point of service organizations (P.O.S.'s), managed fee for services (F.F.S.'s), and independent professional associations (I.P.A.'s).

We will be opting for a form of managed care in the administrative standards of our first tier and will discuss some of the details in Part Three below. Under the system envisaged, managed care would not be "imposed" upon the second tier but would be freely adopted by providers if and as they see fit. In view of the strong movement toward the various forms of managed care in the United States at present, in the public sector as well as the private sector, this trend is likely to continue in the second tier under our system. The type of managed care we will be selecting for the first tier may be fairly labelled as a form of "rationing," a term frequently misunderstood as we have already seen regarding the terms "socialized insurance" (i.e., single payer) and "socialized medicine" (i.e., single provider).

The "market" for health care has had other failings which have contributed to persistently rising costs. In addition to insulating insured patients from the cost awareness which usually accompanies the ultimate incidence of economic costs, by having most of the costs directly paid by third parties, the
market has also engendered monopolistic-type conditions for many services. Whereas individual providers had long enjoyed considerable independence and autonomy in the health care market, the consolidation of providers and integration of providers and insurers have resulted in new concentrations of economic power (Altman and Wallack 1996, page 4). In real dollars, health care expenditures per capita tripled between 1970 and 1993, roughly double the rate of economic growth; this difference is more than the per capital amount spent on education at all levels in 1993. Roughly half of the real per capita increases have been due to increased use of new procedures and greater intensity of use for all services (Ibid., pages 6-7). Legislation designed to satisfy the demand for hospitals has also served to create demand for hospitals.

Beginning in 1946 with the Hill-Burton Hospital Construction Act, and continuing with other laws to similar effect, communities were encouraged to build or expand hospitals by the ready availability of Federal funding. Underutilization of hospital beds has often been the result of this largess, a state of affairs which persists to this day.

Comparisons with other developed countries show the United States to spend far more liberally on health care than any other nation. For 1991, the United States spent at least thirty percent more of its gross domestic product on health care than
any of the other twenty-three nations listed, while per capita health care spending for the same year was more than fifty percent greater than for each of the other countries (Schieber, Poullier, and Greenwald 1993, pages 120, 122). This indicates we live in a highly "medicalized" culture. Some of the relatively high expenditures are attributable to results available from the use of cutting edge technology, but inefficiencies and maldistribution are undoubtedly involved as well. Infant mortality is significantly lower in a number of countries spending considerably less on health care and, at the other end of the life cycle, life expectancy in the United States is exceeded in many countries for males and females both at birth and at age eighty (Ibid., page 121). The measurement of such matters is complicated, and there can be arguments about their accuracy and salience, but clearly these figures show a portion of the United States population is underserved. Currently, more than forty million people have no health insurance and many millions more are underinsured.

The United States is purportedly the only developed nation other than South Africa that does not have some form of universal coverage. Given our unequalled resources, medical and otherwise, this is an unsatisfactory state of affairs. While there is no moral requirement that a system of universal coverage be put in place, there are self-regarding as well as
altruistic reasons for adopting such a system. A healthier nation would be a more productive nation and greater social solidarity would result. In addition, many of the costs now sustained could be reduced or even eliminated if there were universal coverage. Many of the emergency room visits by the uninsured would be obviated by the continuous availability of primary care. Both the uninsured and the underinsured would also require less acute care under a system emphasizing primary care. The administrative savings from adopting universal coverage could be channeled into medical care. In Part One, we rejected an "egalitarianism of jealousy" which would achieve a leveling by sharply curtailing the second tier. Instead we propose an "egalitarianism of altruism" which would achieve a leveling by improving the lot of the majority of those now in the first tier, of all of those now outside of the system save for emergency care, and of many of those now underinsured while the inherent moral rights of those in the second tier would remain intact. Although the first tier of the present system is sizable, accounting for some forty-four percent of health care expenditures, it is seriously flawed. We will argue below that both Medicare and Medicaid, the principle components of the first tier, have become too costly and that Medicaid even rations people instead of medical care. Our proposal will be designed to broaden access
to the first tier while installing policies and procedures which will provide better cost control.

A. Medicare and Medicaid

Medicare represented something of a political compromise when it was enacted in 1965. Proponents had hoped for universal coverage but settled for universal coverage of those aged sixty-five and older. There was virtually no regulation the first five or six years as costs spiraled. In 1972, the End Stage Renal Program was added with the Government pre-empting the field. Eleven years later, in response to sharply increased costs, the Prospective Payment System (P.P.S.) was instituted, which applies to in-hospital Medicare and in some states is under Medicaid. Medicare has taken shape on an incremental basis, responding to cost and demand pressures, and has not reflected the scope of planning appropriate for such a large mission (Marmor 1993, pages 1057-1060). Alone in providing compulsory health care for its elderly citizens only, the United States Medicare system purchased some twenty percent of personal health services in 1991 (Iglehart 1992, page 1467). Part A of Medicare applies to hospital services and is entirely Government subsidized through payroll taxes while the optional supplemental coverage of Part B, which is traditional indemnity coverage, is financed seventy-five percent by Government tax
revenues and the remainder by premiums paid by Medicare recipients; in fact premiums paid by Medicare recipients account for only about nine and one-half percent of Medicare's annual outlays (O'Sullivan 1999, page 2). Financial pressures have steadily mounted over the years. Between 1980 and 1995, total expenditures increased by four hundred percent (Vogel 1999, page 12) while, because of demographic factors, the projected number of future enrollees will continue to increase in relation to workers paying into the system. While the P.P.S. determines the amounts to be paid for hospital services, physicians are paid on the basis of a Resource Based Relative Value Scale (R.B.R.V.S.) (Feldstein 1994, pages 77-78). At present, roughly half of all physicians are "participating" in Medicare, agreeing to observe applicable rules and procedures while being subject to peer review by a network of organizations guided by "patterns of care."

Medicaid is a means tested program utilizing welfare-based categories and income-assets tests. Enacted in 1965, the program is a partnership between the Government and the states, the latter paying seventeen to fifty percent of the costs, according to their ability to pay. Costs for Medicaid have risen even faster than those of Medicare, increasing sixfold between 1975 and 1990. Anomalies of coverage abound in this program. On one side of the ledger are the complete exclusions of people
from coverage, the "rationing" of people. On the other side of the ledger are the wholesale inclusion of conditions typically more limited in scope under private arrangements. Single individuals, childless couples, and two-parent families are excluded from coverage under Medicaid even though the core purpose of the program is to serve those below a given measure of means, essentially "the" poverty line. On the other hand, extensions of coverage since the program was enacted include mandatory long-term care, coverage for those above the poverty line, and increasingly more coverage for substance abuse (Rowland and Hoffman 1993, pages 1060-1063). Under private insurance coverage, few subscribers elect to pay additional premiums for long-term care, partially because it includes a substantial element of general living expenses and is therefore relatively expensive. Similarly, second tier coverage for substance abuse is typically more limited than that provided by Medicaid. In extending coverage to those above the poverty line, the Government has elected to benefit those who are economically better off rather than strengthening the coverage of those who are economically worse off.

We believe a public program must be keenly aware of priorities at least implicit in the choices made. In the three major exclusions on the basis of family status noted above, and in the three added inclusions also noted, conscious policy choices have
been made in the Medicaid program. Under our proposal, everyone would be covered and thus exclusions on the basis of family status would not apply while inclusions for long-term care and substance abuse would be reviewed in the same manner as other prospective conditions and treatments. For the balance of this effort, our primary concern will be to determine the choices which are morally preferable among options which are morally permissible. Those treated differently should be so treated because they are different in ways which can reasonably be used to justify such treatment. Ceteris paribus, it is morally commendable to increase coverage of substance abuse, for example. How high a priority such coverage should be is another matter, there being no shortage of medical needs to be funded. In Part Three, we will discuss in some detail the critical need to set priorities, thereby selecting criteria which justify the imposition of limits on coverage; appropriate limitations will be necessary if a system of universal coverage is to be adopted. Similar questions about priorities can be raised concerning the above-mentioned Medicaid exclusions on the basis of family status. As one commentator has noted, less than half of all Americans below the poverty line were eligible for Medicaid benefits in 1992 (Iglehart 1993, page 897). A pattern of highly skewed expenditures was also noted. Low-income families are seventy-five percent of the beneficiaries yet these families account for only thirty percent of
spending, largely because of institutionalized care for the elderly and services for the disabled (*Ibid.*). At first glance, such a pattern shows restricted access for many and extensive coverage for relatively few. Any attempt to broaden coverage would have to take a hard look at such results and the priorities which drive them. We sharply disagree with the view that the public nature of any first tier somehow makes pervasive inefficiencies, overlapping priorities, and systemic cheating both more likely and more acceptable. A concerted programmatic effort must be made to overhaul the public tier of health care. Only comprehensive change is likely to result in substantial improvement. The need for widespread reform has come to be increasingly recognized.

III. The Impetus For Reform

The impetus for reform has been largely the dilemma of inadequate access and insufficient cost control, the paradox of access and excess, and the clash between individual autonomy and social accountability, inadequate access encompassing the state of being underinsured and as well as that of being uninsured. While few would argue no real change is needed, the range of comprehensive proposals extends from insurance reform to socialized medicine. For example, the Prospective Payment System discussed below is not a comprehensive reform but rather a piecemeal attempt to curtail costs in a specified area;
nonetheless, many of the elements of such a standardized cost system and many of the objections registered against such a system are likely to be found wherever a standardized cost system is implemented. As we move to more comprehensive schemes, the standardization of medical costs is generally accompanied by a myriad of provisions concerning coverage and payment. Permeating such arrangements are the various philosophies of medical care and its place is human affairs. We will begin here with some diagnoses of the current system to flesh out potential elements of reform, and will then proceed to analyze comprehensive proposals, emphasizing the Clinton Plan and the Oregon Plan as being particularly productive subjects for us to study. Since we have identified increased access and improved cost control as the levers of meaningful reform, we will approach the respective proposals in terms of those two. On the access side, this will entail transfers of wealth in the form of either payments in money or in kind; on the cost control side, proposals are concentrated on restrictions in coverage which take the form of standardized coverage, whether it be viewed as "managed care" or some form of "rationing."

In a 1994 article, Audrey Chapman advocated a number of changes pursuant to a call for comprehensive reform (Chapman 1994-1, pages 1-31). Stating that "... a right to a basic and adequate standard of health care should be adopted as the
fundamental premise of a reformed health care system for the United States" (Ibid., page 1), Chapman notes the United States is the only developed country [sic] which still does not provide a legal entitlement to health care. Four negative trends are said to account for the momentum toward change: 1. Escalating health costs. 2. Increasing gaps in health care coverage and longstanding inequities in access to health care. 3. Anxiety about obtaining sufficient health insurance. 4. Too much emphasis on technology and treatment at the expense of prevention and basic health care. Conceding inherent tensions between access, cost, and quality as well as the need to recognize limits on care which is futile, experimental, tertiary, or expensive relative to benefit, Chapman calls for a right to a "decent minimum" for all people, consistent with the resources of a given society (Ibid., page 7). The author lists three alternative approaches to articulating such a standard: 1. General criteria by which all prospective services are measured in being included within or excluded by the standard. 2. Outlining of a fair procedure for deciding upon a minimum standard. 3. Listing of services to be included within the standard (Ibid., page 13).

Significantly, Chapman acknowledges the extreme difficulty in articulating a minimum standard, quoting Beauchamp and Childress:
Despite its attractions, the proposal of a decent minimum has proved difficult to explicate and to implement. It raises problems of whether society can fairly, consistently, and unambiguously structure a public policy that recognizes a right to care for primary needs without creating a right to exotic and expensive forms of treatment, such as liver transplants. More important, the model is purely programmatic unless one is able to define what 'decent minimum' means in concrete operational terms. This task is, we believe, the major problem confronting health policy in the United States today. (Ibid., emphasis supplied)

Another noted commentator, Daniel Callahan, considers the "right to health care" to be ambiguous and vague to the point of virtual uselessness (Callahan 1990, page 56). We have argued in Part One that there is no moral right to health care while advocating the formulation or creation of a legal right to health care in this country. Given a legal rather than a moral footing for such a right, it is far easier to accept the pitfalls inherent in rendering concrete such an intractable concept. We should note again that such ineliminable vagueness and resistance to concretized designation serve to argue against the status of a moral right. While a legal right of this nature would have similar shortcomings, such a right carries a great practical advantage which is absent from the moral sphere, that of closure and the attendant procedural means to
achieve it. A legal right to health care in a public tier could be gradually given its distinctive contours by the system which created it and which continues to nurture it in response to operant social pressures. We will argue below in favor of Chapman's third option for the casting of a legal right to health care, i.e., a list of covered services which define the standard. This option essentially embodies that of the Oregon Plan, while the standard of a general level of medical care, Chapman's first option, is closer to that favored by Beauchamp and by the Clinton Plan. Both of these major initiatives will be discussed below. Chapman's second option, the outlining of a fair procedure to decide upon a standard, is roughly equivalent to Rawls' view; here the particular series of steps to be followed is taken to be the best guarantee of a fair outcome. Not only does such a perspective point away from a canonical standard, but it also strongly implies that the right to health care does not rise to the level of a moral right.

A distinction should be drawn within Chapman's first option between a standard of "medical necessity," and one of a "decent minimum" (*Bayer, Callahan, Caplan and Jennings 1988*). The authors disdain the latter as a license for a sharply bifurcated system, one for those dependent upon public support and one with higher standards for those not so dependent, while embracing the former as one which guarantees all Americans access to the medical services which can
reasonably be considered sufficient for meeting their medical needs (Ibid., pages 710-711). Even on this account, which is so clearly hostile to a robust second tier as to virtually rule it out, it is conceded that interventions at the "margins" will be a matter of negotiations along political, scientific, and moral lines; however, the authors argue that a sufficient consensus already exists to make a standard of "medical necessity" useful. Such a consensus may exist within the medical community but, where the larger question of social benefit is concerned, this is hardly the case. In fact, questions raised by the authors themselves concerning costly interventions, age-based criteria, and life-sustaining procedures, among others, call into question the existence of a meaningful consensus even within the medical community. At bottom, this is probably because the great preponderance of interventions, whether extremely expensive or rather inexpensive, do confer some degree of medical benefit. In effect, this can only cause questions of medical priority to arise more often, and to be more difficult to resolve, than previously when fewer procedures were available and the technology was far less sophisticated. We will see throughout the remainder of this project both the need for setting medical priorities and for considering medical benefit in light of relevant costs as the primary guiding light for those priorities. In practice, "medical necessity" has often meant any intervention which might render some medical benefit. In calling
for a need-based standard of medical care which goes beyond providing a decent minimum, the authors have rightfully distinguished the two standards, however, which are sometimes confused. Although we do not endorse the authors' standard for universal coverage, they raise a number of points well considered in any comprehensive reform package.

Two additional important points often raised concern: the need for "portability" of benefits under a universal system and the elimination of "pre-existing conditions" as a basis for limiting coverage (O'Keefe 1994, page 43). While these glaring weaknesses, which are often present under current coverage, are not as serious as the complete failure of all but emergency coverage for some forty million people, they do exemplify the significant problem of the "underinsured." Indeed to be underinsured is to be "uninsured," at least in part. Presently, people who change employers are frequently confronted by new restrictions on coverage after making such a change. They must run the gamut of a new system of coverage which typically has provisions temporarily reducing the available coverage. A particular common restriction is that triggered by pre-existing conditions. If the employee was treated for a particular condition within a certain time period prior to current coverage, usually one year, coverage will not commence for the treatment of that condition for a certain period, also usually one year. Such a gap
in coverage can be extremely costly for that ongoing health problem since charges would have to be paid by the employee during that period.

The social cost of having forty million uninsured, and of having countless others who are underinsured in one way or another, is staggering. A system of universal coverage would immediately eliminate the class of uninsured people. The underinsured would be a more complicated matter, since not all conditions could be covered and there would be limitations on some coverage. However, portability restrictions and pre-existing conditions, which are now among the major restrictions on coverage causing underinsurance, would be immediately eliminated under universal coverage. Restrictions and limitations would still be needed but would be the product of open and democratic procedures, and would apply to all first tier coverage. The medical priorities and related cost controls would reflect, not the vagaries of private wealth, but the will and means of the American people.

IV. **Universal Insurance Costs, Administrative Savings, and Overall Cost Controls**

Important cost savings can be realized under a system of universal coverage regarding insurance costs and administrative charges. The administrative savings would be considerable if
difficult to quantify prospectively, being derived from the consolidation of all Federal health care programs into a universal public tier. The need for personnel, facilities, equipment, and materials would be notably less. In a more complicated way, significant savings in insurance costs can also be effected under a system of universal coverage.

The basis for determining insurance rates has been almost invariably that of past experience. Typically, this past experience is that of the insuring organization. Insurance rates tend to vary in inverse proportion to the size of the insurance pool. Thus the rates charged by a carrier of health insurance for the employees of a large employer like Dupont will be notably lower than they would be for the employees of a much smaller employer. This result is made possible by the insurer being able to spread the applicable risk over as large a pool of insured as it can. This principle can apply with even more force where the number of commonly identifiable risks is greater; in health insurance the risk of insuring hundreds and even thousands of medical conditions may be covered. Since the ways a person can become sick are so great in number, people need to be protected against a great number of risks and that is more easily accomplished at an economical rate if the pool of insured is larger. Thus, a condition which is relatively rare, such as the need for an artificial arm, could be more easily included under a health insurance plan if
there are more participants because the additional premium per participant needed to cover that condition would be proportionally smaller. Conversely, an expensive condition such as AIDS would be extremely expensive to cover in a small plan of, say, twenty-five employees because the additional premium for each employee would be proportionally larger. Under what is called "experience rating," only a segment of the potential pool at risk is insured and rates are based on the long-term costs previously experienced.

"Community rating," on the other hand, does not distinguish among applicants with regard to the individual risk they present; instead all are "... charged the same irrespective of their health condition or illness. This basic tenet of social insurance ensures that the healthy subsidize the sick... Community rating also has the potential to reduce the overall cost of health care by providing incentives to all purchasers to work together to control aggregate costs" (Ibid. 1994, pages 49-50). Under universal coverage, the pool of insured would number in the hundreds of millions and the majority of health care services delivered in the United States could be rendered in that public tier. The cost of coverage could thus be spread over all these participants, "paying" for such coverage by means of the taxes most of them would pay, thereby potentially increasing the extent of coverage otherwise available while reducing the cost.
A universal system would allow greater coverage for a given amount of money or a reduced amount of money for a given amount of coverage, largely for two reasons: 1. Savings derived from administrative consolidation. Not only would the some forty-four percent of health care expenditures now paid out of public funds under several programs be administered under one program but some of the remaining fifty-six percent of health care expenditures as well could be included if numbers of additional people gravitate to a revitalized public sector. 2. Savings derived from spreading the insurance risk over such an unprecedently large number of Americans. With a far larger pool of insured, more conditions can be more economically covered; "standard" coverage under such a new system could try to replicate much of present coverage at less cost, increase coverage above that level at less cost than would now be the case, or some combination of these. We advocate a system which would cover much of what is now typically covered but with more costly interventions being curtailed, especially those of relatively marginal medical benefit. In so doing, we can make comprehensive coverage universally available.

The inseparability of broader access and more effective cost control is readily apparent. Cost effectiveness is the gateway to meaningful reform and the improved health care system it can bring. Consolidation of current programs and the establishment of
community rating are two of the major means by virtue of which this can be achieved. They synthesize with universal coverage in a wholly compatible way, forging a bond of seamless texture. What is ultimately needed to secure the needed health care package is a blend of factual information and ethical knowledge: ". . . two kinds of knowledge. The one kind is factual information concerning the outcomes of various health interventions on the course of people's lives and the costs of those interventions. This data is essential, but instrumental to the second kind of knowledge we need: ethical knowledge, well-defended, widely shared insights into what it is that we owe to one another in the name of justice" (Nelson 1994, page 188). Nelson is not alone in thinking we do not currently possess the requisite degree of knowledge in these matters. Yet, as we argued above, consensus in these matters will always be somewhat elusive and one must always start somewhere if meaningful reform is to be effected; further, it is a given that standards in these areas are inherently provisional and will require regular if not continual revision. Nelson mentions an attribution to Paul Ellwood, a noted figure in health care reform, that it would be ten years (from 1992) before outcomes research produces useful results; comprehensive reform could hardly be in place much before ten years from that date but could proceed from there. As Nelson suggests himself, diagnosis-treatment pairs could be derived in lexical order based on representative samples
eliciting which services and states of health are most valued by the populace and by those with various medical credentials; cost considerations would only then come into the picture with the appropriate political body balancing the preference of the people and the resources available to them, against a backdrop of other competing social needs.

In calling for universal coverage, we are mindful of the uneasy balance between broadening access, on the one hand, and the need to maintain quality care at acceptable levels of cost, on the other hand. To satisfactorily control costs, our proposed system will also have to incorporate extensive practice guidelines, global budgets, and explicit rationing. Existent practice guidelines would be increasingly fine tuned as sound empirical studies become more numerous. Global budgets would comprise overall limits on public spending which would ensure prioritization among first tier medical interventions across the board. Explicit rationing is the cornerstone of our attempt to control costs; it virtually guarantees prioritization of services, overall budgetary constraints, and tighter practice guidelines. By taking the form of a "laundry list" of covered services, it can avoid the expansive tendency of a general standard framed in vague terms; in addition, it places in sharper perspective the panoply of public choices confronting a diverse and complex society like ours. We will discuss explicit rationing and its constituent elements in much more detail in Part
Three. We now turn to the available means of paying for the projected system.

V. Paying for Universal Coverage

The financial resources required to fund a system of universal coverage would undoubtedly be considerable. Yet the level of these expenditures need not be an invitation to financial disaster as some would have it. This is true under our proposal for two reasons: 1. The minimum level of funding we suggest would not exceed present Governmental expenditures for health care, i.e., the overall burden on individuals, states and the national Government would remain at present levels. 2. If this minimum level is attained, efficiencies of scale involving insurance and administrative consolidation, global budgets and practice guidelines, and extensive reliance upon a scheme of explicit rationing grounded in a network of Quality Adjusted Life Years (Q.A.L.Y.'s--more of this below) would effectively increase the overall level of public medical care. Accordingly, in this section, we turn to the various funding mechanisms which such a system of universal coverage might employ to best achieve its goals.

In a well-considered article of extensive scope, Troyen Brennan discussed three avenues of reform as possible solutions to the ability to pay problem which continues to plague our health care system. The three areas are labelled by him as insurance
reform, financing reform, and cost reform, respectively (Brennan 1993, pages 37-74). The alternatives discussed in this article can provide an effective vehicle for our discussion. In tackling insurance reform, Brennan outlines the following key ethical propositions after calling for reform which envelops broader insurance coverage: 1. Moderation of the differential in the level of care offered by the first and second tiers through a tax on second tier services which is used to subsidize the services available in the first tier. 2. Ethical neutrality of the choice between a single payer system and a system which regulates competition among health care organizations as long as the differential between the first and second tiers is reasonable. 3. Segregation of physician duty to individual patients and the class of patients to be served through the use of specific clinical guidelines. 4. Disclosure to patients sufficient to elicit informed consent in the context of care management incentives which may create a conflict of interest between the patient and the provider. We are in agreement with the goal of the first proposition, which is to ensure an adequate minimum of services for all, but question whether a tax on the second tier is an appropriate way to achieve this. Such a tax should not be levied for two reasons. First, the best way to raise revenue for a first tier, including "additional revenue" needed to improve the care in that tier, is a general tax and not a tax calculated to affect medical decisions made in the
second tier. Secondly, this tax might well encroach upon the moral rights of those seeking medical services in the second tier. Not only can the level of care in the first tier be more directly and efficiently served by general tax revenues, but we see here a lapse into an egalitarianism of envy rather than an attempt at an egalitarianism of altruism, a moral choice addressed in Part One when we examined the moral necessity of a second tier. An additional reason for fostering a high quality first tier exceeding notions of an "acceptable minimum," with which Brennan would no doubt agree, is to maximize participation in that tier. While we strongly favor a robust second tier, our goal is to have a public tier actively sought out by many of those not now in a public tier. Achieving such a goal would depend on a number of factors, the most important being: 1. How much Congress chooses to allocate to the first tier. 2. How efficiently and equitably those resources can be utilized, where efficiency encompasses both an approximation of optimum long-term health benefits for the population and a rigorous application of carefully considered medical priorities in light of relevant costs. More of this is in Part Three.

Brennan's second proposition, that of the purported ethical neutrality between a single payer system and one of regulated competition among health care organizations, is probably "true" in some abstract sense but our stated goal, given that no moral
rights are being violated, is to choose an alternative which would be "morally preferable" to other alternatives. "Morally preferable" here means the balance of morally desirable consequences over morally undesirable consequences is reasonably clear, given the moral permissibility of alternatives under consideration. This was discussed in some detail in Part One. We will examine a single payer system below and will discuss regulated competition in Section VIII.

Brennan's third proposition is an indispensable part of meaningful reform. The traditional standard of physician duty to the individual patient, that of unswerving loyalty to the virtual exclusion of other co-existent duties, went hand-in-hand with the now largely superseded fee-for-service basis for the delivery of health care services. We have already discussed the need for physician duties to shift in emphasis to the classes of patients to whom a duty is owed; beyond this, a duty is owed by physicians to the society which has treated them well, heavily subsidizing their education and much of their research, to use available public resources in a judicious way. We will examine this duty in some detail in Part Three where the need for limits, respect for limits, and the implementation of limits will be our primary concern. We will be suggesting a bifurcated standard for the duty owed by physicians to their patients, a standard of medical expertise which is owed to all and which is completely consonant with tradition,
and a standard of resource use dependent on relevant contractual
and other legal rights, which is a departure from tradition in
recognizing a stronger obligation to society and private parties in
interest. Brennan's fourth proposition, which calls for a
strengthened standard of informed consent in an era of managed
care with its demonstrably greater potential for conflicts of interest
between physician and patient, will also be treated at some length
in Part Three. We agree that the limitations introduced by
managed care, which we will be endorsing in certain forms,
present a broad challenge to traditional physician-patient
standards; sensitive issues involving the proper extent of
disclosure and the very context of medical practice must be
addressed with a sharper focus than before.

In the area of financing reform, Brennan's discussion virtually
encompasses the spectrum of possibilities. These include a single
payer system, Government subsidies, employer-mandated
coverage, high-risk pooling, re-insurance for smaller markets,
 quasi-Government agencies to regulate managed care and to
promote a system of managed competition, and the awarding of
vouchers and credits. The proposals may be divided into four
classes: 1. A single payer model such as the one in Canada. 2. A
multi-payer system which would include employer mandates and
Government subsidies to assist those not included under employer
mandates. 3. Use of quasi-Government agencies to oversee a
system of managed competition. 4. A scheme of individual choice wherein vouchers and/or credits would be used. The strategies of high-risk pooling and re-insurance would be supplementary to a multi-payer system and would be geared to initiating economies of scale to reduce costs and thus to facilitate the broadening of coverage.

The choice between a single payer system and a multi-payer system is not a simple one. If a single payer system is adopted, administrative costs would be minimized since all funding would come from general tax revenues or, possibly, from a specific tax such as a payroll tax. Presently, the Government funds its share of the health care bill mostly through a blend of general revenues, collections under the social security system, and various subsidies under particular programs such as that of the Veterans Administration. If a multi-payer system is adopted, a further choice is whether to use a single fund or to have funding proceed from more than one fund, probably several funds reflecting different points of origin. The selection of a single fund narrows the gap between single payer and multi-payer systems. The use of a common fund also would be a giant step in the direction of more effective controls. As one commentator put it: "The existence of this common fund is the critical innovation to permit the use of budgets for hospitals and clinics, and to most effectively control the growth of total revenues flowing to the health care
sector" (Beauchamp 1992, page 127). Beauchamp links the use of a single fund to global budgets and maintains that those two features, plus that of universal coverage, are the three key elements of substantial reform. He suggests combining the single fund feature with multiple sources of funding. We believe this combination is preferable to a single payer system or to any multiple fund system.

Thus we favor a multi-payer system with a single fund. The former is preferable in our view primarily because it would enable the system to tap more directly into a wider range of likely sources of funds, the main sources being the Government and private employers. Although one could plausibly argue this is not far different than a single payer system where the Government would take tax revenues remitted by employers and then transfer those funds to the public tier, a single fund would have clear advantages over multiple funds in any case. Besides the savings in administrative costs such a feature would bring, the gain in administrative efficiency and control could be substantial. A single fund would greatly facilitate the implementation and monitoring of a global budget, an overall accounting measure of great potential in controlling costs.

The sources of payment would be the following under our proposal: 1. Government general revenues. Amounts now collected under Social Security, the specific Medicare levy, or any
other separate Government collection would be taken in as
general revenues; this would be a matter of eliminating separate
levies specifically earmarked for medical care while raising general
levies by an offsetting amount. 2. Employer mandates. This
funding source has been widely endorsed and is an integral part of
both the Clinton Plan and the Oregon Plan; employers would be
required to pay eighty percent of the premium for a standard
health care package for each employee according to family size,
the employee paying the remaining twenty percent with
safeguards against duplication for working families; all payments
would be remitted to the Government; employers unable to pay in
full or in part by some appropriate measure would be subsidized to
that extent by the Government; subsidization would also be
available to low wage employees, again according to a suitable
means test. 3. Payments by individuals, whether employed or not,
for coverage beyond the standard health care package. These
amounts could be remitted directly to insurance companies as well
but, if this is done, the coverage and the carrier could still be
disclosed to administrators of the single fund to ensure an
accurate overview of health care resources for policy-making
purposes.

Brennan's two remaining alternative proposals in the area of
financing reform are the use of quasi-Government agencies to
oversee a system of managed competition and the institution of a
system of vouchers and credits to promote individual choice. In Section VIII, we will evaluate managed competition as developed by Alain Enthoven and as proposed under the Clinton Plan and will conclude that such a system must be subject to a first-tier standard of coverage which avoids the traditional standard of "medical necessity" or its equivalent to be a truly viable option; to this end, we will endorse the "laundry list" approach taken by the Oregon Plan, which covers a specific listing of condition-treatment pairs beyond which coverage is not publicly provided. Although we endorse this approach, we will have to address the various challenges issued to this new path. A system of vouchers and credits certainly could be a vehicle for delivering health care beyond the first tier but, as a complete system, it would be administratively expensive. In addition, it would introduce complexities best addressed in a publicly formulated, open, and democratic manner in a first tier which balances the need for uniformity and the range of medical needs.

Greater control over health care costs is an indispensable element of meaningful reform in the U.S. This is all the more true if universal coverage is an integral part of that reform. Brennan's suggestions for health care cost reform are those measures designed to reduce overall costs of health care. Although he does not call for a system of universal coverage, he does favor increased access and, in so doing, recognizes the need for more
effective overall cost controls. He states: "To decrease overall health care costs, one must either limit the number of interventions employed per health problem by changing both hospital and physician behavior, or eliminate some of the costs associated with each intervention. Accomplishing either of these cost control options usually goes well beyond the financial relationship among payer, provider, and insurer" (Brennan 1993, page 45, emphasis supplied). Conceding that eliminating some of the costs associated with particular interventions is the more difficult to achieve, whatever means are used (managed care, guidelines, global budgets, competition), he declares global budgets, practice guidelines, and explicit rationing are capable of significantly limiting the number of interventions per health problem. We agree that limiting the number of interventions is one of the Archimedian points from which the necessary increased cost control could be derived. However, Brennan has conceived this area of such strategic potential too narrowly. Limiting the number of interventions per health problem should be an integral part of these efforts, but it is also necessary to limit the types of health problems covered. In other words, Brennan suggests limiting the number of interventions per health problem while we insist the number of health problems included in the standard package itself should be limited as well. Our discussion below will advocate in some detail a move away from "medical necessity" or
some such general standard in providing a public tier of universal coverage to a discrete list of covered condition-treatment pairs explicitly limiting coverage. Our motivation here is largely a matter of weaning health care coverage away from a traditional standard which has historically occasioned increasingly higher costs. Here we seek to limit the number of interventions by restricting the number of conditions covered. In both instances, the ultimate goal is to reduce health care costs while concomitantly ensuring access to a good quality of health care. All of this is addressed in more detail in Part Three. We now turn more explicitly and in greater detail to a consideration of available cost control ideals, theories, methods, and procedures.

VI. The Ideal of Transparency and Market Efficiency

Transparency and efficiency have long been staples of economic theory and rightly so. When true costs are revealed and when standards of measurement are an accurate gauge of what is being measured, greater competency and efficiency all around are the likely result. Our goal is to incorporate into our proposal many of the features of the marketplace now found all too infrequently in the present system. The public dimension is quite compatible with the transparency, the accountability, and the efficiency required for a system of universal coverage to be viable. Models of
efficiency have been transferred on a piecemeal basis from the private to the public sector in health care and can be successfully implemented in a comprehensive way if a coordinated effort is made. By squarely facing some of the more intractable health care problems, we can increase our chances of success. Some of the more serious objections to Government intervention in the market include the following: 1) costs and benefits are reflected only fractionally in the public market since external or collateral costs are typically ignored, 2) changes adopted generally matter a great deal to the few and very little to the many, 3) regulation tends to lessen competition and to thereby "promote" inefficiency, 4) awarding of public goods often ignores the "moral hazard" associated with those who are covered (Friedman 1991, pages 267-296). These objections are in part too general and too contentious to be addressed at length here. Nonetheless, they are instructive; all of them contain more than a kernel of truth and therein hangs a cautionary tale.

The first objection points to a serious shortcoming. Take an example we will be looking at below. If a policy successfully reduces the length of average hospital stay, ceteris paribus this is a good result, but if some of the cost is merely shifted to outpatient facilities, the savings are thereby diminished; an appropriate degree of transparency would require all of this to be openly and completely taken into account. The second objection
is a political problem almost universally experienced. The most effective antidotes are a principled legislature and an informed populace. We are advocating a cooperative three-way partnership between the Congress, the citizenry, and the medical profession in the adoption of our proposals. The third objection is at least partially ideological. Friedman concedes that he believes "health care should be provided entirely on the private market" (Friedman 1991, page 301) while we are calling for a strong public tier of health care. The lesson here is that regulations must be genuinely responsive to the situation they purport to address, fully taking into account the departures from a competitive model which have been put in place. The fourth objection may be ineliminable, but it can be minimized largely through a forthright transparency. Take the practices known as "skimming" and "dumping", for example, which are two sides of a policy of a health care agency electing to treat the relatively well-off and less sick while leaving other agencies to treat the relatively less well-off and more sick, respectively. If these practices are simply forbidden, the tendency will be surreptitiously to shift costs from those who cannot pay to those who can pay. A far more effective response would be either to re-imburse adequately the agency tempted to subvert the system or to provide adequate public care (Engelhardt 1991, pages 340-344). A thoroughgoing transparency, a direct approach to this historically intractable problem, would offer the
prospect of a satisfactory solution; to discern where the costs actually lie, where they should lie, and how to reallocate the relevant resources is clearly the outline of an effective response.

While we disagree with a purely market-oriented approach such as Friedman's, the market model remains a paradigm of efficiency with a large role to play in any free society. To suggest a system of universal coverage as we are requires that particular attention be paid to deviations from a market approach, lest the more important lessons to be derived from it be forgotten. Many of the alleged shortcomings of Government-initiated deviations are all too real. An all-encompassing transparency is the most important tool to mitigate these shortcomings and to shed light on those which should remain for policy reasons. As we move to some of the means used to identify, measure, and limit costs, our goal is to strive for accuracy of measurement conjoined with policy considerations rendered as transparently as possible. In the final analysis, when our program has been laid out, we will have balanced the projected increase in access with the various restrictions in coverage needed to make that increase feasible. The one criterion which undergirds our mission is the maximization of long-term medical benefit for the covered population as a whole, taking due account of relevant costs, without violating inherent moral rights. We seek equity without pure equality, commensurability without unseemly prejudice, and benefit without
undue burden. We now turn to specific methods for controlling costs.

VII. Cost Benefit Analysis,

Cost Effectiveness Analysis,

and Their Progeny

The two main cost control techniques used on a systematic basis are cost benefit analysis (C.B.A.) and cost effectiveness analysis (C.E.A.). They are both attempts to quantify expenditures in a way which highlights their effectiveness or productivity. Cost benefit analysis is more far ranging, enveloping the evaluation of both health care options and non-health care options, while cost effectiveness analysis is concerned only with health care options. Incommensurability is a problem for both techniques, especially cost benefit analysis where benefits as well as costs are stated in monetary terms (Menzel 1993, pages 649-652). A couple of examples will show how commensurability can vary in cost benefit analysis. If a city had to decide whether to use a certain sum of money to build a bridge, it may be possible to estimate with reasonable accuracy the economic benefit to be derived from the additional commerce the bridge could bring; this figure would then be compared to the projected cost in evaluating the option to build or not to build. If instead the option was to build or not build a public park, on the other hand, quantifying in a
meaningful way the potential benefits from having the park would clearly be more difficult.

Since cost effectiveness analysis compares only health care options, the difficulties with it are less, even if considerable. A couple of examples here will also show how commensurability can vary when this technique is used. If an agency needs to determine whether to use vaccine A or vaccine B, where the risks and benefits are quite similar, it would be largely a matter of comparing costs. But, in another instance, vaccine A might produce better short-term results while carrying more risk, vaccine B might produce better results but only after a much longer period, or all of these factors might converge with the medically "preferable" option costing considerably more. The weighing and balancing process would accordingly be more complicated and less "accurate." Far more difficult examples easily come to mind and will implicitly surface throughout the remainder of the thesis. Much of the attempt at meaningful reform will necessarily involve choices which are uncomfortable as well as arduous.

The general techniques of C.B.A. and C.E.A. are more fully implemented through specific methods designed to help accomplish their ends. When C.B.A. is applied to health care problems, it is often necessary to translate empirical data into an economic value of a given life. Here the primary models used are discounted future earnings (D.F.E.) and willingness to pay
Discounted future earnings can be used to value a person's projected earnings based on life expectancy, earning power, and a representative rate of interest; it can also be used to value diminished earning capacity and can be used for years until retirement as well as life expectancy. This model has been controversial in its application to health care since the values assigned are directly related to age and earning power; many agree with Rawls that disparities of income and wealth are products of the natural and social "lotteries," and thus should not have a bearing on health care decisions at any level. Largely for such reasons, D.F.E. has now been largely surpassed in favor of W.T.P. (Ibid., page 652). This has been the case even though W.T.P. would seem to be open to similar objections. Here a choice is assigned the monetary value an individual would be willing to pay for it, e.g., the extra compensation one would require in an extra hazardous, potentially life-threatening occupation. The objections to the model are "answered" by stressing the role played by choice and preference. What amounts to a variation of W.T.P. will loom large in the justification of our reform proposals. This will be the case for both the first and second tier. Since there will be numerous restrictions and other limitations on first tier coverage, those desiring more extensive coverage will be free to purchase it in the second tier. The value they place on such coverage will show in the choice made or not made. While some
would not have the means to do so, many people would have such means. Those who may not have the means do not have a moral right to health care and thus, provided that public decisions are reasonably "democratic," restrictions on first tier coverage will not violate any moral right where they are concerned.

Quality adjusted life years (Q.A.L.Y.'s) is another specific method which will be especially important in our reforms. A type of C.E.A., Q.A.L.Y.'s are designed to provide a common currency for health units. Questions of commensurability and controversy abound here as they do for the other techniques. The goal is to derive a cost per Q.A.L.Y. by dividing the cost by the gain in Q.A.L.Y.'s. "Quality of life" considerations are paramount under this method and they have engendered considerable discussion, much of it hostile. Since we will be calling for maximum usage of Q.A.L.Y.'s in Part Three as a major element in controlling costs, it will be incumbent on us to respond to the major arguments against the extensive use of this technique. Principal among these are "unfair" treatment of the elderly, the disabled, and the poor. We will discuss these issues in some detail and will describe the technique at some length, all in Part Three.

A more general argument made against the use of Q.A.L.Y.'s, often made against other proposed changes in standards to be employed in the delivery of health care, trades heavily on the uncertainties inherent in shaping and implementing important
change. When Q.A.L.Y.'s are under consideration, it is argued they should be substantially restricted or even rejected altogether because empirical studies of condition-treatment pairs are not accurate enough or because the use of pre-established standards virtually guarantees some individual cases will not be properly diagnosed or treated; yet no one is denying empirical studies could be more accurate or that standards could not be more refined; this is a well nigh permanent state of affairs. The point is that any system which is priority-based and reliant upon Q.A.L.Y.'s will have to begin somewhere and can be steadily improved. We will return to these themes in Part Three and will address more specific concerns about Q.A.L.Y.'s and their comprehensive use in a schema of rationing.

The use of Diagnosis Related Groups (D.R.G.'s) under the P.P.S. in Medicare, an instance of C.E.A., is probably the best example of a specific and comprehensive program undertaken by the Government to control rising medical costs. This system applies to inpatient hospital charges for all of Medicare and to some of the states under Medicaid. Many of the issues arising under this system are parallel to those which have arisen under various privately-administered systems of managed care which also formulate comprehensive guidelines governing reimbursement amounts and the extent of coverage. Strictly speaking, the P.P.S. does not "reimburse" for costs previously sustained but rather
determines prospectively what the amounts to be paid will be for
the treatment of a patient in a given diagnostic group. The move to
a prospective system signalled a move from a system driven by
hospital costs to a system where hospital costs are "determined" by
statistically-generated figures. By the late-1990's, the designated
groupings were nearly five hundred in number and are designed to
be medically relevant and statistically applicable (Franco 1999,
page 125). Values assigned to the diagnostic groupings are based
on average figures for the United States as a whole, taking into
account: 1. Primary diagnoses; 2. Secondary diagnoses;
5. Patient age (when it affects length of stay); 6. Patient sex;
7. Selected other factors (Dolenc and Dougherty 1985, page 19).
The weighted D.R.G. index derived from these enumerated factors
is an index representing the respective amounts of resources used
in the treatment of illnesses, i.e., diagnostic groups. The weighted
D.R.G. index for each group is in turn multiplied by a "dollar rate" to
determine the amount of "prospective payment," the dollar rate
itself being determined for each hospital by its geographical region
and its character as an "urban" or "rural" facility. In the great
majority of cases, the hospital receives this predetermined amount.
Where the costs actually sustained by the hospital exceed the
predetermined amount by a certain percentage, the hospital
receives the greater of a certain percentage of the excess or a
fixed dollar amount but limited to a certain percentage of total costs of the hospital. Patients falling into this special reimbursement category are called "outliers" and, as we will see, the level of compensation for services rendered for such patients has been a bone of contention. With refinements, including those mandated by the Balanced Budget Act of 1997, this general schema remains in place (Franco 1999, pages 124-128).

The P.P.S. was designed to control hospital costs, which had been rising rapidly, by limiting compensation to reasonable pre-established levels. While the measure of "success" in the endeavor is reckoned largely in terms of reducing the number of hospital admissions and the length of hospital stays, to better appreciate the impact of this system, the overall effect should be sought out in other quantitative and qualitative measures as well. We do not question that P.P.S. was a response to perceived abuses. When checks and balances are feeble, overusage of medical resources is a real danger. Yet all relevant factors must be adequately considered pursuant to wholesale change. For instance, even in considering only the twin goals of reduced admissions and reduced average lengths of stay, there is a fundamental tension. To raise the medical criteria for admission all but guarantees those who are admitted will be more acutely sick on the average. Ceteris paribus, a more acutely sick population would signal longer and not shorter hospital stays. In addition, both higher medical criteria for
admission and for continued stays point to the likelihood of higher outpatient costs, especially where reduced lengths of stay are concerned. If one digs deeper, a number of other considerations emerge which are of a more qualitative nature or which have a wider economic impact on participating hospitals.

The financial impact of P.P.S. on a given hospital is rooted in its particular economic circumstance. Given the consistent pattern of payment under this system, it is primarily the confluence and the character of its various cost centers which determine the financial direction of each hospital within the orbit of that system. Here the chief determinant is that of patient mix, which is itself largely the product of geographical correlates and their determinants. Some hospitals, because they are located in inner cities, have a severely disproportionate share of disadvantaged people whose average state of health is well below average. It is also often difficult for such hospitals to secure highly qualified personnel because of their location. In addition, a disproportionate number of elderly people may be patients, largely for demographic reasons. In rural areas, the isolation may result in patients being more acutely sick and there too it may be more difficult to attract highly qualified personnel. Any hospital with a patient mix heavily skewed toward patients in poor general health, patients who are more acutely sick, and/or patients who are elderly will suffer under a standard system which does not adequately allow for such factors. For such
institutions, outliers will be far more common than average and a shortage of highly qualified personnel will tend to raise costs in all areas of operation, not just that of actually delivering medical care. For a system like P.P.S. to be fair to all of its participating hospitals, sufficient allowance must be made to ensure a level playing field. In theory at least, the P.P.S. has made such allowances, but there are reasons for doubting they are sufficient. There is a cap on compensation for outliers, there is no provision for a severity index within each D.R.G., standards are derived from regional averages and not the historical costs of a given facility, and other non-medical factors which could make costs unusually high are not taken into account. While an early study did show the program reduced both admissions and average length of stay (Schwartz and Mendelson 1991, pages 1037-1042), the larger picture is demonstrably more complicated since these cost reductions may have been merely shifted to other sectors of the health care system. We have focused mainly on the quantitative fallout of the P.P.S. In microcosm, these concerns are broadly representative of those likely to follow in the wake of significant change. The same is at least as true where general "qualitative" concerns are addressed.

These general qualitative concerns include the following:
1. Reduced level of care due to denial of admission. 2. Reduced level of care for in-patients. 3. Reduced level of care for patients
shifted into outpatient care. 4. Erosion of physician-patient relation.
5. Impingement of non-medical factors on the practice of medicine.
Perhaps the common denominator for these listed concerns is that
the changes engendered by P.P.S. all change the practice of
medicine as it relates to elderly hospital patients in some way. This
serves to underscore the difficulty of our task, for we will also be
proposing to alter the practice of medicine by changing the
standard of care owed to the patient. These concerns are all too
real, yet the need to strongly contain costs is denied by few. We
will address in Part Three the parallel concerns our proposal is
likely to foment. The five listed concerns are essentially two in
nature. The first three involve the quality of care actually received
by patients while the latter two involve changes in the way
physicians practice medicine. The only truly effective means of
dispelling the first three concerns is to make the relevant guidelines
as accurate as possible. To accomplish this, the guidelines must
not only be based on the best available research; they must also be
regularly updated. At the same time, standards cannot achieve
their considerable potential if they are not put into effect in the first
place and given room to grow into the tool they can be. While a
degree of tension between pre-established standards and the
nuances of the individual case is ineliminable, sound and flexible
guidelines can minimize this tension and, most importantly,
maximize the level of care available to all. Accurate standards
would not only help to eliminate care which is not medically indicated, but would minimize medically marginal care as well. In addition, such standards would promote the least expensive way to achieve comparable results; more troublingly, they would be the means through which competing legitimate demands are mediated and the means by which the challenge of incommensurability would be met.

Changes in the way physicians practice medicine are an inherently serious matter. The establishment of mandatory guidelines and the intrusion of cost considerations into the equation will have a profound effect on the practice of medicine. Guidelines and cost considerations have long been factors in the practice of medicine but only in recent years have they begun to approach center stage. Few would deny that anything which impinges on medical judgment in a given case is of the utmost importance. While physicians traditionally tempered their purely medical judgment for various reasons, a major change in recent years is the increasing direct influence of sources other than the attending physician and the medical team. This signals a shift toward greater concerns for the relevant patient population, but this shift need not give rise to a correspondingly lesser concern for the individual patient. Particularly where social resources are at stake, the need for long-term accountability cannot be obviated, even for a calling with the stature of medicine. The challenge is to retain as much as
possible of the uncompromisingly loyal dedication to the best interests of the individual patient, which has been the glory of medical care in this country, while ushering in a new era of social accountability for the good of all. In Part Three, we will propose a bifurcated standard of care to be implemented by the medical profession, a standard under which a sharp distinction is drawn between the loyalty owed to a patient and the resources appropriately available to that patient. The pervasive issue which arises here is that of "bedside rationing." The two poles or extremes are those giving virtual absolute discretion to physicians in determining (with appropriate consent) what is to be done and the minimization of such discretion in favor of pre-established guidelines, respectively. Even if one opts for unfettered physician discretion, the issue of bedside rationing would remain because it would still have to be decided whether the physician would be a traditional patient advocate as before or in large measure an "enforcer" of standards established by the profession itself, the public, and various experts. As one commentator summed up the difficulties:

While a fuller commitment to beneficence is the more obvious candidate for an expanded ethic, *justice* may be the more legitimate principle for assigning weights to D.R.G.'s and making other cost containment decisions. D.R.G. weights should be viewed as a scale of the relative ethical claims of
patients in the different diagnostic groups. If these social principles become a central part of a medical ethics of the future, we shall have to decide whether health professionals in their clinical role should incorporate them into their ethics or whether they should be given a special duty to remain patient-centered. (Veatch 1986, page 40, emphasis supplied)

We will articulate a standard at some length below in Part Three, taking care to separate as much as possible, and in as many instances as possible, the concerns of physicians for their patients and the concerns of society for the health of all its members. There can be little doubt that the fulcrum of concern has been shifting toward the broader concern and that this is likely to continue; however, this trend must be carefully modulated so that the traditional beneficence-centered standard can continue as the primary aspect of an ancient and venerated relation.

Before turning to the Clinton Plan and the Oregon Plan, we will take a closer look at Enthoven's influential and long-incubated conceptions of "managed competition" and the major components of the relatively new organized delivery systems ("managed care"). Many of the elements of these reforms should be seriously considered in formulating a blueprint for substantial change. However, our comprehensive proposal goes well beyond incorporating some of these elements.
VIII. Managed Competition and Managed Care

Much of the discussion in the last two decades has crystallized in the wake of the evolving recommendations of Alain Enthoven. Judging the ensconced fee-for-service system to be irredeemably inflationary and ineffectively cost-controlled, he decried the lack of provider competition and consumer choice in the midst of the perverse incentives peculiar to that arrangement as far back as 1978 (Enthoven 1978-1, pages 650-658). Considering the market to be at least potentially responsive to consumer interests while viewing direct Governmental economic regulation as more responsive to focused producer interests, he rules out any form of universal Federal third-party reimbursement as failing to provide sufficient incentives for efficiency for both producers and consumers. Enthoven's proposal is for a system of National Health Insurance (N.H.I.), a network of competing health care plans called a "Consumer Choice Health Plan" (C.C.H.P.). Even in 1978, he was calling for a basic benefit package, open enrollment, portability, community rating according to market area, and limits on out-of-pocket payments. He envisaged an organized system with efficiency incentives encompassing managed care entities such as health maintenance organizations (H.M.O.'s) and independent practice associations (I.P.A.'s). A decade later, retaining the basic features of C.C.H.P., he added more detail and thereby set the agenda for much of the discussion to follow, most especially the
Clinton Plan which was the lightning rod for health care reform throughout most of the 1990's.

Prescribing a system featuring a strategy termed "managed competition," Enthoven called for employer mandates for eighty percent of premiums, with employees paying the balance and those unable to pay receiving subsidies (Enthoven and Kronick 1989-1, pages 29-37). Under this system, all would be directly insured by either their employer or their "sponsor." Each state would feature a sponsor which would act as a broker for its members to purchase insurance. The sponsor would for the most part serve small and medium-sized employers as well as individuals while seasonal and part-time workers not otherwise covered would be covered through a special payroll tax. Sponsors could mitigate biased risk through rating stratification with subsidies covering any remaining shortfalls. Overall financing would leave Medicare and Medicaid unchanged for the present. The payments would be remitted by the Government (approximately fifty percent), the states (approximately thirty percent), and individuals (approximately twenty percent) with these amounts being paid to the fifty state sponsors which, in turn, would purchase insurance with a view to the best health care purchase for the money; amounts paid by employers would be collected by the Government and would be remitted by the Government to the various sponsors. The ultimate incidence of taxation here again would be approaching eighty percent for
employers, approaching twenty percent for employees, with the balance coming from general revenues of the Government and the states.

An alternative payment plan considered by Enthoven, but rejected by him as too radical a change to be acceptable in the United States, would be a single payer plan on the order of the Canadian health care system. Under that system, physicians are paid on a fee-for-service basis according to a fee schedule worked out within each province by the local medical association; the central government pays about three-fourths of the health care expenditures with the provinces being liable for the balance (Enthoven and Kronick 1989-2, page 100). Conceding the huge administrative savings under such a system, Enthoven argues that the absence of market forces leaves insufficient incentive for optimal quality and efficiency. This objection certainly sounds more serious than any objection based on the single payer feature itself. As we have shown, however, the use of a single fund blurs the distinction between a single-payer and a multi-payer system. In our previous discussion, we opted for a single fund multi-payer system. We also indicated, in response to Troyen Brennan's assertion that the choice between a single payer system and one of regulated competition among health care organizations was "ethically neutral," that the choice of options where the care is actually rendered should turn on the arrangements which can produce the
best consequences without violating any moral rights. We are in broad agreement that a system with competitive features at the point of delivery of medical services can well provide many of the checks and balances needed to mitigate the non-competitive aspects which would otherwise operate to the overall detriment of the system, i.e., monopolistic practices in the form of "collusion" between competitors, "collusion" between providers and insurers, or "collusion" between providers and patients. However, we favor a higher degree of regulation than does Enthoven. We favor a system, like the P.P.S presently in effect for Medicare, that would foster the fullest non-price competition while instituting a system of administered prices for the first tier. In Part Three, we will outline such a system which includes major aspects of the P.P.S. and those of the Oregon Plan. Through extensive use of C.E.A., especially Q.A.L.Y.'s, while addressing important criticisms aimed at those two systems, and at managed care in general, a system of explicit rationing will be introduced.

The core concept of all forms of managed care is the attempt to control costs by reducing unnecessary expenditures. The types of managed care (H.M.O.'s, P.P.O.'s, P.O.S.'s, and managed F.F.S.'s) vary largely in terms of the patient choice allowed and the cost of exercising it, the range moving in this listing from the more to the less restrictive with I.P.A.'s falling somewhere in between. Demands for value and accountability as well have been nearly as
strong as those for cost control. Increasingly, the trend is toward more tightly organized delivery systems featuring "... a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population(s) served" (Shortell and Hull 1996, pages 103-104). The authors distinguish "managed care" and "organized delivery systems," considering the latter to be more extensively integrated both horizontally (services at the same stage in the continuum of care) and vertically (services at different stages in the continuum of care), but they readily concede the lines have been increasingly blurred between the various types of managed care. They seem in effect to be advocating larger and more closely coordinated systems of "managed care"; these systems do not include ambulatory surgery, home care, and skilled nursing, however. This higher degree of integration is said to deliver greater cost advantages, greater access to capital, and greater access to an array of management services. The success factors in organized delivery systems will be their use of population-based data, their delivery of demographically attuned services, their employment of outcomes measures, and their ability to assume financial risk while, for managed care, the authors maintain they will be physician concern for patient populations, greater use of information systems, greater flexibility, and greater size. Whether one accepts the additional category of "organized delivery systems"
apart from that of "managed care," the future of privately delivered
care does seem to depend on the achievement of greater efficiency
with a balanced perspective toward physician autonomy, physician
responsibility, patient choice, and patient responsibility.

We are in complete agreement with this view of the decisive
importance of outcomes research. The authors concede, as we
must, that results to date have been largely fragmentary. Yet this
is surely the wave of the future if standards are to take hold and a
prioritized system of medical care is to be put in place. The results
which are to emerge will be, at the same time, a blueprint for
physicians and health care policy makers alike. These medical
standards, with appropriate non-medical supplementation in the
form of relevant cost data and the desires-preferences of the total
population served, will be the scientific bedrock upon which the
system will rest. While scientific findings cannot serve as proxy for
policy judgement, they can light the path which must be traveled.
These findings will not only guide the actual makers of policy; they
will also influence the researched desires-preferences of the
population. As we argued above, the incomplete and tentative
present status of outcomes research is hardly a sufficient reason to
run away from it. On the contrary, any complex of sound results
must sustain growing pains on its way to "relative maturity." The
very process of "fits" and "starts" is the basis for greater strength
and confidence in the long run.
IX. The Clinton Plan

We now move to an examination of both the Clinton Plan and the Oregon Plan, two comprehensive visions of health care reform. In important ways, these two perspectives represent competing views not only of health care in the United States but of society and its moral underpinnings as well. Where the Clinton Plan reflects an emphasis on solidarity and equity plus a degree of scepticism about the vaunted efficiency of the market, the Oregon Plan suggests an emphasis on pluralism and diversity, with a clear distinction between society and community, plus a greater degree of confidence in the market. Although the Oregon Plan only applies to the Medicaid program in a single state, in many ways it is a microcosm of a more extensive standpoint. The Clinton Plan and the Oregon Plan have provoked more comment than any other sweeping proposals, both of them thus serving as sounding boards for a number of commentators with widely divergent views. On the whole, we are more favorably disposed toward the Oregon Plan, particularly its recognition of a robust second tier and its straightforward approach to limitations on coverage; however, much that is in the Clinton Plan is notably constructive, particularly its stance on inclusion and comprehensive coverage.

The Clinton Plan grew out of the grim recognition that far too many Americans are either uninsured or underinsured while the only medical service uniformly available to all is emergency care.
Signalling a shift from individual health to public health, the proponents of the Clinton Plan sought to remove the United States from the short list of developed countries without some form of universal coverage. Mindful of the absence of a national consensus, the Ethics Working Group of the Clinton White House Health Care Task Force (Ethics Working Group) opted to develop a set of mid-level principles and values, not ranked by priorities, that should govern health care reform. These rather general principles included universal access, comprehensive benefits, equal benefits, fair burdens, quality care, individual choice, efficient management, personal responsibility, and fair procedures. The foundation of these general principles was even more general: equality, justice, liberty, and community (Brock and Daniels 1994, page 1189-1192). No attempt to achieve a canonical perspective is made and no serious search for common denominators is in evidence. Not surprisingly, Brock and Daniels have no illusions about the "cash value" of such general principles: "A feasible ethical framework recognizes that not every principle and value can be fully satisfied. People may disagree about how these tradeoffs should be made, reflecting their different philosophical, cultural, and religious traditions as well as the different values we affirm as individuals" (Ibid., page 1189). Furthermore, even these nine general principles identified by Brock and Daniels are not innocuous enough to achieve "consensus." Even if one concedes a consensus on
universal access and comprehensive benefits, two goals with which we are in agreement in any case, "equal benefits" reflects neither a consensus nor our acquiescence. Brock and Daniels, both members of the Ethics Working Group, assert the following concerning "equal benefits": "The health care system must not create two or more tiers among citizens, leaving less advantaged citizens with lower-quality health care and more restricted services. Ability to pay should not give some people access to important medical services that others cannot afford. . . . Providers should not have to determine patients' insurance coverage before offering needed care" (Ibid., page 1190, emphasis supplied).

This concept of "equal benefits" has a number of serious defects. The moral requirement of a second tier is not only violated in the first portion of the statement by essentially denying a basic freedom, but this position on the whole also fails to recognize the limits of what can be morally imposed by disregarding the distinction between society and community. In implicitly transmuting our various communities into the society of the whole, the "moral" obligation to others outlined here far exceeds what can be legitimately mandated across the various communities which constitute American society. The last portion of the statement illustrates all too well the inherent conflict between a needs-based standard and the mandate to marshall a portion of social resources for the benefit of everyone; not even a hint of medical priorities is to
be found here. The middle portion of the statement reflects an egalitarianism of envy and not an egalitarianism of altruism. This notion of equal benefits clearly stems from an unarticulated recognition of an inherent moral right to health care. Although at least one commentator has strongly criticized the absence of an explicit recognition of such a right by the Clinton Plan (Chapman 1994-2, pages 276-278), the underlying moral basis is tellingly revealed by Brock and Daniels: "Health care differs even from other important goods such as housing. Modest housing typically will suffice for shelter and not restrict opportunities, but limitations in health care services can often profoundly limit our opportunities, result in preventable pain and suffering, and even cost us our lives" (Brock and Daniels 1994, page 1190). Apart from the realization that health care needs are more highly skewed than our housing needs (the same could be said in relation to our need for food and drink), this statement places health care needs and their related satisfaction on a par with any material need we might have. Since limitations on needed health care services are viewed with such strong disfavor, it seems fair to conclude that the imposition of such limitations would violate an inherent moral right. Indeed the virtual abolition of a second tier is itself tantamount to the concomitant recognition of such a right. Recall our discussion in Part One. We showed not only the existence of an inherent moral right to pursue health care in a second tier but the strong incompatibility of such a
right with the recognition of an inherent moral right to health care as well.

Our point is not diminished by the permitting of some "tiering" by the Clinton Plan because virtually all of the areas covered by supplemental insurance, which would have been allowed under the Clinton Plan, were for coverage excluded under the comprehensive coverage of its first tier. The final draft of The White House Domestic Policy Council reads: "A supplemental benefit policy may cover all or some portion of benefits not included in the comprehensive package. . . . No health plan, insurer, or other person may offer anyone eligible for the guaranteed benefit package a supplemental insurance policy that duplicates coverage in the national benefit package" (The White House Domestic Policy Council 1993, pages 88-89). In fact, however, a more detailed examination of the Clinton Plan would uncover permissible patches of supplementary coverage in areas which overlap with projected coverage (e.g., insurance against accidents or insurance against specific diseases), but these fragmentary exceptions to the general rule need not detain us here. In substance, the great preponderance of available coverage under the Clinton Plan cannot be duplicated through supplementary insurance. Thus, it violates the moral requirement of a second tier and, to this extent at least, must be rejected.
Another major area where the Clinton Plan falls short and should be rejected is that of the absence of appropriate limitations on coverage. As the above-quoted statement of Brock and Daniels that reads in part "Providers should not have to determine patients' insurance coverage before offering needed care" indicates, architects of the Clinton Plan tended to see the two-way street of comprehensive benefits and concomitant limitations on coverage as more of a one-way drive leaning in the direction of comprehensive benefits. The dilemma of the co-incident need for health care reform which broadens access while better controlling and limiting costs is insufficiently acknowledged. This is the case for essentially two related reasons: 1. The proscription against incorporating "rationing" into the Clinton Plan with the very word itself being verboten. 2. The adoption of a needs-based threshold of intervention framed in terms of "medical necessity." Writing of her experiences as the Co-chair of Ethics Working Group 17 of the Health Care Task Force, one contributor freely admitted: "There were disagreements about the extent to which we should insist that certain approaches, if implemented, would ultimately result in rationing or a continuation of multi-tiered delivery systems. Politically, the "R" word was strongly discouraged and other euphemisms began to take its place. . . ." (Secundy 1994, page 412). Although the dispute referred to here is partially about
implicit versus explicit rationing, some phase of "denial" is clearly in evidence. As one thoughtful commentator put it:

Lawrence Brown's arguments can be taken as representative of those, like the Clinton Administration, who think that health care rationing is escapable, or at least minimizable. . . . For Brown rationing . . . requires that an *Identified individual* is denied a significant health good for *economic reasons*. . . . The paradigmatic case(s) of rationing in this sense [is] Coby Howard in Oregon being denied a bone marrow transplant for his leukemia. . . . (*Fleck 1994, pages 436-437, emphasis in original*)

The failure to deal directly with this critical issue, which is explicitly recognized as such by an overwhelming percentage of commentators, is a serious shortcoming. Eliminating waste and inefficiency will not obviate the need overtly to examine the various modes of rationing. Our examination of rationing will be the primary subject matter in Part Three. Unfortunately, the proffered definitions of that term are nearly as multitudinous as the authors thereof; they range from the narrowness of an "absolute scarcity" concept where the supply is substantially less than the demand (e.g., human organs) to the expansiveness of a "price allocation" concept where the demand waxes and wanes in an inverse relation to price (e.g., elective cosmetic surgery). Because of this latter-day "tower of Babel," much of the discussion on this subject is
oblique and circuitous. The ostrich-like approach of the Clinton Plan is redolent of this mold. This constriction fairly permeates its capacity to clearly address many of the pressing issues of health care reform, giving its pronouncements an air of counterfeit coin to that degree.

A related shortcoming of the Clinton Plan on the side of controlling and limiting costs stems from the general standard endorsed for covered medical interventions. The longstanding criterion of "medical necessity," steadily nurtured throughout the period dominated by fee-for-service arrangements, is incorporated into the standard of "medically necessary or appropriate" (The White House Domestic Policy Council 1993, page 40). Such a general standard of extensive flexibility has had a strongly expansive bias in practice over the decades. As our previous analysis in Part Two showed, the fee-for-service system and the traditional standard of medical necessity have blended in such a way as to stoke the burgeoning costs of recent years. The dominant standard has in no small part occasioned the over-emphasis by the medical profession on the individual patient to the detriment of the patient population being served, a pattern which must be reversed if needed controls and limitations are to be implemented. Until a standard is interposed which correlates medical benefits and costs in a more meaningful way, and which places marginal medical benefits in a more balanced limitation-
conscious perspective, such changes will remain elusive. In Part
Three, we will propose a Q.A.L.Y.-based system which attempts to
*balance* the extensive use of practice guidelines with the exercise
of physician discretion; to this end, a blend of explicit and implicit
rationing will be presented. Our hope is that a more population-
based system of medical service will enable this country to solve its
health care dilemma, i.e., the concomitant need to broaden access
and to control costs. We have found the Clinton Plan to be
seriously lacking in important ways, ways we believe would doom it
to failure if it were to be enacted. However, some of its features
are sound in our judgment and could well play a positively
meaningful role in health care reform. We look at these below
before turning our attention to another comprehensive reform, the
Oregon Plan.

The call for universal access to publicly-provided health care is
to be applauded as is, at least in general, the call for
comprehensive benefits. The summons to community rating is also
a constructive and viable concept as long as the first tier is large
enough to spread highly-skewed health care requirements over the
covered population, thus leveling to the highest degree the
allocation of benefits and burdens. Under such a rate, a uniform
charge or capitation rate for each participant would be in place, and
it would remain to be worked out how to reconcile the inevitable
tension between the paradigmatic capitated rate for a given
geographical population and the deviation therefrom occasioned by the actual patient mix. This will be further discussed in Part Three as will the use of global budgets, a feature apparently favored by the Clinton Plan (ibid., page 102) to limit core spending under its projected system of managed competition and to establish target levels for out of pocket payments. The Clinton Plan is clearly more thoughtfully worked out in the increasing of access than in the controlling of costs. This is apparent also when its leaving intact of Medicare and Medicaid is considered. In Part Three, where we will suggest it is decidedly preferable in the long run not to segregate the elderly, the poor, or the handicapped from other people included under an umbrella plan; a coordinated public tier is better advanced than one which continues to take a more piecemeal approach to public health. We hope to achieve a more effective balance between access and cost than does the Clinton Plan. One major way to do this is to embrace some of the cost control measures established by the Oregon Plan.

X. The Oregon Plan

The primary goals of what has come to be known as the Oregon Plan are aimed squarely at the horns of the health care dilemma: 1. Coverage for the uninsured. 2. Measures to control costs. While the Clinton Plan had essentially the same general agenda as the Oregon Plan, commentary on the latter has been
concentrated more on cost control measures while commentary on
the former has been more focused on access initiatives. Oregon's
legislative enactments pursuant to these broad goals have had four
principal features: 1. Extend Medicaid eligibility to all who are below
one hundred percent of the Federal measure of poverty level.
2. Mandated employer coverage meeting the Medicaid standard.
3. Creation of an insurance pool for the medically "uninsurable."
4. Use of a public process to generate a basic package of several
hundred paired condition-treatments (Strosberg 1992, pages 3-4).
There has been relatively little criticism of the first three features
while the fourth feature has been a lightning rod for commentary,
both favorable and unfavorable. This is largely because the
scheme used to define the basic package incorporates explicit
rationing and, in doing so, uses a form of Q.A.L.Y.'s to gauge
medical benefit. Such an approach to controlling costs is
revolutionary in the United States, given the explicit and pervasive
nature of these procedures.

As we stated above, definitions of "rationing" abound across a
wide spectrum of possibilities. In this instance, the public tier of
medical care in Oregon, the limitations on available coverage would
meet nearly all definitions even where the term is narrowly
conceived, the major exception being that of absolute scarcity such
as is presently the case with regard to human organs. Significantly,
although many commentators have reservations if not outright
disagreement with Oregon's approach, praise for its honestly addressing the rationing question is as widespread as is commendation for its confronting the question of medical priorities in general. There are those who contend "rationing" can be obviated through administrative savings, principally through a single payer plan, and the minimization of waste and fraud (e.g., Sanders 1992) but, as Henry Aaron has pointed out, the "one-time saving" secured by the achievement of administrative efficiency is the tip of the iceberg in a sea of rising costs engendered by technological innovation, the aging of the population, and the virtually inexhaustible "taste" or "demand" for medical services (Aaron 1992, page 108). If this view is accepted, and we certainly concur with it, then something further must be done to control costs.

The approach taken in Oregon was to place condition-treatment pairs in rank order and then, depending on legislative resources available in a particular fiscal period, to prescribe a cutoff point beyond which the condition-treatment pairs would not be covered. The original classificatory scheme listed seven hundred nine condition-treatment pairs, of which five hundred eighty seven were covered. Individuals whose condition is not covered would then be obliged to seek treatment in the second tier at their own expense. Back in 1987, in the biennium prior to that which produced the actual "Oregon Plan," the Oregon legislature had already been willing to impose limits on Medicaid coverage to the
detriment of identifiable individuals if such provisions would better
serve the subject population. Based on information that anticipated
transplants in its Medicaid program would cost the same amount
needed to cover another fifteen hundred persons under that
program, the legislature voted to exclude transplants (Welch and
Larsen 1988, page 171). Later that year, a seven-year-old boy
(Coby Howard) was denied coverage for a bone marrow transplant;
unable to raise enough money for the operation, the boy died.
Importantly, the Oregon legislature, knowing such a "victim" would
soon emerge, had in effect "decided" that the all-but-inevitable
event was to be viewed as unfortunate but not unfair. A difficult
choice such as this one is paradigmatic of those which must be
made if some form of medical prioritization is to be incorporated into
the first tier of the system in this country. While few choices could
be as stark as this one, the prioritization of seven hundred nine
condition-treatment pairs embodied a thoroughgoing policy under
which thousands of difficult choices were made. The procedures
used to formulate and rank the condition-treatment pairs was rather
complex and underwent a number of changes. What were termed
"community values" were combined with the ranked condition-
treatment pairs, the latter being multiplied by weights attached to
the categories of the former. Thus the input of the public as well as
that of medical experts was utilized in crystallizing the prioritized list
of covered services. In Part Three, we will be proposing a
partnership between the public, through its representatives, the Congress, and the medical profession along with associated caregivers. Largely in response to criticism, the results of a phone survey used to rank the "quality of well being" (Q.W.B.) of certain states of health, categories and data concerning symptom control, and the use of cost data (other than as a "tiebreaker") were eventually eliminated as active components of the process (Garland 1994, pages 217-219). The criticism of the inclusion of these items represents opposition to "quality of life" considerations and to prioritization even partially on the basis of cost. In our proposals, we will find it necessary to counter both of these areas of criticism; the reluctance of many people to deal with the relation of "quality of life" and of cost to medical prioritization, perhaps even a majority, is not of itself sufficient for them to be excluded from the process. As we will see in Part Three, a chorus of voices has arisen among commentators declaring that limits must be more sharply drawn as priorities are more clearly delineated, that some form of rationing must be devised to imbue the system if it is not to founder in the wake of spiraling costs and burgeoning demand. "The Oregon experiment in rationing health care for some Medicaid recipients provides a long awaited, desperately needed attempt to do something serious about our moral priorities for health care" (Veatch 1992, page 78).
Veatch has well summarized the "worries" about the far-reaching provisions of the Oregon Plan, both "surmountable" and "real." The surmountable worries are said to be: 1. There is no need to ration. 2. Quantification is repulsive. 3. The rationing plan unfairly targets the poor. The real concerns in turn are grouped under: 1. Defining what "basic" care is. 2. Inadequate attention to justice. 3. Inability to differentiate within a particular condition-treatment pair. We will save the "surmountable" worry about the alleged unfair targeting of the poor for Part Three and will also reserve for later treatment those concerns about justice for the elderly and the handicapped under a rationing scheme such as Oregon's. Veatch argues from his egalitarian perspective how irrational it is and would be for our society to allocate medical resources whenever there would be some medical benefit to be derived; as the marginal utility of additional medical resources declines, the incremental benefit becomes increasingly tenuous in relating to the incremental effort which could be expended in ways which might better serve other social purposes. He points out the rejection of the allegedly dehumanizing effect of quantifying suffering and psychological effects, and of attaching probabilities to serious medical interventions, is a preference for an intuitive, subjective basis for decisions over more scientific and objective bases. Much of our previous discussion echoes these concerns.
The "real" concerns advanced by Veatch are all too real. We have already argued in Part One that the inherent difficulties in deciding upon a package of publicly provided medical services militate against the right to health care being considered an inherent moral right. As Veatch notes, even the meaning of "basic" in the context is fraught with ambiguity. The term "basic" can be a synonym for "essential," denoting a certain moral minimum, or it can be a synonym for low-tech preventive care, denoting a more simple non-moral form of care. The distinction is an important one; while we contend that effective cost control in this century will have to involve a general shift in emphasis from acute care to preventive care, from in-patient to out-patient care, from curing to caring, and from sharply increased reliance on high-tech interventions to at least a decrease in the rate of increased reliance on such interventions, the goal of our quest for an appropriate public tier standard bridges the distinction between "basic" in its moral sense and its non-moral sense, i.e., a norm which firmly embraces medical benefit and not need as its main criterion, which fairly elevates extent of medical benefits at marginal levels over the mere presence of such benefits, which squarely places more emphasis on the patient population and correspondingly less on the individual patient, and which more fully encompasses a public perspective with less concentration on narrower medical concerns.
Veatch's concern about "inadequate attention to justice" in the Oregon Plan may be the most difficult one to refute, enveloping as it does a wide-ranging moral terrain. He mentions possible discrimination against the poor, the elderly, and the handicapped, which we will address in Part Three, and he criticizes the absence of any weight being given in the methodology to the distribution of benefits, maintaining that the greatest net benefit per unit of resources may not yield the best moral result (Ibid., page 82).

However, the philosophical foundations of our proposals, as outlined in Part One, are in part a defense of the view, given that moral rights are being observed, that the morally permissible and morally preferable result is the one yielding the greatest overall net benefit. Veatch never directly claims moral rights are thus violated, but he does mention the Rawlsian-style position of giving priority to the least well off as a possibility here, even where persons in medically similar positions would otherwise be treated similarly. He revealingly states: "At the stage at which the computer ranked net benefits, there is no way the data on to whom the benefits accrue could influence the ranking" (Ibid., page 83, emphasis supplied).

We have already shown Rawls' particular reluctance to apply his political theory to what he has viewed as a legislative-level problem. We concede the moral permissibility of such results while denying their moral preferability; to view them as morally mandatory, which
apparently Veatch has stopped short of claiming, is to mistake the
operant moral terrain.

The third area of "real" concern for Veatch is that of the
inability of the Oregon Plan to differentiate within a condition-
treatment pair. This objection refers to both the severity of a
condition within a given category and to the threshold of
intervention for that condition. The claimed shortcoming of a lack
of a severity index for the initial seven hundred nine condition-
treatment pairs in turn points to the relatively small number of
conditions addressed and vice versa. As Henry Aaron has
forcefully reminded us: "... Oregon proposes to classify all
medical care in 709 categories of diagnosis-treatment pairs. This
classification should be compared to the more than 10,000
diagnoses in the Dictionary of Medical Diagnosis ... if one wants to
combine diagnoses with a reasonably sensitive awareness of the
variability of potential outcomes, one is not talking about 10,000
categories, but some multiple of 10,000" (Aaron 1992, page 109,
emphasis in original). While it is arguable that a system prescribing
a basic package of coverage such as the Oregon Plan or that of
our proposal need not include all ten thousand conditions referred
to by Aaron, the seven hundred nine categories originally
addressed by the Oregon Plan could easily be an insufficient
number, especially in the absence of a severity index. Much like
the content of the categories of diagnosis-treatment pairs, the
number of categories used is something which will have to be steadily fine-tuned for the indefinite future as the product of a dialogue between input and feedback. This dialogue is analogous to that which we are projecting for practice guidelines and the respective rates of payment for the condition-treatment pairs. In the strictest sense, all of these standards are "provisional" in that they are subject to constant re-evaluation and accordingly may need to be revised at any time. Oregon's list of covered services, a freestanding criterion constrained by "medical necessity" on its own terms, is sufficiently new and even somewhat revolutionary so that it will no doubt require more extensive revision than either practice guidelines or prescribed rates of payment.

XI. The Clinton Plan and the Oregon Plan Compared

The Clinton Plan and the Oregon Plan can be evaluated in a general way in terms of the three main elements of our health care reform proposal: universal coverage, explicit rationing, and a second tier. The options of mandatory private insurance and of a single payer system per se do not present comprehensive schemes, but rather are best viewed as aspects of suggested comprehensive reforms. As we have seen, the gradations between a single payer and a multi-payer scheme do not demarcate any necessary difference which is fundamental, and mandatory private
insurance would require such extensive emendation that it too cannot constitute a truly comprehensive reform.

The Clinton Plan and the Oregon Plan differ considerably in the standard by which universal coverage is to be conferred. The former would have incorporated a standard of the "medically necessary or appropriate" while the latter opted for a discrete list of covered condition-treatment pairs. The Clinton Plan thus would have been essentially a continuation of a standard born of fee-for-service plans in its ultra-flexible standard for determining coverage, a standard which has long been extremely malleable and which has served as an instrument of expansion. On the other hand, the Oregon Plan represents a more specific scheme of coverage less prone to manipulation, a scheme easily amended to adjust to changing legislative priorities. In addition, the standard of the Oregon Plan is a more comfortable fit with the view that the right to health care should be recognized as a legal right, but not as a moral right, a position we argued for in Part One. At a time when priorities and limits are indispensable to meaningful comprehensive reform, the Oregon Plan standard is more appropriate than that of the Clinton Plan.

The Clinton Plan and the Oregon Plan differ in fundamental ways in their respective positions on a second tier of coverage. We argued in Part One that a robust second tier is a moral imperative.
While this imperative is steadfastly recognized in the Oregon Plan, the Clinton Plan virtually proscribes a second tier. This fundamental breach is sufficient, in our view, to render the Clinton Plan a morally impermissible option. The essential denial of the right to pursue health care in a second tier would constitute a significant reversal of a right which has always been implicitly recognized in our laws. While the impending crisis in health care in the U.S. does call for important changes in health care policy if it is to be averted, the virtual proscription of a second tier is a recipe for moral catastrophe. The Oregon Plan assigns to the second tier its rightful place in the moral spectrum.

Explicit rationing presents a more mixed picture; although the official documents comprising the Clinton Plan do not formally embrace "rationing," its proponents not only concede it is a part of the Plan, but also decry its failure to explicitly acknowledge it as an integral part of the Plan. We will show in Part Three that the best approach to rationing is to combine first tier standards of coverage which explicitly incorporate rationing with the implicit "bedside rationing" of the medical profession. We will reject both the position that introducing explicit rationing into a system which of necessity must include rationing must be rejected because introducing it is at times to lay bare the tragic conflicts which can destroy our social fabric, and the position that physicians must never be placed in the position of denying services to their patients which will likely be of
medical benefit. These two flawed positions, which are not always sufficiently distinguished, derive from two different untenable assumptions, respectively: 1. That it is immoral to deny more serious forms of medical treatment likely to confer substantial benefit for financial reasons. 2. That it is immoral for physicians to serve as anything but unqualified advocates for their patients. Both positions, however clearly well-intentioned, fail to take adequate account of the wider implications for medical care in the United States. As Reinhardt has reminded us, medical care is intermediate to a "private consumer good" and a "public social good" and must be so regarded if it is to be placed in appropriate moral perspective. By placing discussion of rationing squarely in the public domain and explicitly incorporating rationing into its scope of coverage, Oregon has done much to render the process more transparent at each stage; not only are the values of the populace embodied in the Oregon Plan itself, but the explicit provisions serve as "fair warning" where marginal or uncovered services are thus identified. None of this can be fairly said of the Clinton Plan. Not only was "rationing" removed from discussion among the experts engaged, but public input was never part of the equation; as a result, the approach to rationing is oblique and implicit, in spite of an apparent consensus among these experts that rationing was unavoidably a major issue in health care reform, and its likely effects would be a hazard for a public unwary of its
machinations. At each stage of the process, including projected operations, the lack of requisite deliberation represents a fealty to values too ephemeral to fully serve the lofty aims of the undertaking. Thus, the rationing program we will tender in Part Three will owe virtually nothing to the Clinton Plan and rather a lot to the Oregon Plan; the latter is a bold and forward looking vision well attuned to the mounting difficulties in the allocating of our health care resources and the potential means of surmounting those difficulties.

XII. Concluding Remarks

We have attempted to show in Part Two that a system of universal health care coverage in the United States would be morally preferable to the present situation, a patchwork of systems, under which some forty million people have no coverage at all except for emergency care. To do this, we have measured our proposal against various alternative proposals, both comprehensive and piecemeal. We began with the central dilemma of the concomitant need to broaden access to medical care while controlling increasing medical costs. As many others have noted, the twin goals growing out of this dilemma evince a tension between themselves which renders any "solution" a path littered with pitfalls. This in turn points to the interdependency of the two goals with each having to be kept in mind even as the other is
being served in some way. In Part Two, we have focused primarily on the goal of broadening access while emphasizing the elements needed to successfully implement that goal. This had to be approached in a way appropriately sensitive to related costs; thus to a degree our cost control proposals had to be introduced and even justified to some extent here even though our main proposals in that area will be discussed in more detail in Part Three on rationing. We had to give rather specific indications in Part Two as to how we would limit the coverage we would make available to all.

We looked to the present first tier for some guidance in selecting means of cost control. The P.P.S. was found to be fertile ground in this area even though its present application is far from universal. Its longstanding feature of D.R.G.'s is a forerunner of the condition-treatment pairs which are an integral part of our proposal. We found cost controls in the public tier to be insufficient even for the P.P.S.; controls would have to be more efficient and more pervasive if a universal system is to succeed. To this end, while more people would be covered, first tier coverage would not be as "deep" as it now is to help compensate for that broadening of coverage. Specifics on limiting depth of coverage will be supplied in Part Three. A global budget for the first tier will be prescribed. In addition to a well-conceived network of condition-treatment pairs, more extensive use and refinement of practice guidelines is called for in our project; utilization review in turn would be an effective
backstop for the guidelines, nourishing and enriching them along the way.

To achieve a broadening of coverage, we have studied various reform proposals, notably the comprehensive reforms as suggested by the Clinton Plan and as actually enacted through the Oregon Plan. In addition, the Oregon Plan has provided a powerful example in its honest and explicit approach to rationing. The Clinton Plan, on the other hand, is an equally powerful beacon in its attempt to actualize the concept of universal coverage. Other reform proposals, especially those involving insurance, have helped to broaden our range of choice. However, to the extent they are less comprehensive in scope, they are of interest more for specific aspects of their content. One noted "insurance-based" comprehensive scheme is that of Enthoven, whose deliberations have foreshadowed much of what became the Clinton Plan. Trumpeting a system of managed competition, which was to become the watchword of the Clinton Plan, Enthoven's N.H.I. encompassing his C.C.H.P. evolved into a proposal with a number of features we endorse in principle.

Foremost among these features are "open enrollment" (universal coverage), the offering of a standardized basic package, and the use of community rating according to market area. We support a nationwide community rating system which would serve to minimize the rate used, whether payments come from employer
mandates, public subsidies, or individual remittals. Complete portability would be available with pre-existing conditions no longer a factor. Suitable cost adjustments could be built into the system to compensate for patient mix, geographical variations, and other aberrant factors. While we consider a multi-payer system to be satisfactory, we are calling for a single fund a la Beauchamp. Concerning the standardized package, depending on the cost involved, there could either be an extra charge for any deviant coverage or the package could be cast as a certain range of coverage beyond which there would be an additional charge. The larger the pool of people covered by the system, the greater the likely range of "standard" choices. In addition, the stronger the basic package the greater the participation in the first tier is likely to be. Our expressed hope is that somewhat more than the current forty-four or so percent of the services rendered will be in that tier, by virtue of both economies of scale and the greater availability of effective care. In contradistinction to the Clinton Plan, and in accord with our proposal, Enthoven apparently imposes no morally unacceptable restrictions on the second tier, at least in earlier versions (Enthoven 1978-2, pages 718-719). At that juncture in any case, an egalitarianism of envy is rejected in favor of an egalitarianism of altruism. These features are all designed to increase access to the point of universal access, representing as
they do our measured response to the first horn of the health care dilemma.

The second horn of the dilemma, that of controlling costs, will be addressed in some detail in Part Three; we will propose a comprehensive system of explicit rationing and will defend it against some of the stronger criticisms made against it, principally alleged invidious discrimination against the elderly, the handicapped, and the poor. These charges are fueled by strong concerns about medical prioritization and quality of life considerations; it will be incumbent on us to meet these serious challenges in justifying our program. In our treatment of cost control in Part Two, we began with data on runaway medical costs and the lack of effective overall controls; projections indicated the situation would likely worsen in the absence of decisive action. We noted the significant effort to control costs by the Government’s P.P.S., which utilized prescribed D.R.G.’s to standardize the costs (i.e., the reimbursement rate) of hospitalization procedures under Medicare. We endorse this approach as one which should permeate the entire public tier which, under our proposal, would supplant the various programs which now constitute that tier. In Part Three, we will call for the extensive use of Quality Adjusted Life Years in the formulation of system-wide standards. Buttressed by a global budget, practice guidelines and utilization review are additional tools which can sharpen and improve these standards, continually fine-tuning them
as a new system finds its way. This explicit rationing system is a comprehensive attempt to prioritize the care offered in the public tier; the goal co-extensively is to promote greater cost efficiency while attaining a higher degree of social equity and a higher quality of care than that now received in this tier. This is to be accomplished in as open and democratic a manner as possible to ensure public faith in the system and a knowledgeable public perspective on what the system offers. The managed care organizations competing for first tier patients would be competing largely in terms of quality of service and cost efficiency; the conflicts of interest characteristic of that spectrum of care, notably different in nature than the conflicts of interest under the previous dominant fee-for-service arrangement, will require corresponding modifications to the salient relationships in the health care matrix. Throughout Part Three, these and other social conflicts will be close to the surface and will require our studied and unswerving attention.
Part Three
of Three

I. General Orientation

Our main goal in Part Three is to show that a system of explicit rationing is needed in the United States if a scheme encompassing universal health care coverage is to be put in place. We have shown that universal coverage would require efficient cost control measures if it is to be viable. To this end, we have introduced in a general way types of techniques which might be employed, such as C.E.A. and C.B.A. We now come to more specific discussion of these control measures to actualize the proposal being made here. To implement the theme of Part Three, the adumbration of a comprehensive and coordinated cost control system, we will be discussing some of the longstanding attitudes which have produced a crisis of ever-rising costs, such as the increasing "medicalization" of our society and the open-ended faith in technology, as well as more apparent structural causes, such as the aging of the population and the many legacies of the historically dominant fee-for-service system. Factors such as these are prominent among
those which must be addressed by any serious attempt to rein in a
cost curve which has long risen too sharply.

While medical care, as one important industry among many, is
tied to the general movements of the American economy, for some
years now it has marched according to its own drumbeat to a
remarkable degree. An explosive mixture of structural factors and
cultural attitudes has produced strong upward pressures on costs
which have far exceeded those of the general economy at least
since the advent of Medicare and Medicaid in 1965. As we have
noted, about forty-five percent of all health care expenditures are
now in the public sector, even in a system which does not
recognize a general legal right to health care outside of emergency
treatment. We are suggesting a first tier which would be of
sufficient quality to attract many of those not now in a public tier.
To accomplish this in a cost-efficient manner will require far greater
and more encompassing attention to medical costs than heretofore.
Yet such a level is attainable if certain trends now ascendant can
be appropriately harnessed and refined while others are
significantly slowed. We propose changes which might be seen to
have a "revolutionary" effect if instituted but which are more
appropriately viewed as evolutionary in approach. Indeed most of
the elements of our reforms can already be identified at some point
within the existing system; these elements are for the most part
subsumed under "managed care," though they are by no means to
be virtually identified with the various systems coming under that rubric.

We have already referred to managed care and have specified its best known forms. The term is defined and described by Iglehart as:

... a system that, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians and hospitals that provide comprehensive health services to enrolled members for a predetermined monthly premium... restrict[s] the access of their insured populations to physicians who are not affiliated... contract[s] with or employ[s] more primary care doctors and fewer specialists than now serve the general populations, and primary care physicians assume broader roles in these systems... places specialists at particular risk, because they are more likely than primary care physicians not to be selected by a plan. (Iglehart 1994, page 1167)

What we will propose can be loosely described as one giant-sized managed care plan. Because this plan would provide universal coverage, many of the purported disadvantages of such a system would be either eliminated or substantially mitigated, while the advantages would be enhanced or at least maintained. We will take some of the features of managed care a bit further. We will suggest a prospective payment system with predetermined levels of
compensation or reimbursement attaching to the various prescribed condition-treatment pairs. Key to this arrangement is the prioritization of these pairs in lexical order according to their respective Q.A.L.Y.'s; this would be done in "laundry list" fashion a la Oregon so that marginal, experimental, and unduly costly interventions can be relegated to the second tier. The unremitting expansiveness of inherently vague standards on the order of "medical necessity" is thus avoided in favor of a standard which would better serve the public purposes of our sweeping reforms. This prospective payment aspect coupled with a Q.A.L.Y.-generated laundry list of covered services is the cornerstone of our system, enabling it to benefit the enrolled population much more efficiently over the long run. However, any system resting on such a foundation, representing as it does a sharp point of departure from the past, must be prepared to defend itself against the status quo and the allegations on behalf of various interested parties. In Part Three, we will defend our proposal against a number of critics, principally those alleging: 1. Morally unjustifiable discrimination against the elderly, the handicapped, and the poor. 2. Morally unjustifiable erosion of historical standards of medical care and the fiduciary relationship between physicians and their patients.

In addition to providing a master mechanism to oversee the more equitable allocation of medical resources, our proposal would also obviate a number of problems endemic to present
arrangements. Complaints about choice of doctor should all but disappear as long as sufficient numbers of physicians choose to treat patients in the first tier. Given the large pool of patients likely to participate, questions of cost shifting, "dumping," and "cherry picking" should be minimized while concerns about portability and pre-existing conditions would be virtually eliminated. Given the judgment required at all levels to administer any system, controversies would remain, but free and open procedures can do much to mitigate these dissatisfactions. At all levels, a virtually constant process of self-evaluation and independent checks would serve to insure both the integrity and the efficiency of the system. Thus, all members of the covered population can be reasonably assured at each stage of the process, including early recognition of what is covered and what is not covered, that the system is fair and responsive while providing a reasonably high quality of medical care.

To get to the point where a system so heavily prioritized and rationalized can be put in place, a number of conceptual and attitudinal transformations must be fostered. This is particularly true where perspectives on autonomy and on technology are concerned. As we noted at the beginning of this project, greater recognition of patient autonomy and boundless faith in technological innovation have been the primary engines which have driven the field of medical ethics in the last forty years or so after having
initially spurred its recognition as a separate endeavor which both subsumes and critiques existing codes of ethics of the medical profession. Modification of predominant perspectives on autonomy and on technological innovation is, however, only a necessary but not a sufficient condition to engender the changes envisaged. The acceptance of a "rationing" scheme is itself an obstacle, given the negative connotations now attached to that widely misunderstood term. Closely linked to these connotations are "quality of life" considerations which are widely viewed as a means of restricting rather than of expanding available medical care. In both instances, the unpopular instruments are already being applied on a largely implicit basis. We propose to widen their scope of application and to explicitly acknowledge them in a manner befitting a free and open society while clarifying their nature and the role they are to play. The attainment of a high degree of transparency is indispensable here if public participation and understanding are to be maximized.

We advocate a system of explicit rationing to the greatest possible degree, being mindful that an implicit aspect in the form of "bedside rationing" is ineliminable. We seek to minimize this implicit component thereby to minimize the risk that confidence and trust in the medical profession will be diminished. Indeed we must acknowledge that both facets of rationing, the explicit and the implicit, pose a major threat to the historically high levels of
confidence and trust patients have had in their physicians. Accordingly, we will strive mightily to address these fears which should be kept in mind at each stage of the process. We will suggest the longstanding univocal standard which has governed must give way to a more complex standard, one which more saliently responds not only to the changes which are to come but those which have long been in process.

Part Three will begin with further discussion of autonomy, outlining the need to re-emphasize the distinction between autonomy (freedom) as a side constraint and autonomy as a value as well as the critical importance of choice as a component of responsibility. As our analysis in Part One showed, the negative side of autonomy is far less controversial than its positive side, yet much of the work in contemporary medical ethics has been loathe to recognize that autonomy on the positive side, though an exalted value, is one among many values with which it must compete in many contexts. The relations between autonomy and technology will be of particular concern here as we examine the apparent abdication of traditional autonomy in favor of a "technological utopia." While our tone will of necessity be rather general, we hope to point the way to changes in attitude and belief which can help to pave the way for needed change. Perhaps the key notion here is that of the more explicit recognition of limits, both in terms of the natural and in terms of the political-economic. Although few
continue to adhere strictly to the ethic engendered by the fee-for-service system, the remnants of that system are still very much with us; the posture that all must be done in each instance of perceived medical need is far from dormant even if the message has been blunted to a degree.

A strong correlative of the "all must be done" attitude is the increasing "medicalization" of our society. This is notably true where the elderly are concerned but can be increasingly found in such disparate areas as the academic failings of students and the criminal transgressions manifest by deviant conduct. Although the expression of medical opinions goes well beyond the scope of this work, we are calling for increased diligence and greater critical examination in areas where "non-medical" considerations may be uncritically assimilated to matters medical. A prime example of this lies in the area of long-term care. We find ourselves in agreement with proposals to "de-couple" the living expenses component of long-term care from its medical component. Such a move does nothing to relieve perceived shortfalls of means to cover living expenses for many of the elderly, but it does bring a helpful transparency which enables us to separate "welfare" concerns and those which are medical. Even where living conditions themselves have ascertainable pathological effects, divergent policy considerations, e.g. housing or welfare, respectively, will be brought to bear in addition to those of a medical nature. Thus, the
distinction could be of great assistance in policy deliberations on both sides of this problem. Evolving norms of "health," "disease," and "illness" have played a pervasive role in this medicalization and will be briefly examined to reveal a surprisingly rich normative content in these key concepts. Here we at least hope to show the purportedly objective basis of the aforementioned medicalization is less solid than might be supposed and that these norms reverberate throughout the system albeit in ways which are hard to measure.

II. The Double Helix of Autonomy

We are generally thought to be most fully defined by our ability to make choices, by our capacity to map out our own course in the face of an often barbarous and unyielding natural world. This celebrated characteristic, that of our autonomy, has been the major catalyst of the changes in the climate in the field of medical ethics in the past forty years or so. We say this because the other major catalyst of change, technological innovation, is in a sense an instrument of our autonomy, even though it is an instrument with its own protocols. We have already discussed "positive" and "negative" rights at some length in connection with moral rights in general and the purported moral right to health care in particular; in this vein, we distinguished autonomy (freedom) as a side constraint and autonomy (freedom) as a value (positive), noting that even
Kant lost sight of this distinction. Restrictions on freedom as a value were found to be at the very core of the most fundamental inherent moral right of all, essentially freedom as a side constraint. Put very simply, not every exercise of freedom proves to be in our best interest, even if the exercise itself is viewed as licit. Indeed the exercise of freedom can itself result in the diminution of freedom; one need only harken back to the extreme example of selling oneself into slavery to find an exemplar.

In recent years, our society, whether in the form of "experts" or that of the many patients who must make such choices, has effectively opted for a technological "utopia," which is a different type of utopia in that no clear goal is envisaged. As one thoughtful commentator has put it: "To the extent that the task of medicine is to continue to indefinitely to expand our choices and eliminate suffering and thus to relieve our subjection to fortune and finitude, it is justifiably viewed as utopian" (Mc Kenny 1997, page 5). By ceding some of our autonomy to the technological imperative of minimizing human suffering, we have lessened our suffering only to fall prey to a new form of control. As Mc Kenny reminds us, the problem is not technology itself, but our failure to place that technology in a sufficiently rich moral framework, one from which a morally meaningful critique can be rendered. He views what he calls "standard bioethics," which consists at its core of the decisive unexamined assumptions that human suffering is to be eliminated
or minimized where possible and that human choice is to be expanded where possible, as having become need dominated in conjunction with a technological imperative while ignoring or obscuring inquiry into the role that technology should play in our self-regarding and other-regarding moral projects. The linchpin here is the unduly expansive view of human autonomy taken all too often by advocates of this ethic. The freedom spawned by this view is seen as having exalted the positive, value-laden side of autonomy in the name of neutrality. Individual patients have come to be increasingly overwhelmed by a health care industry-technological complex which has to a surprising degree inexorably usurped the effective exercise of autonomy still said to reside with those patients. To illustrate how this state of affairs has come about, Mc Kenny provides the examples of "physician-assisted death" and "human germ-line gene therapy" (Ibid., Chapter 2). These particular issues were deemed representative of the untimely confluence of the desire to eliminate suffering by expanding choice.

In the matter of physician-assisted suicide, the building standard consensus is that the presence or absence of true self-determination on the part of the patient has become the morally salient characteristic in determining whether what is involved is indeed "physician-assisted suicide" or the morally proscribed nonvoluntary or involuntary "euthanasia" or mercy killing. Noting that, while some decry the progression from the acknowledged
right to refuse useless medical treatment to the moral permissibility of physician-assisted suicide as a "slide down a slippery slope" as others see the progression as a gradual fruition of a patient's right to self-determination, Mc Kenny sees the unifying element of these divergent points of view to be a "... series of efforts to draw morally significant lines between an acceptable activity and killing" (Ibid., page 26). He notes that the line drawn changes from time to time as new conceptual demarcations enter the fray; inexorably, as new technological interventions come to blur these lines of demarcation, most notably that between "intentional killing" (proscribed) and "letting die" (permissible), acts or courses of action which appeared to be instances of "intentional killing" (e.g., stopping life support) began to seem permissible as new examples of self-determining choice by the patient. The conceptual underpinnings used to justify such a result in turn are seen as reflecting one of two alternative accounts given of the origins of the "new" field of medical ethics (i.e., bioethics) found by the "standard view": 1. The need to respond to unique challenges presented by modern technology. 2. The need to carve out a common morality in the face of a crisis of moral values engendered by the widespread perception of the failure of the Enlightenment project (Ibid., pages 29 and 10, respectively). The culmination of the response to these challenges is a "basic moral content shared by standard bioethicists in spite of their disagreements... and the kinds of issues standard
bioethics fails to address due to its moral commitments" (Ibid., page 15).

As indicated above, this moral content consists largely in an uneasy enthronement of both a belief that suffering should be eliminated and choice maximized without attention to ways in which this involves unacknowledged forms of suffering and power. Autonomy lies at the center of this amalgamation, but its true locus may well reside in the medical-technological complex which, in a sense, no one controls but which "controls" everyone. The shortcoming here lies more in the largely unacknowledged content of the prevailing view and in the related failure critically to examine the presuppositions which are concomitant to it than in the content itself. The relatively uncritical acceptance of an ethic which has superseded the more traditional one in place at its ascendancy is to be regretted, for it is not self-evident that the positive side of autonomy should be thus shaped.

The example of human germ-line gene therapy is to similar effect. Here the line between permissible and impermissible interventions has generally been drawn between somatic cell therapy (permissible) and germ-line cell therapy (impermissible). The former was deemed permissible largely by virtue of patient consent when such procedures began to be seriously discussed twenty-five years ago while the latter was deemed impermissible largely because the effects of tampering with germ-line cells were
unknown and medically acceptable procedures were still being
developed. It was all but inevitable that progress would be made to
make germ-line cell therapy less risky. As this occurs the
distinction between somatic and germ-line cell therapy is more a
difference of degree and not of kind. A "new" distinction between
"therapy" and "enhancement" has the potential to completely
supplant the old distinction. Concerns about tampering with germ-
line cells diminished accordingly. As Mc Kenny points out:

\ldots germ line therapy greatly expands the range of
consequences of our interventions and thus the risks
they involve. Given our vast ignorance about the human
genome, we may eliminate deleterious genes that, unknown
to us, are essential to human survival of an unforeseeable
future threat. However, this risk would apply equally to
widespread use of somatic cell therapy.\ldots Moreover, any
such threat is highly uncertain while the benefits of
eliminating serious diseases from the germ line would be
immediate and obvious.\ldots Furthermore, concerns about
eugenics per se and about the resulting inequality and
discrimination would apply also to somatic cell therapy\ldots
it is a question of the efficacy of genetic factors alone and
a matter of degree rather than of kind. (Ibid., page 33)

He goes on to summarize, in response to an influential work on
this subject:
... obligations to prevent and remove evil derived from the principles of non-maleficence and beneficence render in-principle objections to germ-line therapy immoral. However, the effort to draw a line between therapy and enhancement is fraught with difficulties [while] the line between somatic cells and germ cells is scientifically clear since the cells are distinct biological entities. The line between amelioration of disease and enhancement of traits has no such scientific basis. Moreover, any trait that has a significant association with the onset of a disease can be thought of as a proto-disease and thus a candidate for genetic intervention. (Ibid., page 35)

We have come full circle with this second example. Again, as we saw in the case of physician-assisted suicide, the moral mandate of eliminating human suffering almost regardless of the consequences and an unbridled faith in the ability of technological innovation to "solve" in a vacuum our medical problems come together under the agenda of patient autonomy tending to produce a value-laden fait accompli in the name of a value-neutral response to new challenges presented by a burgeoning technology. Autonomy has again been turned on its "other" side and effectively taken for granted. Mc Kenny's analysis clearly shows what is intended by it: that largely unexamined (or at least under-examined) assumptions now lie close to the core of many perspectives which can be fairly
characterized as within the orbit of "standard bioethics" and that these assumptions have nurtured an ever-expanding view of what are appropriate medical interventions while discouraging adequate consideration of applicable limits engendered by the verities of the human condition. One might well disagree with the content-ful aspects of his analysis and locate the center of gravity concerning the role of health and the human body at a different point of the spectrum, but the relatively uncritical acceptance of the assumptions concerning human suffering and technology and the related embrace of a value system interposed into a rightly perceived "crisis of values" can scarcely be doubted at this point.

The connection between the treatment of autonomy in this section of our paper and that in previous sections should be underscored. The fulcrum of our denial of a moral right to health care was essentially that of the distinction between positive and negative rights; it was also fundamental in our affirmation of a moral right to pursue health care in a second tier. In an important sense, negative rights do not conflict with each other while positive rights are always in potential conflict with each other. This is because positive rights represent competing values in the race to secure the resources needed to implement them whereas noninterference or forbearance is the primary ingredient in the recognition of negative rights. Thus, to recognize a moral right (and/or its corresponding legal right), a society must marshal a measure of its resources for
that purpose. Since resources are inherently scarce, those used for such a purpose will not be available for other social purposes and thus a multi-faceted political choice will have been presented in advance of such a decision. While some purposes may clearly be more worthy than others, this is not a realm where self-evidence reigns. Accordingly, when society at least implicitly declares the elimination, or at least the minimization, of human suffering as a goal to be pursued according to the technological state of the art, it has elected to use resources for this avowed purpose, to be done in the name of patient self-determination in this instance; the choice would equally be made with regard to positive rights if society chose not to pursue the goal with such fervor but rather to implement a more balanced view incorporating more fully notions of human finitude, as Mc Kenny advocates.

It should be apparent that the extent to which "rights" may actually be an explicit factor in such deliberations does not diminish the force of the correspondence between "positive" and "negative" rights, on the one hand, and autonomy (freedom) as a "value" and as a "side constraint," on the other hand. Positive rights represent a choice among values in a way that negative rights need not represent such a choice. The freedom from interference which is to be demanded in the recognition of negative rights is logically prior to the particular purposes a human agent may have. Purposes which are legitimate in this context are all those which are
not proscribed. On the other hand, the recognition of positive rights, and the concomitant demand that they be recognized, is logically co-terminous with the particular purposes of the human agent and the decision of society to endorse such purposes and to commit resources which will abet such purposes. This is not to say the distinction is always a clear one to be made with relative ease. As with the important analytic-synthetic distinction, that irresolvable cases may exist with regard to the distinction does not render it an unimportant one.

What mattered in Part One was that the distinction between positive and negative rights could be tellingly applied to a paradigmatic positive right, the (alleged) moral right to health care; what matters here in Part Three is that the distinction between autonomy (freedom) as a value and autonomy as a side constraint can be tellingly applied to a perspective on autonomy regarding human suffering and the social response to it which is fairly representative of the received or standard view in bioethics. This in turn has served to create an increasingly strong bias in favor of patient autonomy as a value, in favor of more frequent and acute interventions of an increasingly greater technological sophistication, and in favor of greater reliance on the technological innovations in various stages of incubation. A need-based emphasis has come to dominate the allocation of our medical resources in a way which has skewed the pattern of distribution away from the medical
benefit basis which would be morally preferable in our view. We will show in Part Three that a more efficient and morally preferable basis for distribution of medical resources is one based on medical benefit in light of relevant costs, as derived largely through a system of Q.A.L.Y.'s, one which embraces both explicit and bedside rationing. We now take a more direct and detailed look at technology itself, at its role in shaping medical costs, and at aspects of the current climate in this area. We are not by any means anti-technology; we share with Mc Kenny the view that technology is clearly a blessing which can be of great benefit, but the de facto failure of the system to place it in a larger and well-considered context has led to undesirable imbalances in the delivery of medical care. He states: "Nor do I believe that it is possible or desirable to reverse the technological revolution in medicine and simply return to traditional ways of life . . . modern moral discourse provides no vocabulary with which to deliberate about . . . what goods health should serve, or what limits the control of our bodies by technology should observe" (Ibid., page 21).

III. Technology

Our fascination with technology is perpetual. The latest advance is automatically of interest. This is perhaps even more the case where medical technology is concerned, given that
improvements in medical care do far more than amuse us or make things more convenient in some way. They have often been our very lifeblood or our only hope for the future. Few thoughtful people could be found who would favor a return to a time when technology was far less developed. This is especially true where medicine is concerned. Many who would repudiate ringing telephones, air polluting vehicles, and industrial threats to the purity of our water supply, etc., would be loathe to repudiate the increasing sophistication of medical interventions. The strategic place of medicine in all of our lives fairly guarantees such a perspective. Yet our collective grip on technology is not unlike the proverbial grip of one having a "tiger by the tail." There is an increasing awareness that even a continuous cascade of impressive technological innovation cannot by itself supply us with greater means of addressing increasingly difficult issues in medical ethics. In any event, we contend there must be a heightened perception of the distinction between means and ends in these pursuits if we are not to founder on the rock of means in our sea of dreams. In short, technology must be more consistently placed in a wider context so that the "tail does not wag the dog" instead of vice versa. As we will see in this section, the confluence of a number of disparate factors may actually "help" to encourage greater overall awareness of the need to limit the effects of technology.
In a thorough article, Goodman and Gelijns outline the major aspects of the current climate in medical technology. Although the authors' primary perspective seems to be one of regret at noting the increasing pressures on technological innovation, we believe many of these factors may be a healthy signal to slow things down a bit. The authors include the following factors among those impinging upon technological use and development: 1. Regulatory requirements have increased. 2. The "entry fee" for startup companies is becoming increasingly prohibitive. 3. Closer scrutiny of health care delivery and payment, especially practice guidelines and the standardization which comes with them. 4. Budgetary restrictions at various levels for investigational technologies. 5. Limits on research funding in government and industry. 6. Financial curtailment limiting the role of academic centers as leaders of medical research. 7. A general trend toward centralized technological decision making (Goodman and Gelijns 1992, page 267); other factors such as tort law, patent law, and supply and demand dynamics are mentioned as well, but these are the ones effecting the greatest change in this area. Our main focus here should be on the aspects of managed care and related factors which have had an important impact on technological innovation.

The authors seem to have mixed feelings when they summarize the effects of greater cost consciousness:
Technical wizardry alone no longer carries the day. What is axiomatic for innovation in other industries--improve quality at acceptable costs--is relatively new to health care. Providers are far less willing than they once were to ring bells or blow whistles that cannot produce demonstrable, cost effective . . . improvements in health outcomes. Although innovators are responding with agility and resourcefulness in the revamped health care climate, it does pose tangible risks to environments for innovation. (Ibid., pages 304-305)

They seem to regret the "restriction" of innovation here but, at the same time, do not appear to be attacking the greater, cost-oriented scrutiny seen in more recent years in the health care industry. What the authors have to say about the specifics of managed care, in effect policy as to whether to pay and how much to pay, is perhaps more revealing.

The categories discussed here are Medicare and the P.P.S., the coding of D.R.G.'s under Medicare's P.P.S., cost containment strategies of largely private health care organizations, guidelines and standardization, and payment for investigative technologies.

The P.P.S. under Medicare is said to have "... put downward pressure on important health care costs and has encouraged migration of care to the outpatient setting" (Ibid., page 270). We have noted as much in Part Two, calling for greater transparency to render overall costs more apparent, but the implicitly negative
impact of this "downward pressure" on the use and development of technology is hardly to be regretted absent specifics which constitute unwise policy. They do make the point that the use and adoption of technologies by hospitals have been affected by the D.R.G.'s to which the use of a given technology is assigned; however, for this point to have significance, one must at least allege that the D.R.G. assignments are in general too low and that the use and adoption of technologies is thereby inappropriately lessened. The aggressive cost-containment strategies of largely private health care organizations are cited as having the greatest impact on health care technologies; here the authors focus mostly on the greater buying leverage of many of these organizations, the centralization of their organizational structures, and more cost-conscious purchasing policies; the adverse impact of these factors, particularly upon smaller technological firms, are commented upon, but where the "blame" might lie here is left up in the air. Remarks on the standardization of care follow a similar pattern; perhaps the caution sounded here is efficacious in that systematization can be too strict or rigid, thereby causing a lack of responsiveness to the legitimate needs of the population being served. Payment for investigational (i.e., "experimental") technologies is an area where the authors' view seems to have more resonance. Certainly the resistance to "unproven" technology is very real where prospective payers are concerned. Our proposal for a system of universal
coverage would probably minimize, or at least somewhat reduce, the isolation now felt by many private payers who are understandably reluctant to "subsidize" costs better viewed in a public context; our system could provide policies which are not only uniform but which would be in a better position to balance commitments made to "experimental" and "therapeutic" interventions, respectively. As is the case with any process which is essentially a political one, regardless of what its outer clothing may look like, this is properly a matter of give and take with relatively few "obvious" choices. All in all, the authors do not seem to object in principle to the major tenets of managed care, nor do they seem significantly opposed to the actual administration of this network of health care systems. Instead they seem to be knowledgeable but rather uncritical proponents of technology; it may not be a stretch to say that, at least implicitly, they favor the sort of "technological utopia" discussed above. We must look to other authors for further cautions, beyond those built into the political process itself, regarding the continued high rate of growth in health care of increasingly sophisticated technological applications.

Among the other "caution factors" is the alleged "ratchet effect" of the cost of technology. As Engelhardt has put it "... the costs may be greater (financial and moral) in the case of the development of new technologies than with the use of those already at hand.
These costs are especially troubling when set in the context of the competition for scarce resources . . . " (Engelhardt 1982, page 179). This effect is said to be due not only to general and specific inflationary forces which are applicable. A principle of diminishing returns also may be operant. The eminent scientist Max Planck has stated: "To be sure, with every advance [in science] the difficulty of the task is increased; ever larger demands are made on the achievements of researchers and the need for a suitable division of labor becomes more pressing" (Planck 1949, page 376). A more recent commentator has put it more colloquially: "The need for increasing specialization and division of labor is but one indication of this. A devotee of scientific biography can easily note the disparity between the immense and diversified fertility in the productive careers of the scientific colossi of earlier days and the more modest scope of their latter day successors" (Rescher 1982, page 35). The author notes the greater intractability of problems in modern medicine, given the herculean accomplishments of earlier researchers. Whether all this is true for technology as a whole and for medical technology in particular may be highly debatable, but the ever-rising cost of increasingly sophisticated technology is less so. The causes of these increases are undoubtedly difficult to isolate, but "diminishing returns" may well be among them in some important way. From an ethical point of view, this phenomenon could exacerbate the situation as resources become less adequate
and more and more difficult choices must be made. Ends and objectives come to impinge upon such choices and the means to implement them bear the stamp of greater social input. Therapeutic options appear more and more as alternatives to research; less sophisticated technological interventions become increasingly plausible as scarcity shows itself in more subtle ways. A notable rather specific area where diminishing returns has become all-too-apparent is that of non-infectious, chronic diseases and conditions. Progress in eradicating, or greatly minimizing, many infectious diseases has been steadily impressive, while many noninfectious diseases and conditions have remained incurable as technological advances have in effect rendered them increasingly chronic in their incidence. "Major technological advances, however, have been made specifically for treating incurable chronic diseases, many of which have varying implications for the level of functional ability patients are able to regain . . . improvements in medical technology have produced increasing levels of disability in Western society" (Evans 1983, page 2049). The ramifications for rationing here are evident and will be addressed below; the point here is that diminishing returns in key areas of medical technology have made it increasingly difficult to justify increasingly larger expenditures in these areas while strong competing claims become correspondingly easier to justify.
The burgeoning costs of medical technology and the related increases in the costs of medical care as a percentage of gross domestic product have created a greater need for social control. The macroallocation and the microallocation of medical resources must increasingly involve choices among research options, the production and development of technological equipment, therapeutic remedies, and available clinical resources. Incorporating a denial of an inherent moral right to health care into his analysis of social choices concerning medical care, Beauchamp highlights the primacy of social context here:

Yet we do not agree as a society on the existence of any list of moral rights beyond (perhaps) very abstract rights to life, liberty, and personal property. Specific rights, such as the right to equal employment opportunities or to a new application of technology, are never forcefully assertable independent of a social and legal context within which those rights are granted and insured. Any right to new products of technology or even to health care would be a right of this sort. (Beauchamp 1982, page 57)

The need for social control is perhaps even greater, given our lexicographical preferences for medical care; the demand for medical services comes "off the top" in a way which diminishes the force of the economic factors present.
Let me clarify . . . the meaning of lexicographical preferences, especially in application to medical services. I have suggested that as an empirical generalization, persons demand the outlay of medical services that is 'necessary to maximize survival and longevity' and that such a target of medical care comes to be determined technologically, relatively independently of the manner in which the delivery system is financed or organized. If we are to question this working out of lexicographic preferences on ethical grounds, we must isolate and identify just who is damaged or harmed; in some comparative sense, who suffers as a result of lexicography in preferences for medical services. (*Buchanan 1994, page 63*)

This underscores an even greater need for social control in the areas of medical care and related technology; again the relative uniqueness of the forces under examination requires greater scrutiny and control if they are not to be unnecessarily damaging.

All of these economic and technical factors signal an increasing urgency to rein in our use of social resources in the area of medical technology. These factors are related to, but are distinct from, those cited in the previous section in connection with the relation between autonomy and technology. The ratchet effect of the trend in the costs of medical technology, the phenomenon of increasingly diminishing returns in many areas, the increasing importance of
chronic diseases and conditions, the increased relative scarcity of medical resources, and the lexicographical preference for medical services and related technology have all served to add to this need for greater control. The far-reaching effects of technology must be better understood so that the mixed nature of its providence can be better contained. We celebrate the unparalleled technology now available and that which is to come. We seek only to widen the context of its deliverance so that we may be better served by this marvel. Our stated goal is to integrate these matters into a well-considered system of explicit rationing and thereby to maximize the long-term medical benefit of the entire population.

IV. The Medicalization of Society

The "medicalization" of our society goes hand in hand with the wholesale embrace of autonomy as a value and the headlong pursuit of a technological utopia. The effect here is more subtle and perhaps more "psychological" in makeup. The term encompasses the ever-growing tendency to render more and more of our physical and mental shortfalls within the purview of medicine and therefore of medical coverage as well. Before turning to more theoretical considerations of "health," "disease," and "illness," we offer a few examples to help set the landscape, examples given only to illustrate the considerable potential ambiguity and related flexibility lurking here, and not to express a definite opinion on
these particular matters. The area of long-term care presents a blurring of the line between "medical" and "living" expenses. People must eat but sometimes a special medically-prescribed diet is needed; if people need help for an indefinite term to perform the daily tasks of life required to maintain themselves, are these personal living expenses or are they properly considered "medical" in nature? The tension between "statistical norms" and "functional norms" can be illustrated by the need for corrective lenses. By the age of forty, only some two percent or so of the population does not require some form of vision correction to maintain "normal" vision. Clearly it is statistically overwhelmingly normal for such people to need correction yet it is functionally normal not to require mechanical correction while only about two percent can function normally without it. Typically, corrective lenses are a medical concern but are not covered by standard packages of insurance. Should this be routinely covered?

The line between medically "prudential" periodic examinations and possible wasteful use of resources may be illustrated by tests for breast cancer and for prostate cancer. Absent specific medical indications, beyond what age or ages should these tests be performed as a matter of annual or biennial, etc., medical routine and should such tests be part of the standard insurance package? Recent backtracking by the American Medical Association on the beginning age for routine annual mammograms after a public outcry
tells us more about politics than it does about medicine; to treat this as a purely medical question at this late date may be all but impossible. Lastly by way of example, consider children perceived to be doing poorly in their academic work in school. A line which could be drawn here is that between sub-par academic performance due in part to medical problems such as dyslexia and the like and that which is due to a "lack of aptitude". Not long ago, the latter was largely taken for granted, again except for interfering medical problems; in recent years, the former has come to the fore as a range of "learning disabilities" have come to be increasingly recognized. Are these problems clearly of a medical nature, such as dyslexia is acknowledged to be, or might some of these diagnoses be politically engendered at least some of the time? We do not know "the answer" but it may be becoming more likely that a purely medical answer will not be available. In any event, these examples all seem to illustrate an at least potentially expansive tendency where the "medical" is concerned and what is "medical" virtually by definition is of greater social concern. At a time when limits and priorities are becoming increasingly necessary, such a tendency must at the least be examined more critically.

The concepts of "health," "disease," and "illness," and their numerous progeny have long exhibited the sort of malleability shown above. Depending on the relevant mores, the customs of a given society, the efficiency of particular medical interventions, the
political climate, and doubtless other factors as well, these concepts have increasingly shown expansive tendencies as medical science and the practice of medicine have steadily progressed. The World Health Organization (W.H.O.) has defined "health" in the broadest of terms as a "... state of complete physical, mental, and social well-being" (World Health Organization 1958, page 459). To formulate health policy on the basis of such broad and soft-edged definitional strokes would be unduly idealistic. Although practitioners of medicine have collected and analyzed data on various diseases and conditions at least informally for thousands of years, widespread attempts to come to grips with the notion of "disease" and related concepts like "health" and "illness" are of more recent vintage. Engelhardt and Wildes see a major aspect of the philosophy of medicine to be reflection on key concepts deployed in medicine such as "health" and "disease" as well as more general philosophical questions relating to medicine such as those relating to "life" and "death" (Engelhardt and Wildes 1993, pages 1682-1683). They view "health" as being largely the absence of the dysfunctions, pains, and deformities, rejecting the more positive definition offered by the W.H.O. In "Ideology and Etiology" (Journal of Medicine and Philosophy, vol. 1, no. 3, pages 256-268), Engelhardt took a stance intermediate to those of Boorse and Margolis on "disease" and "illness".
Christopher Boorse had taken the view that health should be analyzed with regard to physiological medicine alone. His position is grounded in a firm distinction between "disease" and "illness," between diminution of function, on the one hand, and incapacitation on the other hand. Two examples will underscore the sharpness of the distinction drawn here, those of fairly serious mental disease and of homosexuality, respectively. According to Boorse, a "fairly serious" mental "disease" (i.e., a condition interfering with function) need not incapacitate a person (i.e., be undesirable for the bearer, entitle the bearer to special treatment, and provide the bearer with an excuse for otherwise criticizable behavior) and therefore need not necessarily reflect an "illness". He views homosexuality as a "disease" because it interferes with the reproductive function but as often not being an "illness" because incapacitation is not present (Boorse 1975, pages 49-68). These examples themselves indicate the unsatisfactoriness of the distinction since any mental disease would have to be rather mild instead of "fairly serious" for its bearer not to be "incapacitated" and since homosexuality has no necessary or even a clear connection with reproductivity. Interestingly, Boorse has since backed away from grounding his position in the distinction between "disease" and "illness," moving to a view of normal function which is statistically-based rather than natural (Boorse 1997, pages 3-134). This purported "value free" account is also seriously flawed, as he continues to view function
entirely in terms of life expectancy and reproductive capacity while virtually ignoring quality of life considerations. Joseph Margolis takes a strictly normative view of "function" and "disease," strongly tying both concepts to the present environment. Declaring Boorse to have greatly underestimated intra-species variation and to have ascribed too much importance to the species at the expense of the individual, he rejected Boorse's dichotomy of "disease" and "illness" while affirming an inextricable link between function and human goals or purposes (Margolis 1976, pages 238-254). For Margolis, medicine is primarily an art and dependently a science.

Engelhardt acknowledges that the essential core of diseases in general is "meager" and "abstract," but recognizes the clear somatic basis of the vast majority of infectious and metabolic diseases. In so doing, he takes a more balanced approach than either Boorse or Margolis. He sees "disease" as an explanatory structure tied to a given syndrome which need not be known to the patient while "illness" is viewed more like a cluster of phenomena to be explained and to which a "sick" role applies (Engelhardt 1976, pages 256-268). Engelhardt's position between Boorse and Margolis leans toward the latter. He sees the former as relying too much on what is "normal" and the latter as relying too much on what is "normative". His position is encapsulated as follows: "... through our own value judgments... we construct a world of communal action and reaction, of planning and reflection--including
the arts and sciences of medicine. To find that value judgments are core to our language of health and disease is not to deny that there are real causes of disease or real empirical factors important in maintaining health or causing disease" (Ibid., page 267). Abraham Rudnick characterizes the "normal" as a regulative idea rather than as an end state, emphasizing the processes of "self-creation" and (mostly) "self-repair" (Rudnick 2000, pages 569-580). Decrying the tendency of modern diagnostic and therapeutic medical technology to emphasize means to the relative exclusion of ends, he sees the normal, not as that which is "common" or that which is "ideal," but rather as a process of self-organization which is operative. Here the perspective is pragmatic and strongly geared to the individual. The "... solution to the demarcation problem requires a gradation between the normal and the pathological" (Ibid., page 577, emphasis supplied). He concludes that his view allows more room for preventive medicine and is more patient-oriented.

We need not engage in a far-reaching discussion about the extent to which our concepts of "disease," "illness," "deformity," "disability," etc. are a social construct which cannot be adequately understood independent of the particular interests of a given community or society. What is of importance here is the degree to which these conceptions have an impact on the threshold, duration, and intensity of our medical interventions, particularly those in the
public sphere. What we are referring to as the "medicalization" of our society is the growing tendency to enlarge the scope of that which is deemed "medicable," i.e., curable or remediable through the ministrations of the science or practice of medicine. Clearly, a good measure of the growing body of conditions considered "medicable" is due to advances in treatment and these developments, at least in principle, should be resoundingly approved. Yet, even here, where the efficacy of new techniques is not to be doubted, one must distinguish the types of interventions which are clearly called for in a societal context from those which are marginal. Certainly not all instances of potential medical benefit should be realized. This point becomes increasingly stronger as the benefit becomes increasingly marginalized. We will examine in some detail below forms of marginalization which turn on other characteristics of classes of patients and individual patients, such as life expectancy and co-morbidity. Here we are more directly concerned with the nature of the benefit itself. Let us briefly re-visit the four examples given above. The nutritional component of long-term care is not unambiguously a medical concern at all, at least in many instances. An individual aged seventy, if covered for the correction of near-sightedness by a public program, does receive a medical benefit but a condition so overwhelmingly normal statistically may not be a medical problem in terms of a broader social focus. The question of the medically appropriate onset age
for, say, annual examinations for breast cancer (or prostate cancer) in the absence of indications cannot be a purely medical one for, if it were considered such, some marginal benefit could be attained from such examinations being given at virtually all ages. What are now called "learning disabilities" may well reflect advances in the diagnosis and treatment, as we believe it does, but is this the whole picture? Might not some of these diagnoses challenge the threshold between a lack of academic aptitude and a medical problem? As Part Three continues, our focus will increasingly be on the need to set medical priorities. Medical interventions which confer benefits which are marginal would come under increasing pressure under a system which incorporates priorities as an integral part of its makeup. The criteria of such a system will of necessity cast a cold eye on interventions at the threshold of the "medical". Such a perspective could not only discourage social commitments for marginal purposes, but could also help to reverse some of the attitudes which have fueled these tendencies.

V. **Rationing**

The term "rationing" ranges from the absolute scarcity situation as, for example, where there are ten people needing a liver transplant when only six are available or where food quantities intended to feed twenty will only feed ten before rescue can occur, to the more common allocation of the marketplace with its price
mechanism providing the fulcrum for the forces of supply and demand. In between these two extremes, one can have a variety of arrangements where some administrative authority is given the office of allocating resources according to prescribed criteria, the variations being limited mainly by the human imagination. Indeed few terms of such considerable impact can boast of such a wide range of attributed meaning.

Reinhardt views "... all limits on the distribution of a scarce good or services to be 'rationing'..." (Reinhardt 1996, page 63) and considers the basic distinction between price and non-price rationing to be a meaningful one. Price rationing operates on the demand side of the equation while non-price rationing operates on the supply side. Reinhardt notes that, in the current "three-tiered" system, the bottom or public tier utilizes supply-side rationing in the form of fixed budgets and reduced capacity, the middle tier of the employed middle class utilizes both supply-side and demand-side rationing, and the top tier utilizes an open-ended fee-for-service system for those who can afford it. In a reorganized fashion, our proposal envelopes these elements. Under our nascent two-tiered system, the public or bottom tier would incorporate only supply-side rationing, i.e., those covered in this first tier would have access to a predetermined list of services for various medical conditions. The second or upper tier would in effect "combine" aspects of the other two current tiers. People would privately pay for services which, in
many cases, would not be covered in the first tier. Unlike the Clinton Plan, which virtually proscribes the attainment of services outside the public tier which are provided in the public tier, our plan would allow for such a "duplication"; the hope, however, is that the majority of such services will in part be provided in the public tier as numbers of additional people gravitate to a revitalized public tier. Those seeking services outside the first tier would make whatever arrangements they are able to make. Some would opt for managed care of some sort or perhaps both managed care and fee-for-service coverage while others might use fee-for-service arrangements exclusively and a few might simply pay for the services as they are received.

Two general points made by Reinhardt concerning schemes of rationing should be taken to heart: 1. All rationing systems deny care to some who would (or might) benefit. 2. The system is to be properly judged in terms of its averages. The first point refers to the need to recognize limits and to set priorities in a system of rationing. It also at least implicitly refers to the important distinction between the unfortunate and the unfair, the former being morally permissible in such an instance and the latter being morally proscribed. The second point may be considered a more specific extension of the first point. In any standardized system where standards represent a "summary" of many actual and potential cases and where patient groupings under condition-treatment pairs
are a critical aspect, some patients will receive care which is substandard or even harmful due to the tension inherently present between a given set of standards and the nuances of the individual cases which arise under them. If the average level of care is sufficiently high, a certain amount of substandard care may be acceptable. A rather stark example may illustrate. The polio vaccine has been extremely successful in a very high percentage of cases and, therefore, the small number of related fatalities is generally viewed as acceptable, given sufficient precautions, etc.; in both instances, success is relative to the number of "successes" and "failures," given what an acceptable level of precautions would be for the task at hand. We will address this in more detail below when the number of covered conditions, the severity of patient conditions, and the mix of patient diseases and conditions are discussed.

The need for a more explicit and coordinated system of rationing in the U.S. is generally recognized by economists, according to Reinhardt, but is recognized far less by caregivers. We have noted the avoidance of the "R" word itself by those working on the various task forces of the Clinton Plan. We have also noted the enduring legacy of the fee-for-service system, an attitude that everything beneficial should be done regardless of collateral consequences. The upshot of all this is that prevailing attitudes, even among those in the health care industry who are in
a position to know, remain an anomaly. However, as we will see below, the receptivity to some form of supply side rationing is growing, especially among leading commentators in the area of allocation of health care resources. Commentators who deny the need for rationing claim that other areas of social expenditures could be cut to make room for increasing health care expenditures (Etzioni 1993, Public Policy In a New Key), that a needs-based system can continue if only we can start spending less of our gross domestic product on health care by relying less on sophisticated technology (Ayers 1992, pages 132-142), that we can avoid rationing by sharply reducing inappropriate expenditures for excessive administrative costs and for treatment which is essentially futile and therefore wasteful (Tartaglia 1992, pages 44-50), or that we can avoid rationing by returning to the widespread pre-managed care practice of cross-subsidization where the more healthy "subsidize" the less healthy (Wikler 1994, pages 263-273). Implicit in much of this is the view that any major move away from a needs-based criterion of distribution is morally impermissible, a denial of the inherent moral right to health care. The status of this alleged moral right was examined in Part One and it was found to be lacking.

Unfortunately, many of the arguments against specific aspects of rationing, as well as those which oppose it in general, continue to rest on this often unstated premise. When we propose, for
instance, that expenditures for the elderly should be limited in certain ways, opposition will crystallize around the argument that this would constitute invidious discrimination. Putting aside legal considerations which can readily and rightly yield moral consequences in many instances, such arguments on behalf of the elderly amount to a need-based appeal to a moral right. Since health needs increase with age, resistance to limitations in this area in effect prioritizes the health care needs of the elderly while attempts to impose restrictions are seen as discriminatory attempts to diminish the status of the elderly vis-a-vis others. Attitudes of this sort are enhanced by the fact that nearly all of us have agonized over the decline in health of older relatives and by the natural fear we all have of growing old and infirm. Attitudes involving the handicapped are parallel to those concerning the elderly. Greater needs are readily apparent here as well and, again, a de facto prioritization of these needs is much in evidence. Again, attempts to impose restrictions are often seen as being discriminatory in an invidious way. Here the Americans with Disabilities Act (A.D.A.) of 1990 is a potentially imposing barrier, as we will see below, to virtually any form of supply side rationing. Here again, many of us have relatives or friends who must contend with a handicap and all of us realize we are one unlucky event away from a similar fate. Attitudes such as these are clearly the product of a needs-based criterion for the allocation of health care
resources. While a needs-based criterion is not *logically* wedded to an inherent moral right to health care, the affinities are exceedingly strong; conversely, to argue in favor of a benefit-based criterion in light of costs is to have an affinity for positions which oppose the recognition of an inherent moral right to health care. Thus, the arguments we are offering in favor of a benefit-based criterion in light of costs are closely related to those made in Part One against the recognition of an inherent moral right to health care. As we suggested at the close of Part One, this position is central to our overall position, directly supporting much of it while also serving as a part of its core which sets a general tone for this project as a whole.

Our position, in a nutshell, is that it is morally permissible to have a public system for the allocation of medical resources which is efficiency based (i.e., medical benefit per unit of cost or Q.A.L.Y.'s) so long as no inherent moral rights are violated; we deem such a system to be, if not morally mandatory, at least morally preferable, based on a greater overall benefit in the long run to the population being served. The system is to be rule-based, rather than act-based, and should be judged more according to its averages and not its anomalies. Administrative procedures are to be reasonably democratic, blending the expertise of caregivers and the population to be served. While long-term benefit to the population being served is to be the measure, the
allure of numbers must not be allowed to impose its own form of tyranny bespeaking a precision on the surface which is the product of countless compromises and unavoidable inexactitudes as well as of scientific thinking and its technological apparatuses. Considerations of fairness are to be a counterbalance to the cadence of the numbers, at the interstices of the system. An efficient yet balanced system is to be the product of these reforms. The goal, perhaps somewhat paradoxically, is to achieve greater fairness through greater efficiency and greater freedom through greater responsibility.

Macro-allocation and micro-allocation are both needed in a system of rationing. At the highest macro-economic level are the amounts a society apportions to health care in general. Amounts allocated within those amounts are in turn apportioned within the health care sector, to hospitals, to education, to research, etc. Amounts allocated for particular types of services are included here such as A.I.D.S. vaccines, the E.S.R.D. (dialysis) program, or the amounts allocated by a hospital for emergency care or its I.C.U. division. Allocations of a more micro-economic nature occur at the level of amounts apportioned for particular services such as ventilators or machines for heart-lung transplants or choices to be made among individual patients such as candidates for organ transplantation as well as decisions regarding particular patients. The distinctions between macro- and micro-allocations are not
always firm and clear since they are essentially relative to a given health care entity or to some Governmental unit. As we noted in Part Two, the primary general tools for allocating or rationing health care are C.B.A. and C.E.A. While the latter deals with the more narrow concern of comparing the cost of alternative health care initiatives, the former has the more daunting task of measuring in dollars benefits, as well as costs.

C.B.A. makes use of the D.F.E. and W.T.P. techniques, respectively, both of which are subject to strong ethical objections. The former is firmly tied to actual and potential earnings and thus the existing wage structure is effectively incorporated. As we noted in Part Two, this method is not only open to the objection that some lives would then be "worth" more, even much more, than others--a morally repugnant conclusion, but is also open to the more fine-grained objection that large groups of people, women and racial minorities, earn systematically less and would fare much worse under such a measure. Also controversial but more widely used as well (Menzel 1995, page 652), is the W.T.P. method. The objection here is to the means-related basis for the method, the natural reluctance we have of trying to convert health care benefits into an economic equivalent. At the highest macro-economic level, that of the U.S. Government, C.B.A. must enter the equation at some point since health care benefits must be weighed along with and "against" education, national defense, various entitlements,
and a host of other items. Though flexible to a degree, the Federal budget is a finite resource and hard, intangible choices must be translated into equivalent economic units, regardless of how distasteful many may find this. W.T.P., again as noted in Part Two, will figure in our proposal in some way in both the first and second tier. Especially in the second tier, people will have to decide for themselves the relative monetary value they place on various health care coverage options vis-a-vis other competing economic choices. W.T.P. will be part of the decision-making configuration in a parallel way for the Government in its budgetary deliberations while Q.A.L.Y.'s (importantly, a C.E.A. technique) will be the dominant technique in formulating the prioritized "laundry list" of services. We will also elaborate below on the decisive importance of W.T.P. in the second tier while Q.A.L.Y.'s will be the fulcrum for deciding on the preferred medical package. We will defend the extensive use of this technique in opposition to allegations of discrimination primarily against the elderly, the handicapped, and the poor.

Given the rather broad prevailing notions of "rationing," arguments that it is not needed seem quaintly moot. Arguments that it is not morally permissible, as we have seen, turn on the discredited view that there is a need-based inherent moral right to health care; however, we maintain the case for a comprehensive and systematic plan of rationing in the U.S. should be recognized
on the basis of compelling positive claims which can be saliently made on its behalf. As we will see below, a number of leading commentators believe a more systematic rationing function is needed in this country; this is the case even if one assumes something like the current "system" (see Mc Cullough 1994, pages 483-490), denying we have any such thing) will continue. If one posits a new plan featuring universal coverage, as we are, the need for rationing is, if anything, even more clear as the need to carve out medical priorities within an essentially fair schema designed to implement new patterns of distribution emerges. We are, however, at the same time mindful that new benefits for millions of people also trigger a need for more efficient cost controls at each level. Fortunately, the savings from administrative consolidations and the efficiencies of standardization will provide a strong start in that direction so that concerns about maintaining and impairing the quality of care can be minimized at the same time.

Although a rather lukewarm endorsement of rationing is forthcoming, in a 1995 article Ralph Forsberg raised important questions on the moral preferability ceteris paribus of rational justifications over random procedures (Forsberg 1995, pages 25-42). He does not attack the use of random procedures and their attendant random results where there is no apparent good reason for proceeding otherwise, but argues the use of random procedures where there are good reasons for the use of non-random
procedures is itself an *irrational* choice. A random procedure is seen as being capable of being systematic but lacking in the particular justifications needed to make it rational in many instances. Forsberg maintains that "... other procedures such as *social worth* or purely *medical evaluations*, are more thoroughly rational, in that they are both systematically and particularly rational ... than random procedures" *(Forsberg 1995, page 26, emphasis supplied)*. As we have indicated, medical benefit in light of costs is to be the main criterion in our proposed system for assigning medical priorities. However, it would be naive to view "medical benefit" and "social worth" as being neatly distinct; any realistic contextualization of medical prioritization will intrude into the realm of social worth. What is important here is to create an environment of transparency, as we saw above in a more general way, so that the open texture of these categories can be more clearly seen. Consider the example given by Forsberg of a life-saving kidney which is to be made available either to C. Everett Koop (the former U.S. Surgeon General) and a "hobo," with both candidates being virtually equal in terms of "purely medical" criteria. Forsberg contends that, since the lifestyle of an essentially homeless individual is at odds with the meticulous follow-up care which is an integral part of the transplant process, Koop should get the kidney; here the boundary between the "medical" and the "social" is crossed but in a way which never completely steps outside of the
former. While some might still argue for a selection by purely random means (e.g., *Childress 1970*), far more troublesome would be a case where the hobo is replaced by a respectable middle class individual less "distinguished" or "accomplished" than Koop. Here few would approve of awarding the kidney to Koop *simpliciter*, in spite of his apparently greater "social worth". Even if a suitably representative body at the appropriate level were to be installed and given the power to go beyond "medical" criteria, such an authorization would seem ill advised even if *arguendo* it is morally permissible. To mix in this way medical criteria and criteria which are not "medical," even in an extended sense, would be recklessly to risk loss of public confidence. Indeed such a policy could lead to more general challenges to the overall legitimacy of such bodies.

A ringing endorsement of explicit rationing is offered by Baker (*Baker 1992*, pages 208-229). Writing from the perspective of an Englishman versed in the British National Health Service, he decries the implicit rationing of that system which, in his view, only tends to reintroduce longstanding social biases. Specific recommendations include a de-emphasis of acute care, chronic care, and home care, while Rawls' "publicity principle" is cited in support of an *explicit* approach to rationing. We will argue below that a system of explicit rationing is needed but, as we will also argue, *implicit* rationing must also be part of the system to implement and supplement any scheme of explicit rationing.
Daniel Callahan, perhaps best known for his writing on health care and the elderly, endorses rationing as the only way to guarantee a decent minimum to all and to effectively control costs (Callahan 1992, pages 2-13). He also recognizes the challenge of setting the first tier at a level high enough to eliminate basic disparities and the moral necessity of a second tier. The Oregon policy of rationing health care procedures instead of people, as under present circumstances, is applauded by Callahan. The decent minimum, in his view, should take into account: 1. medical need; 2. the efficacy, costs, and benefits of the various treatments; 3. the use of a political process and public involvement to set priorities. In outline, we are in firm agreement with these positions; in practice, the balance between need and benefit in relation to cost would reveal the depth of this agreement. There is nothing in this article which would rule out in principle our proposed heavy reliance on Q.A.L.Y.'s to achieve the proper balance.

David Eddy makes a number of definitive points in an unusually forceful way. At the very beginning of a 1994 article entitled "Health Care Reform: Will Controlling Costs Require Rationing Services?", he answers: "Unfortunately, it will" (Eddy 1994-2, page 324, emphasis in original). He supports this conclusion with the following propositions: 1. There is a critical need to better control costs. 2. The needed cuts in costs are deep. 3. Cost controls which are needed cannot be controlled by administrative
efficiencies alone. 4. The content of care is growing faster than the G.D.P., i.e., beyond general inflation and increases in the population, due to medical price inflation in excess of general inflation and increases in the volume and intensity of medical services. The latter point is especially strong, since it isolates medical costs in such a cogent way. Over the thirty year period from 1961 to 1991, health costs exceeded the per capita Consumer Price Index by an average of 5.2% per year, with seventy percent of this excess deriving from increases in the volume and intensity of services (Ibid., page 327).

These figures strongly support the view that, the more we have increased public expenditures for health care, demand has increased even faster. Any successful system of rationing will have to come to grips with the burgeoning increases in the volume and intensity of medical services. Another unusually salient point is made by Eddy concerning the limits of the effect of administrative savings at present. Such savings can only "buy time" rather than providing any more permanent "solution" to the explosion of costs. He states:

... it might seem that if we eliminate an item that is three percent of the budget, then that three percent should be saved every year thereafter and the problem should be solved. However, that would be true only if the portion of health care costs that was growing faster than the G.D.P.
were contained completely in that item, which is not the case. The fact is that every component of health care costs is growing at a faster rate than the G.D.P. Even as successive components are reduced or even eliminated, the remaining components continue to increase . . . faster than the G.D.P. . . . the fact is that as long as any of the remaining components in the budget are growing faster than the G.D.P. we will need to continue to find savings. (Ibid., page 326)

The empirically-driven themes of this article receive much of their philosophical impetus from an article published less than two months before (Eddy 1994-1, pages 1792-1798).

The article is aptly titled "Principles for Making Difficult Decisions in Difficult Times." Eddy emphasizes here the necessity to set priorities for any sizable program funded from shared revenues but that this is all the more the case where our present situation is concerned. The recognition of priorities is said to entail the further recognition that it will not be possible to cover every treatment that might be beneficial. The central objective of a health care system is seen as being the maximization of the health of the population served, subject to the available resources. Although Eddy views the "population served" as being that of the particular constituency to be served (Medicare beneficiaries, members of a particular H.M.O., etc.) rather than virtually the entire population as under our plan for universal coverage, he speaks of the "health of
the population" as well. In that connection, he states, "The more difficult concepts are how the benefits to an individual should be measured, and how the sum of benefits to a group of individuals should be calculated so as to maximize the total health of the population [which] requires that you think of a measure or scale that you can use to compare the benefits of different treatments" (Ibid., page 1794, emphasis supplied). What is suggested here is a cardinal ranking of treatments paired with the conditions they are designed to treat. To the predictable objection that this would entail denial of treatment to identifiable individuals before us, he makes four points in reply: 1. To give in to this attitude is to run counter to the need to set priorities. 2. Such choices have already been implicitly made for decades. 3. The overall benefit available to the patient population served is thereby enhanced. 4. Treatments which have a high value would receive a low priority only if its benefits were too small to justify its cost.

Alternatives to this proffered central objective of a health care system which are rejected are the giving of "priority to treatments in the order of the severity of the health problems they treat" (roughly "need") and "to rank treatments by the amount of benefit they provide to an individual patient." The former is rejected because it is not tied closely enough to the likelihood and degree of benefit while the latter is rejected because it is not tied to the cost of the treatment. Thus, even "medical benefit" is insufficient as the
overriding criterion if it is construed too narrowly, encompassing benefit to the individual patient rather than to the patient population served, and does not envelope the social sacrifice or cost involved. Eddy acknowledges such a criterion would have an impact on the traditional physician role of patient advocate, since they would be required to look beyond their own patients to all of the patients in the population they help to serve. He seems to think, however, that the apparent resulting need for "bedside rationing" can be obviated by establishing appropriate guidelines for physicians to follow.

We will address below the impact our proposed changes would have on professional standards and on the physician-patient relationship. As we indicated above, in Part Two, we will propose a bifurcated professional standard, following the suggestion of Morreim, which separates the "standard of medical expertise" which is owed to all from the "standard of resources use" which governs the level of medical resources available to the patient. We do not believe, as Eddy does, that physicians would be able simply to follow guidelines "without having to suffer the anguish of making the decision themselves." There will always be "borderline" cases and the "letter" and the "spirit" of a rule do not always command the same result in a given case. In addition, much of the "give and take" of assigning medical categories, more or less spread out among the patients treated by a given physician, which we see
under the present system, would remain even if the categories become more nuanced and responsive as expected. Then, as now, excessive unexplained systematic "deviation" from the patterns set in the controlling guidelines might well trigger an institutional response.

Q.A.L.Y.'s are not mentioned in either of Eddy's articles, yet the explicit recognition by him that prioritizing treatments will require estimating costs as well as the probability of relevant benefits and harms seems to open the door to such considerations (*Ibid.*, page 1796). Eddy does call for input from people who would be receiving treatments as to what their preferences are. As we will see below, this at least alludes to a major controversy involved in installing a Q.A.L.Y.-based system of priorities, i.e., how to weight the opinions of those who are not afflicted as to the relative quality of a given sub-normal medical state vis-a-vis the opinions of the afflicted themselves. We will examine this controversial issue below in our defense of the extensive use of Q.A.L.Y.'s. Eddy's principles are certainly compatible with our proposed reforms; he gives a superb analysis of the need for rationing and in calling for a system of rationing which explicitly takes into account cost as well as medical benefit and need.

The rationing of care and not people in Oregon has been applauded by no less than Norman Daniels (*Daniels 1992*, pages 185-195). Acknowledging that the broadening of access in Oregon
was achieved through prioritization, he declares that, on balance, the Oregon Plan does serve equality. For Daniels, "equality" is achieved if equality of opportunity is protected at each stage of life and "normal opportunity range" is thus promoted. We concede Daniels would not approve of the contours of our rationing plan, but he clearly does not believe that rationing per se is morally incompatible with the "right" to health care. At least he has come to recognize the increasing need for some form of rationing. We will examine in the next section Daniels' analysis of some of the more intractable questions to be encountered on the road to rationing (Daniels 1994, pages 27-29) and his related views which impinge on the "rule of rescue" and the hold it appears to have on us (Daniels 1986, pages 1380-1385).

VI. The Rocky Road to Rationing

In this section, we will encounter some of the more difficult moral questions presented as one moves toward the construction of a system of rationing. Along the way, we will consider issues presented under conditions of absolute scarcity and situations involving triage. The purpose is generally to clarify and clear the way conceptually for the Q.A.L.Y.-based system of rationing to be proposed and to strengthen the arguments to be made on behalf of that system. We have acknowledged need as an important criterion for the distribution of public resources for health care but
have rejected a needs-based criterion as the focal point. We are opting for a benefit-based criterion as the focal point but only in light of cost. Although advocacy of a needs-based criterion has by no means disappeared from our position, a benefits-based criterion as the focal point can be more strongly defended, not only in terms of superseding considerations of need but also in terms of substantially including cost as a central factor. Advocacy based on need is usually done in the name of "fairness". While Rawls seems to have been intent on avoiding detailed discussions of the relation of his two "principles of justice" and the distribution of health care resources, appeals to fairness against the minions of efficiency are not uncommon and may well reflect Rawlsian influences. We believe, however, that our emphasis on the larger context of health care distribution and on the long-term consequences of the policies in place can achieve a better balance between medical benefits and costs. Fairness is relevant to our deliberations but is largely supervenient upon our search for a just scheme based on these considerations.

We begin here with two articles by Daniels. The first is "Why Saying No to Patients in the U.S. Is So Hard" (Ibid.). He begins with the system in England and shows why saying "no" is far easier there than here. He notes that, while rationing does occur at the macro-economic level of publicly funded health care in both countries, it exists at the micro-economic level of the individual
patient only in England. The system in England provides universal coverage and is "closed," meaning that all medical resources within that system, where physicians are employed by the Government, are constrained by a centralized budget. These are the two essential differences which account for the difficulty in saying "no" to individual patients in the U.S., thereby not denying them beneficial care, while in England this is routinely done. Daniels points out that, under the English system of universal coverage with centralized budgetary constraints, there is widespread recognition that ordering services for a given patient at public expense can prove to be unfair to other patients within the same system. Physicians in the U.S., on the other hand, cannot make the same appeal to fairness in saying "no" to individual patients, instead responding with beneficence to perceived medical need, there being no assurance that a denial of service to a given patient can be justified so as to better serve the subject population. Thus the individual patient remains the all-but-exclusive concern.

A comparison of the "closed" system in England and the system of universal coverage we are proposing for the U.S. would be rather complicated with regard to the appeals to fairness that could be made to patients who have been told "no". Clearly we are not advocating a system of socialized medicine where budgetary limitations within a closed system can easily produce a "zero sum game" where one patient's ill-gotten gain of service can signal the
undeserved loss of service by another patient, and where the same considerations might apply on a wider scale to certain decisions made with regard to a class of patients. Under the system we are suggesting, whether services are offered in the first tier or not, they would very likely be available in the second tier, reflecting the "open" character of the system. In addition, we recognize the limitations of a rule-based system in terms of the amount of detailed guidance which is feasible and the further limitation which requires a la Rawls and others an open and public codification of rules. In the foreseeable future, in any event, no health care system in the U.S. could succeed in having its rules implemented by the internalization of rules and policies to the extent this is apparently done in England. The upshot of this comparison in terms of the rationale supplied to individual patients in the event of denial of desired care is roughly: 1. The explicit side of the rules of rationing under our proposed system must be more robust than in England, so that patients are aware of these public and open provisions. 2. The implicit side of the rules of rationing (i.e., bedside rationing) under our proposed system must be less robust than in England, so that patients would be subject to less covert rationing. 3. Our proposed system will not produce "zero sum game" situations except where conditions of absolute scarcity attach as with organ transplants or triage conditions as with I.C.U.'s, so seldom can anyone assume that "improperly" conferred services will directly
prejudice the availability of services to another patient. 4. The crucial ethical constraints needed _here_ may be viewed in terms of the averages represented, so that, given due allowances for patient mix and other such factors, it will be the responsibility of the physicians actually rendering care and, derivatively, those who must monitor the resulting practice profiles, to achieve a matrix of care which approximates in the long run expected rates of morbidity built into the system. 5. The ethical appeal to be made to physicians and patients alike, but with the former bearing the brunt of the responsibility, is roughly this: If you bend the rules too often, knowingly falsifying official documents or resolving all doubts, whether reasonable or not, in favor of ordering more services, you will be a factor in the distortion of future allocations, both in terms of the services improperly ordered and the other types of services affected by any resulting re-allocation. For example, if an expensive open heart procedure is ordered significantly more often than it should be, the procedure may be eliminated from coverage altogether or the guidelines for the procedure may become more stringent, thereby reducing (or eliminating altogether) the coverage formerly available to others who have not been the recipients of questionable care. Obviously, any number of examples come readily to mind in this area; the common aspect is that deliberate distortions which abuse the system, beyond their inherent dishonesty toward all others within the system, will beget
adjustments not previously intended and not otherwise appropriate, thereby resulting in further distortions. And so on.

The relation of the problem of saying "no" to the "rule of rescue" may be noted, although Daniels does not explicitly mention it in this article. While this rule requires rescue in some instances, even its adherents do not view it as requiring undue sacrifice if that is what would be required to achieve the "rescue". But somehow the rule retains a hold on us; we are made to feel we are callous in some way if we even think of limiting our assistance in a given case, yet we should not allow the emotional hold of the rule of rescue to blind us to the most general requirement of justice: morally similar cases are to be treated the same. One commentator who sees the rule of rescue as a significant block to the universalizing of coverage is Morreim (Morreim 1994, pages 455-470). Where medicine is concerned, she declares society must decide whether to rescue at all and, if so, which levels of effort are reasonable. In mentioning areas which should force us to think in terms of limits and a requirement of similar treatment for similar cases, she lists not only the E.S.R.D. program and emergency room policy, which reflect conditions of absolute scarcity, but mandatory insurance coverage and the law of health insurance contracts as well, which reflect conditions of relative scarcity. The inclusion of the latter refers to more typical types of states of affairs and is the key to Morreim's analysis. Disdaining
the economic insulation often engendered by the "buffer" of
insurance and the "unholy alliances" it can produce, she
emphasizes the positive side of insurance. If patients have a
reasonable amount of choice between and among umbrellas of
health care coverage, they are deemed to have chosen which
rescues should occur and which, by implication, should not occur.
The union of choice and responsibility here is pervasive and is
emblematic of our approach.

The choices and the concomitant responsibilities engendered
by our proposal reflect both public and private exercises of
autonomy. The public choice of a public tier with a host of
provisions and procedures, grounded in open and reasonably
democratic proceedings, is a valid exercise of autonomy at the
social level. Such a choice would be legally (and consequently)
morally binding. At the individual or private level, choices freely
made to secure second tier coverage to supplement or supplant
coverage in the first tier represent choices among medical and non-
medical options as well as choices among medical options. As
such, once our moral requirement of a reasonably unencumbered
second tier is met, these autonomous decisions would shape the
legal and moral rights which are thereby generated. Thus, choice
and responsibility are integral to our project. Since there is no
moral right as such to health care, no moral claim beyond legally
recognized rights to health care need be acknowledged.
A definitive exclamation point placing the rule of rescue and the rationale for rationing in perspective, respectively, is supplied by Fleck. He isolates and distinguishes the rescue situations by arguing: 1. Rescue situations are far less frequent than cases presenting the rationing dilemma. 2. State of health is a virtual non-issue in rescue situations unlike in rationing. 3. No tradeoffs are made in rescue situations unlike in rationing. 4. Rescue situations are somewhat *ad hoc* and unpredictable, unlike rationing situations which are far more predictable in the long run. 5. The inconsistencies (and even hypocrisies) of rescue situations surface if we try to universalize them (*Fleck* 1994, pages 93-105). These points underscore in a succinct way some of the fundamental differences between the rule of rescue and the rationale for rationing in a milieu of relative scarcity. The former is characterized by situations which are largely *ad hoc*, which typically lack a context beyond the surface situation, and which do not readily lend themselves to universalization. The latter, on the other hand, are not as random, are typically more contextualized, and are more readily amenable to universalization. The needs-based, emergency-generated demands for assistance in "rescue" situations cannot provide a foundation for assistance in the far more frequent "non-rescue" situations which face a prospective system of rationing. Under our projected reforms, all of us would be making public choices in deciding the coverage available in the
first tier and many of us would be making private choices in the second tier by fine-tuning first tier coverage. In any scheme of rationing, the hold of the rule of rescue must be broken; only then can we proceed to make the hard choices involved in an open, reasonable, and democratic way.

The second of Daniels' seminal articles (Daniels 1994, pages 27-29), outlines the intractable general dilemmas and tensions which must be confronted if rationing is to be actualized. He lists four "unresolved rationing problems": 1. Fair chances versus best outcome. 2. How to aggregate benefits. 3. The assignment of priorities. 4. The democracy problem. Although the "democracy problem" can be viewed somewhat in isolation, the other three are intricately related with a generous amount of overlap. The problem of democracy has two essential dimensions. One is the respective weights to be given to the opinions and wishes of the public as a whole and the segment of the population which suffers from the various afflictions the system is presumptively supposed to address, respectively; the other is the extent to which apparently "flawed" results should be accepted when they are the product of fair procedures effectively implemented, while a subsidiary question would concern the design of these procedures beforehand. We will address both of these dimensions of the democracy problem in the next section on Q.A.L.Y.'s; we will have to find a way to balance the concerns of the healthy and the sick as well as the sometimes
different concerns of different demographic and socio-economic segments of our society.

Basic considerations of fairness underlie the controversies which swarm about in the other three areas—abbreviatedly aggregation, priorities, and outcomes versus fair chances. Aggregation presents its own particular problems which tend to center on commensurability between more modest benefits more widely diffused "versus" more extensive benefits less widely diffused, the sort of problem which originally perplexed the consequentialists of the 1800's. Clearly there can be no divining rod of commensurability here, especially where costs enter the equation as well which they often inevitably do. If the costs were equal, a choice a la Oregon between funding some thirty-four transplants or including some fifteen hundred new individuals under Medicaid would be a classic example. Oregon decided in favor of the new participants, a difficult choice but one we are in general agreement with because of the emphasis on broadening coverage and on primary care. Daniels gives the example of X's being sicker than Y's where the benefit per cost (roughly, Q.A.L.Y.'s) is equal for both of them. This example is presented as a "priorities" problem, his response being foreshadowed by his threshold question being framed in terms of which priority should be given to the sickest patients. He states, "Most people believe that if a treatment can deliver equal benefit to X's or Y's, we should give
priority to helping X's, who are worse off to start with" (Ibid., page 28). He suggests X's should win in a tie-breaker in this example as the sicker of the two but then confusingly adds that he probably would favor Y's having some lesser-benefits so that X's could have more benefits but only "up to a point". Here we have an appeal for some priority on the basis of need beyond tie-breaking with the limits left extremely vague. He thus moves from a tie-breaking consideration which is at least plausible to an unarticulated basis for an important trade-off in favor of those who are sicker. Daniels then reverts to a tie-breaking mode in taking to task a pure "slide rule" approach to the setting of priorities here, stating: "... we should give priority to helping X's, who are worse off to start with. This intuition is ignored by some uses of cost-effectiveness or cost-benefit methodologies, which may be neutral between X's and Y's if the benefits and costs are the same" (Ibid.). Daniels' implicit acknowledgment that a canonical gauge of commensurability is not to be found, and that any system which must assign weights to various qualities is in a sense precariously proceeding as though such a "find" has somehow been achieved, is well taken but the analysis here is obscure. He mentions percentage of improvement as another factor to be considered without further comment. This is a factor often introduced to give a measure of priority to the sickest, especially where Q.A.L.Y.-type criteria are relatively equal. The considerations here are somewhat parallel to those mentioned
directly above where one should distinguish tie-breaking considerations, on the one hand, and those which are to be given weight in the formulation of more general standards, on the other hand. We will treat these issues further in our discussion of major objections to Q.A.L.Y.'s. We will not be in favor of moving nearly as far away from C.E.A. and C.B.A. criteria as Daniels appears to be in favor of the sicker but, in general, where the quantitative measures are roughly equal, some considerations in favor of the sicker may be appropriate.

The area of "fair chances" versus "best outcomes" also represents an attempt to limit the scope of influence of probable outcomes; here, however, the appeal to fairness is generally less closely tied to the probable outcomes involved. The example given by Daniels in this article amply illustrates this. He assumes the only relevant difference between Alice and Betty, candidates for a heart transplant, is that the former has a life expectancy of only two years while the latter can be expected to live another twenty years. An example at the macroallocational level might involve a choice between funding Treatment1 which has consistently but not uniformly better results than Treatment2 while a few people can only benefit from Treatment2. In both instances a perspective purely oriented toward outcomes (again C.E.A. and C.B.A.) would eliminate any chance Alice or the prospective beneficiaries of Treatment2 would have to benefit from the choice. Relatively few
would seriously question a compromise "solution" in such cases where some chance was accorded, although the scope of the chance could well be a bone of contention; here Alice might be given a one-tenth chance to draw a successful lot for the organ where, in the other instance, funding could be in the ratio of benefits per patient or perhaps the ratio of benefits per patient times the prospective number of patients for the fiscal period, for the respective treatment options. In the next section, we will be advocating a Q.A.L.Y.-based system of assigning medical priorities. The examples of Alice and the prospective beneficiaries of Treatment2 could be consistent with such a system if the overall prospective measures for the subject population are not thereby compromised. This may well be the case in instances similar to the former example but would be vastly more complicated for the appropriate deliberating body(s) where cases are analogous to the latter example.

As one commentator put it, summing up the severe challenge lurking here: "... there is no perfect fit between intuitions and method-generated answers, but as long as the answers fall within the range of the intuitively acceptable and there is intuitive support for the method itself, there may be no problem" (Kamm 1994, page 29). This rather general statement may leave too much room for our moral intuitions. The author opts for a number of general propositions, most of which seem sound: 1. The tension between
outcomes and maximin is acknowledged. 2. Life expectancies should be taken in account. 3. Outcome differences should count for less in a zero sum situation. 4. Q.A.L.Y.'s matter less than life expectancy. 5. Numbers of people do matter unless the difference is relatively slight. 6. Even a big difference in quality of life should not be weighed heavily so long as the person involved is reasonably content (ibid., pages 29-32).

The first, third, and fourth of these propositions may be fairly said to be superseded by a Q.A.L.Y.-based system, the second and fifth are effectively subsumed by such a system, and the sixth is somewhat contrary to it. Concerning the "alternative" of maximin, whenever it yields a very different result than an outcomes approach, it is the suspect approach. As John Harsanyi put it: "... in cases where the two principles suggest policies very dissimilar in their consequences so they are far from being equivalent, it is ... always the maximin principle that is found to suggest unreasonable ones" (Harsanyi 1975, pages 595-596). Our point is that maximin is superseded by outcomes, producing better determinations in instances where the two conflict. As for outcomes counting for less in a zero sum situation, the dire prospective result suggested by such a circumstance raises the possible benefit by that much more, a factor explicitly taken into account in a Q.A.L.Y.-based system. Similarly, the relatively greater uncertainties associated with quality of life considerations
as opposed to life expectancies are overwhelmingly likely to cause such factors to be less heavily weighted than life expectancy, a far more certain measure.

The propositions concerning taking life expectancies and numbers of people into account are squarely in accord with the Q.A.L.Y.-based system we envisage. As for the point about slight differences in numbers of people being disregarded, this is a question of degree where *de minimis* considerations can be applied where appropriate.

The suggestion that even sizable differences in quality of life should not be "heavily weighed" if the person involved is "reasonably content" seems to conflate the objective and subjective aspects of this matter. As we will suggest in the next section, the subjective input of people directly affected would be an integral part of the process while the policy determinations of the appropriate representative body(s) would be the actual vehicle of decision-making.

A look at situations and policies involving organ transplants and the E.S.R.D. program can further illustrate our views on three of the four areas of "unresolved" rationing problems, i.e., fair chances--priorities--aggregation (not democracy). Further, while transplant situations involve a condition of absolute scarcity, the E.S.R.D. program involves conditions of relative scarcity. Consider the area of multiple organ transplants; in such cases, organs which
could have saved more than one life are used to save a single life; here we see, in effect, "aggregation" pitted against "need". Paul Menzel cogently framed the issue here thusly: "But if organs are scarce, and those used in multiple organ scarce transplants could virtually always have saved more lives if used on others, what can possibly justify any multiple organ transplant candidate's elevation to the top of the queue?" (Menzel 1994, page 22). Here aggregation is clearly called for, given only the very likely supposition that other matters are approximately equal, and yet present policy in the U.S. continues to allow for increasing numbers of multiple transplants. Or consider the area of re-transplants; here we see, in effect, "fairness" pitted against "need"; here an individual likely to be even sicker is allowed a second chance at a transplant before another candidate is afforded a first chance. Clearly it would be an abuse in terms of medical benefit if the re-transplant candidate had a lower survival probability and received the organ, but if the probability of survival is similar then other factors could be considered which might favor the re-transplant candidate.

The E.S.R.D. program, founded in 1972, presents moral questions of priority; here "priority" is pitted against "need". Also, since 1987, the United Network for Organ Sharing (U.N.O.S.) has had the authority to implement a national system of uniform policies for the allocation of kidneys, among other organs; here there is some attempt to balance "need," "benefit," and "fairness". Thus the
two programs virtually cover the public field for those with prospective renal failure and together envelop conditions of relative and absolute scarcity, respectively. The criteria which guide U.N.O.S. are those of likely medical success, waiting list time, and urgency of need (Benjamin et al., 1994, pages 858-860). The criteria are to be balanced in a fair and efficient way. There is no explicit reference to cost or even benefit in these criteria, yet "benefit" and "cost" can hardly be divorced from medical success. Indeed in practice, even age, which is clearly a major factor in determining projected benefit, is largely disregarded in U.N.O.S. Although Benjamin seems satisfied with the policies and practices of U.N.O.S., Arthur Caplan has focused on a number of things which are seriously lacking here (Caplan 1994, pages 1708-1709). Noting that widened eligibility criteria point in the opposite direction of an increasingly tighter supply, he opines that failing to adequately take age into account not only substantially increases the demand for scarce organs, but it also diminishes the benefit to be received from those scarce organs; he also notes that giving priority to the sickest patients also tends to reduce the prospective benefit. Caplan goes on to oppose the role directly and indirectly played by the prospective patient's economic status, but here he seems to lapse into inconsistency and to mistake objections which in fact lie deeper in the system with those which he asserts at the level of current policy. He states: "A primary concern is the role of
money. An individual with good primary care has a better chance of being identified as someone in need of a transplant. . . . Economics also affects who gains access to the waiting list, since a patient must demonstrate the ability to pay transplant-associated costs to be considered" (Ibid., page 1708). If primary care is such a problem in that it is not available to all, a situation we hope to see remedied, the blame should be placed at that level and not further "downstream" as Caplan has done. As for transplant-associated costs, since these must be paid out of pocket at present, it would be counterproductive to award organs without considering these costs. Whether such costs, or the transplants associated with them, should be covered is a separate issue; the "answer" under our proposal would turn on the priority assigned to the relevant condition-treatment pairs and the level of publicly-funded condition-treatment pairs.

A fairly similar tale can be told regarding the E.S.R.D. program, where conditions of relative scarcity obtain. In the first place, the program covers anyone who can benefit from kidney dialysis, even though no such generous universal program exists for any of the prospective organ failures which are parallel to kidney failure, i.e., heart failure, liver failure, lung failure, etc., all of which are equally fatal. Age and cost are not factors in the E.S.R.D. program; in fact, approximately half of the patients entering this program are sixty-five years of age or older (Levinsky 1993, pages 1395-1399). The
treatment is extremely expensive on a per person basis, roughly ten times the average for Medicare. Any meaningful health care reform could not digest the inconsistencies between these publicly-covered acute life-threatening illnesses and parallel conditions with far less generous coverage, nor could such reform plausibly include equally generous treatment for these other parallel acute life-threatening illnesses. This generous benefit has been an anomaly for some time now and it represents an extreme degree of unfairness as well as medical inefficiency.

We close this section with comments on an article suggesting something very similar to Q.A.L.Y.'s to allocate beds in I.C.U.'s under conditions when: 1. further admissions would jeopardize the level of health care for all 2. newcomers to the unit show a greater likelihood of benefitting than early arrivers or 3. the marginal benefits which are likely are disproportionate in relation to the investment of resources (Engelhardt and Rie 1986, pages 1159-1165). The criteria suggested are likelihood of success, quality of success, and likelihood of survival to make decisions regarding admission, continued treatment, and discharge. The criteria are embodied in an "I.C.U. Entitlement Index": P.Q.L./C. where "P" is the probability of the successful outcome, "Q" is the quality of success, "L" is the life expectancy, and "C" is the relevant cost. These suggested bases for social choice are likened to a "... society investing in advance in a particular insurance policy for its
members . . . " (Ibid., page 162). We heartily endorse this approach and now turn to a discussion of Q.A.L.Y.'s themselves and of the major objections to them.

VII. Quality Adjusted Life Years—
A Balanced Criterion For Prioritization

Quality Adjusted Life Years (Q.A.L.Y.'s) is a method designed to measure a prospective medical intervention in terms of the probability of medical success, the projected quality of any such success, the expected duration of such success, and the cost of the intervention. The first three of these elements may be consolidated into "medical benefit" and thus in sum the procedure is designed to measure medical benefit per unit of cost. The key word in this definition is "measure" and, while important questions of measurement can be raised for all four elements, those raised by the projected quality of a prospective medical success are clearly the source of the most contentious objections to Q.A.L.Y.'s. These objections in turn are of two basic types, which are often difficult to separate: 1. Objections to the process of determining Q.A.L.Y.'s, that their measurements are not sufficiently accurate or do not measure what they purport to measure. 2. Objections of a more political nature, often made on moral grounds, which are centered on a concern for the treatment of a particular constituency under a Q.A.L.Y. system. We will begin by describing the elements of the
process and technique itself and its shortcomings, both real and exaggerated, and will then move to answer objections of a more social nature.

So-called "quality of life" concerns have long been a factor in medical practice but have really come to the forefront of medical policy only in recent years. Perhaps two factors above all have brought about this change, the same factors which have been the primary areas of change in the means of medical practice and medical policy: technological innovation and patient autonomy. The former has made it possible to help patients in many new ways but, at the same time, has also been the catalyst for the more recent epidemic of chronic diseases and impairments. Far more people than before are living much longer with conditions requiring the constant care of a physician. Coping with medical conditions has now taken its place alongside the curing of medical conditions. As a result, the quality of the lives of many people has increasingly become one characterized by loss of function, persistent medication, and dependence on others. Patient autonomy has become a major factor here as well, replacing the previously dominant largely paternalistic model. As the number and type of medical interventions have steadily increased, the demand for such services has, if anything, increased at an even faster rate. "Medical necessity" and increasing patient demands have fed on
each other in a way which has bloated the overall supply of publicly-financed medical care.

These two factors, technological innovation and autonomy, along with a steadily rising tide of costs which has far outstripped the general rate of inflation, have caused increasing attention to be paid to the results of medical interventions, i.e., the medical benefit received; these "results" are more and more coming to include the "quality of life" remaining after these interventions. Unfortunately, for many people, this phrase has distortedly come to mean an indeterminate mix of an invitation to neglect, a commitment to sub-standard care, and perhaps the beginning of a "slippery slope" to euthanasia. As we examine Q.A.L.Y.'s more closely, "quality of life" will instead emerge as an indispensable tool in the midst of a crisis in medical care, a means of charting a more humane and better balanced path to a better future.

The three central questions concerning the quality of life aspects pursuant to a Q.A.L.Y.-based measure are: 1. Which aspects of life are to be considered? 2. Who is to evaluate these aspects? 3. How are these evaluations to be incorporated into the determinations of Q.A.L.Y.'s? A helpful rendition of the aspects to be considered is supplied by Lennart Nordenfelt: 1. The experiential aspect of life (including sensations, perceptions, cognitions). 2. Activities of life, including the results (achievements). 3. The events aspect (those of which the
individual is aware). 4. The circumstances aspect (residual category addressing the awareness of the individual) (*Nordenfelt 1994*, pages 2-3). A certain amount of overlap and vagueness is involved here but these categories can with reasonable effort be clarified and refined with experience. Roughly speaking, these "aspects" are the answer to the "what" question. The "who" question could be answered by a partnership among patients, caregivers, and the general population. This would enable the system to combine the input of those directly affected by quality of life considerations with a policy-making apparatus which utilizes the knowledge of experts pursuant to an open and broadly representative process.

We will discuss below one of the main issues revolving around those with a significantly lessened quality of life, i.e., to what extent they or those with a more "normal" quality of life should "decide" what the quality of life is for their respective states of affairs for purposes of factoring in the quality aspect of Q.A.L.Y.'s; a related issue to be discussed below is whether those with a significantly lessened quality of life, i.e., the "handicapped," are unfairly prejudiced by a Q.A.L.Y.-based system of determining projected medical benefit per unit of cost, since their projected end-state following treatment is virtually by definition a diminished state in comparison with the non-handicapped. A parallel set of issues involving the aged will also be discussed below. In addition, a "who
decides" issue where "the poor" are concerned presents a democracy issue comparable to that involving the handicapped and the aged. Issues of "gender" and "race" have also been raised, but these issues may be subsumed under our discussion of the poor for our purposes since those arguments are either demographically derived, relate to actual clinical practice, or relate to the design of medical research projects.

The "how" question involves concerns about the design of relevant questionnaires and the translation of raw data into numerical form for insertion into the actual formula to be used for Q.A.L.Y.'s. Take the common example of the grading of essay papers by college professors. The applicable university catalogue will typically describe, say, "B" work but will also assign a numerical range to a "B" grade, say, eighty to eighty-nine; if a professor is to be compliant here, a means must be found not only of ranking the various essays in relation to each other but, more challengingly, of converting judgments about the quality of the essays to a numerical scale. Although questions of "validity" and "coherence" are appropriately raised in any number of contexts, they are especially urgent here and address whether a measure "measures" what it purports to measure (validity) and whether the system doing the measuring is consistent with itself (coherence).

Fitzpatrick and Albrecht suggest five primary uses for quality of life measurement in health care: 1. health needs assessment;
2. clinical trials; 3. evaluation research; 4. clinical care; and
5. resource allocation (Fitzpatrick and Albrecht 1994, pages 202-
206). The authors duly note that plausibility in such areas varies
greatly between applications. Of the five primary uses given, only
that of clinical care is said to be used sparingly while that of
resource allocation is said to be the most controversial. Although
the latter state of affairs is mainly the result of the introduction of
cost considerations, something which is absent from the other main
areas of use, the difficulties of the far more complicated
quantification involved here have themselves been a source of
criticism, what the authors refer to as the need "... to assign
single consistent quantitative expressions of the benefits...
gained from interventions [which] has required the derivation of
values or 'utilities' to be attached to varying health states" (Ibid.,
page 206). The goal of this quantitative methodology is to derive a
single value for the overall health state of an individual and therein
hangs the tale.

Objections to the measurement of the quality of life of a
methodological nature are essentially objections to the inordinate
complexity of the calculations rather than to the qualitative
measurements themselves, given the relatively low level of
controversy generated by the use of such measurements in the
four major areas other than resource allocation. Objections to the
introduction of cost and to such measurements in principle are of
an ethical rather than a methodological nature. If the complexity of
the reduction of qualitative manifestations to quantitative values
epitomizes the methodological objections, then it is reasonable to
believe constant application and refinement will be reasonably
successful; after all, results can be continually checked against
intuitions, and any number of relevant comparisons can be
contemporaneously made. The Government could begin with
existing methods, such as the Rosser Distress Disability Index, and
compare them at length, select a method, perhaps refine it a bit
initially, and then continuously update and modify the method per
the feedback received from all constituencies. We are confident
that such "meta-procedures" would be sufficient in the long run to
meet all significant methodological challenges, including the forceful
objections of Mac Intyre: 1. Condition-treatment pairs would be
insufficient in number. 2. A scale of commensurability would be
virtually unattainable. 3. Any cutoff of consequences would have
an element of arbitrariness. 4. Time-frame projections are
notoriously contingent on any number of factors (Mac Intyre 1977,

Each of these objections can be largely met, at least in
principle, through the introduction, the implementation, and the fine-
tuning of a system which is open, has broad-based support, and
which benefits from a correspondingly substantial commitment of
resources. While contingencies and a degree of arbitrariness are
virtually ineliminable, the judicious weighing and comparing of the
elements of the system in light of ongoing results and new
developments can generate additional condition-treatment pairs
where needed, can substantially mitigate the challenges of
commensurability, can broaden the scope of consequences to
minimize the arbitrariness of any cutoff of consequences, and can
refine time projections to lessen their contingent aspects. We
envisage a new system designed to evaluate and refine itself on a
continual basis so as to better meet its avowed purposes and to
better serve its constituency.

The more persistent and lasting challenges to a Q.A.L.Y.-
based system are all but certain to be ethical in nature, and to
focus on the prioritization function and the cost dimension of that
system. At the same time, related qualitative methods can be
extensively used by the Government to determine health needs and
for evaluation research, leaving the use of such methods largely to
the private sector where clinical trials and clinical care are
concerned. It can hardly be overemphasized that any system
seeking universal access with reasonable cost controls must take
medical benefit and related costs heavily into account along with
medical needs. Even if the goal were "merely" a broadening of
access, the same considerations would apply; to pretend otherwise
is to somehow expect the system to correct itself. Our approach
here is, at the same time, duly compassionate, appropriately
aggressive, and suitably restrained; it will take no less to attain the ample benefits and needed prioritization.

Ethical objections to a Q.A.L.Y.-based public system are most serious and must be satisfactorily answered if such a system is to be morally acceptable. As we have indicated, the main categories of objection are focused on the treatment of the elderly, the handicapped, and the poor, all of which effectively subsume issues of treatment by a democracy of its minority constituents. We will begin with treatment of the aged under such system; the effect is greatest in this area, given the general aging of the population and the fact that the vast majority of us will attain at least age sixty-five. In addition, many of the issues here are somewhat similar to those involving the handicapped and the poor in that the general state of health tends to be subpar in all three instances and the incidence of most diseases and conditions is well above average.

A. The Elderly

Any policy change which seeks at least to hold relatively steady real dollar expenditures per patient, if not perhaps even to reduce them in the long run, will have the greatest impact on the elderly because: 1. Risks of mortality and morbidity increase with age. 2. The population is inexorably aging. 3. Interventions on behalf of the elderly are more highly skewed toward both the acute and the chronic, which substantially add to costs, though in
different ways. Each of these factors points toward higher costs, both in the aggregate and on the average, unless appropriate steps are taken. The need to balance medical need, medical benefit, and cost will be critical in the battle against burgeoning costs. While medical needs are far greater for the elderly, as we have shown, the medical benefits to be derived from meeting those needs are lessened by diminished life expectancy and the co-morbidities of generally declining health, while increasing acute and chronic conditions significantly raise costs. Q.A.L.Y.'s are specifically designed to deal with all of these factors and would greatly help in balancing them. The Joint International Research Group of the Institute for Bioethics pointed to the urgency of reaching a consensus on the significance of aging and the goals of medicine for the elderly, the need to set limits and priorities, the greater need for non-medical institutional and individual assistance, and the importance of balancing generational needs (*Jnt. Int. Grp./Hast. Ctr. March-April, 1994*, pages S-3 to S-12). Increasingly, the need for a re-orientation of priorities is being recognized. While some commentators continue to emphasize needs of the elderly, such as that for more long-term care (*Jecker 1993*, pages 91-94), or to cap the out-of-pocket costs for the average Medicare recipient (*Moon 1996*, pages 317-349), or countering the threat to the autonomy of the elderly (*Post 1994*, pages 33-42), or decrying the potential stigmatization of the elderly (*Jecker and Pearlman 1994*, pages
121-142), others have taken a broader view, a more long-term perspective which stresses the need for priorities and limits. Foremost among the latter have been Daniels and Callahan, but others have stressed the need for new limits and changing priorities as well.

Ter Meulen has stressed the negative impact of the increasing tendency to "medicalize" and of a heavy emphasis on individualization (ter Meulen 1994, pages 36-38), Kane has noted the importance of "de-coupling" living expenses and medical expenses in long-term care if cost controls are to be satisfactory (Kane 1994, pages 199-211), Shaw has defended the preferential allocation of medical care to the young (Shaw 1994, pages 188-191), and Lubitz et al. pinpointed seventy-five percent of the projected increase in Medicare spending between the years 1990 and 2020 as being due to purely demographic factors, specifically the size of the cohort (Lubitz, Beebe, and Baker 1995, pages 999-1003). Daniels and Callahan have spoken in less specific but in more telling terms. They are both keenly aware of the need for a substantial change in general outlook toward the elderly if the demands of the future are to be squarely met in a balanced way. While the latter has been somewhat more of a lightning rod for commentary, their views are consonant with each other.

Daniels projects an age-relative opportunity range in his perspective on the allocation of health care resources to the elderly
(Daniels 1991, pages 201-212). At each stage of life, he sees a "normal opportunity range" which applies to all, the central function of health care being to maintain and restore. The key here is the normal function range that would be available if one were healthy at a particular stage of life; this is an extension or application of fair equality of opportunity which is the basis of health care rights for Daniels which, as we have noted, leans heavily on Rawls' general theory of justice. Since the normal opportunity range is greater in the earlier years of a lifetime, people should be receiving greater medical benefits in these years and fewer medical benefits in later years, rather than vice versa, which is now the rule. In theory, Daniels sees us as implicitly consenting to this heavily weighted earlier pattern of distribution, with current heavier distributions in later years being an aberration of this "understanding". Be that as it may, Daniels' scheme of age-related opportunity range is at least a step in the right direction. We do not subscribe in general to the "normal opportunity range" scheme he has developed, nor in particular to its use as a means of curtailing expenditures on the elderly. However, we do subscribe to a well-grounded, Q.A.L.Y.-based system which would tend to reduce expenditures on the elderly by explicitly taking life expectancy into account and by encompassing quality of life considerations which will have the same effect in certain instances.
The approach taken by Callahan in regard to allocating health care resources to the elderly is perhaps the best known. Declaring that the nexus between need and technological possibility must be broken, especially where the elderly are concerned, Callahan seeks a more stable notion of need as a means of providing a foundation for resource allocation (Callahan 1987, especially chapters five and seven). Citing the changes brought about by long lives, rising chronic illness, and escalating costs as a major threat to the financial integrity of our health care system, he declares that our obligation to the elderly is only to help them live out a "natural life span." In understanding Callahan, it is important to keep separate the new concept of aging being formulated and the allocation policy being advanced. It is also important to understand that the book is more about priorities than limits and that, even if there were ample resources, these public funding priorities would be appropriate (Coy and Schonsheck 1994, pages 71-92). If the concept of aging and allocation of resources by priority are to be viewed as separate, then the latter may well be reducible to a "quality of life" criterion where the elderly are concerned. Since the stages of life projected here are normative and not statistical, Callahan felt compelled to recognize an exception to the policy of not extending the lives of the elderly through medical intervention for the "physically vigorous," which does point toward a quality of life criterion (Sytsma 1994, pages 115-120). If this is the case, then the main value of
Callahan's analysis is the general case made for limits: limits in terms of high-powered technology, limits in the portion of the national product allocated to medical care, and limits on life-extending care.

The standard we propose for allocating benefits will result in a lesser percentage of spending on the elderly than is presently the case. Few would argue that, in the previous example of Alice and Betty hoping for the same heart transplant, the respective life-expectancies of two and twenty years should not be very strongly weighted, if not decisive, in choosing between the two of them. Although we did concede that considerations of fairness might allow a one-tenth chance to be afforded to Alice, this "concession" was due partially to the nature of the scarcity involved--absolute and not relative. For the vast majority of the allocations to be made under our Q.A.L.Y.-centered proposal, mitigation of the numbers should only occur within a certain range where the numbers are close. Thus differences in life expectancy which are slight, especially in terms of the number of years involved, might be factored in with the same weight or perhaps only a portion of their actual difference. However, since age correlates so strongly with life expectancy, and life expectancy is an integral component of anticipated results (i.e., medical benefits in light of relevant costs) under a Q.A.L.Y.-based system, age will often and pervasively have an impact on the
projected allocational scheme. As for the quality of life to be factored in, the case against such a consideration is probably stronger where the handicapped are involved, although nearly all of the considerations are similar, and we now turn to these objections.

B. The Handicapped

In a nutshell, the complaint here, stripped of its potent emotional thrust, boils down to something like this: If members of a group cannot be made medically whole (i.e., basically healthy) even by a potentially completely successful medical intervention which is under consideration, then under such a system taking quality of life heavily into account, those who cannot achieve the highest level of health end-states will be systematically assigned a lower medical priority vis-a-vis the potentially healthy or medically whole in regard to the condition-treatment pair under consideration, and such a state of affairs invidiously and unethically prejudices those whose starting point thus limits their potential end-state and therefore their medical priority as well. A further objection centers on the determination of quality of life measurements. The question here is essentially how the input of the handicapped should be weighed, the options being: 1. Much more heavily than their numbers so that they control the outcome, because they have a wealth of relevant experience. 2. In proportion to their numbers, because in a democracy each person's vote is equal. 3. Something in between
where their views are weighted heavily in proportion to their numbers, but the non-handicapped control the outcome. In both of these areas, the general use of Q.A.L.Y.'s and determining the quality of life which attaches to various conditions, we favor the second option, which stoutly considers benefit and cost as well as need. However, as was the case above concerning general issues of the assignment of priorities, "fair chances" versus "best outcome," and the "aggregation " of benefits, we are willing to deviate from a Q.A.L.Y.-driven outcomes approach at least where a tie-breaker is needed to resolve an issue. The benefit of the doubt, in such cases, might well accrue to the handicapped.

John Harris is a commentator situated at one end of the spectrum in both of these areas, arguing as he does that the "value" of a life is the value an individual would attribute to one's own life, that all wanting continued existence should be on a par with anyone else, and that people would not choose Q.A.L.Y.'s from behind a Rawlsian veil of ignorance (Harris 1995, pages 151-157). On the other hand, Singer et al. deny the handicapped are systematically prejudiced by Q.A.L.Y.'s. They concede that difference in life expectancy can disfavor the handicapped, but argue that the change in a person's health status is the key, not some final "end value". They argue further that Q.A.L.Y.'s would be chosen from behind a Rawlsian veil of ignorance and that, in any case, Q.A.L.Y.'s need not be the measure unqualifiedly (Singer et
al. 1995, pages 144-150). Their denial that Q.A.L.Y.'s systematically prejudice the handicapped does point to a certain flexibility in the design and use of the technique. This flexibility is underscored by the work of Bjork and Roos, who emphasize that the questionnaires must be tailored to the particular condition involved, that change is an important way to isolate the effect of both conditions and treatments, and that the factors and perspectives which can be brought to bear in assessing various health-related states of affairs are legion (Bjork and Roos 1994, pages 229-240). They distinguish "quality of life" simpliciter and "health-related quality of life," embracing the latter narrower gauge as being more appropriate, and point to the variety of disciplines using these concepts. In addition, they suggest the possibility of combining the most frequently used weighting methods:

1. category scaling (value of being in different health states);
2. standard gamble (risk of ending up in a certain health state);
3. time trade-off (balancing of certain health states and their duration). Musschenga contends the handicapped have far greater life satisfaction than the non-handicapped believe, that coping rather than level of functioning is the main determinant of quality of life after invasive treatment, and that quality of life has more to do with satisfaction with life than with the conditions that contribute to that satisfaction (Musschenga 1994, pages 181-198). In spite of these views, he concedes "subjective" and "objective" factors must
be balanced and the quality of life considerations are at least relevant to life and death decisions, a scope far less than what we are calling for in any case.

We favor the maximum use of Q.A.L.Y.'s which is compatible with the ethically fair treatment of the disabled, i.e., does not violate their moral rights. As we saw in Part One, there is no moral right to health care, not even for those who are handicapped. In addition, we have taken the position that, in choosing between or among courses of action which are morally permissible, if one choice produces clearly superior consequences, then it is "morally preferable" to the others. Here it is a question of degree. Here the projected results are Q.A.L.Y.-based. Where the measure is found to be substantially higher, the result will be morally preferable, even if the handicapped do not fare as well as the non-handicapped. Where the measure is not found to be substantially higher, no option would be deemed "morally preferable" and other considerations could be brought to bear (e.g., degree of improvement or ceteris paribus an usually high degree of satisfaction). Questionnaires should give due attention to the views of the handicapped but compilations should be predominantly non-handicapped derived since this is more consistent with democratic procedures.

In this area, it can be easier to address specific cases than it is to formulate a generally acceptable rule. Recall the original denial
by the Government, through its Health and Human Services Department (H.H.S.), of the waiver requested by Oregon so that the Oregon Plan could be implemented. Exclusions for alcoholic cirrhosis and low birthweight babies, to which H.H.S. had objected, were rescinded and other largely procedural-methodological matters were modified to secure approval (Menzel 1992, pages 21-25). Yet priority setting per se ties in to a degree with assessments of quality of life, and this is bound to redound to the systematic disadvantage of some. Responding to H.H.S. Secretary Sullivan's view that appeals to "quality of life" and "ability to perform" should be barred to the extent that they place importance on "restored health" and "functional independence" (unpublished letter, Brock 1995, page 175), Hadorn counters: "Banning consideration of quality of life and ability to function is . . . inconsistent with the massive effort to facilitate and fund health outcome research--the lion's share of which deals with quality of life and ability to function" (Hadorn 1992, page 1459). Menzel has summed up concerning the inevitable disadvantaging of the disabled most saliently:

Quality of life considerations as well as likelihood of medical success do get associated with disabilities [but] must not be seen as biased against persons with disabilities just because they catch disabilities in their net. . . . This . . . distinction [is] utterly essential to maintain if we are going to have any significant rationing at all. . . . Rationing that considers
quality of life must be allowed to go forward even if at times it happens to disadvantage persons with disabilities. Indeed it is questionable whether we could ever devise a system of priority setting that was not informed in some measure by assessments of quality of life. (Menzel 1992, page 24)

Our position is completely consistent with those of Hadorn and Menzel. The challenge is to frame a Q.A.L.Y.-based system which, at the same time, is designed to allow deviation from a strict Q.A.L.Y. approach where the measures are relatively close. In this way, even the appearance of unfairness in the eyes of some can be at least minimized. In this area, as in other areas, the standards are to be constantly critiqued and continually improved. Results which are initially more tentative would become increasingly solid and well-grounded. All of these considerations, and many others, would have to be balanced against each other in gathering relevant information and in the design and implementation of a Q.A.L.Y.-based system of rationing. We suggest some departure from a strict benefits-cost matrix, but these departures must be essentially tie-breakers to prevent an incipient reversion to the needs-based perspective which has in no small way engendered the health care crisis of the present.
C. The Poor

Charges of discrimination against the poor is another likely politically-related result of the far reaching changes envisaged here. One need only look to the response of some to the adoption of the Oregon Plan. Although the treatment of minorities is also an issue where the elderly and the handicapped are concerned, it is here that the matter is most poignant. The elderly and the handicapped engage high-powered lobbyists and evince at least some of the characteristics of "special interest" groups, while the poor go largely unrepresented at all levels. In addition, their sub-normal state of general health is more preventable than the medical vicissitudes of age or the afflictions of the handicapped, which makes the failure to reach out to them all the more a moral failing. Even if the representation of the poor were above reproach in the institution of a system of rationing, it would be largely members of that constituency who would suffer reductions in benefits vis-a-vis the current system. In addition, the bias in the current system toward acute interventions rather than preventive care results is somewhat less of an improvement in the overall health of the poor than is reasonably achievable. Against this backdrop, criticisms of the Oregon Plan regarding the position of the poor include the proportionally greater impact on women and children (Thorne 1992), that the aged, blind, and disabled were excepted from reductions (Nelson and Drought 1992), and that there was no true
consent by the poor (Ibid.). In a sharply critical article, Sara
Rosenbaum added to this list that many of the newly covered were
single adults and childless couples and that the poor were
systematically unrepresented at all levels of deliberation
(Rosenbaum 1992).

Our response to these advocates for the poor is essentially
fourfold: 1. The poor must be represented at all levels of
deliberation. 2. The new system must shift some of its emphasis
from acute interventions to preventive care. 3. The system of
universal coverage suggested here would provide a better level of
overall benefits than the Oregon Plan, which was designed to
supplant the Medicaid system. 4. Any reductions in benefits for a
limited few are tempered by the greater overall equity to be
achieved by a more balanced system. The lack of participation by
the poor at all levels in implementing the Oregon Plan can be
avoided here by ensuring they will be involved in filling out
questionnaires, in expressing community values, and in helping to
select the list of covered services. The dangers here are less
ominous than in Oregon a decade ago because we are not
proposing a "poor people's plan," but one geared to encourage
substantial middle class participation as well, with perhaps
somewhat more than fifty percent overall participation being
achievable. A new emphasis on preventive care will be especially
beneficial to the poor in raising their general level of health to a
level within sight of the "norm." These are the types of services which now represent the most inexcusable area of neglect as well as the most efficient means of helping the poor. The relatively few areas and instances of reduced benefits for the poor are not only morally permissible options, but morally preferable as well. These instances would involve expansive acute interventions, marginal medical benefits, and/or procedures benefitting very small segments of the population. Further, our reasoned denial of a moral right to health care makes it much easier to justify changes which are unfavorable to some and allows for more flexibility in making the large number of unavoidable tradeoffs which stand in the way of meaningful reform; again, if no fundamental rights are substantially abridged, the top priority should be the maximization of the beneficial health care offered over the long run. To the extent that some individual benefits may be reduced, a greater amount of medical benefits can be offered to others. These and other difficult choices must be made if the poor are truly to be better served.
VIII. Rationing, Consent, and Professional Responsibility

Concepts such as "consent" and "conflict of interest" have been with us for some time, being legacies from the English common law. These terms are "open textured" in nature, which means that they provide an active window between themselves and the relations they characterize and define. Prior to the genesis of "informed consent," consent was largely a matter of disclosure to the patient with minimal concern for the accompanying level of understanding on the part of the patient; then as patient autonomy began to supplant physician paternalism, passive assent gave way to active understanding and informed consent was born, circa 1957 (Beauchamp and Faden 1995, pages 1231-1241). The elements of informed consent go well beyond disclosure and voluntary consent by a competent person or surrogate to include comprehension or understanding. A concomitant development which followed a few years later was to allow for a cause of action for negligence in instances where consent was not informed in place of the previous requirement of showing a battery, which is an intentionally inflicted tortious contact itself resulting in damage (Ibid., page 1234). For physicians, this signalled a radical change in both a major element of the duty owed by the physician to the patient and in the burden of proof which had to be sustained against a physician by a patient; the former became much higher, a requirement that a patient be
informed of all material risks ("material" risks being those which could lead a reasonable person to decide otherwise) in a manner understood by the patient, and the latter became much lower, a requirement that a patient need only show the omission of a single material risk by the physician. Thus, if an unfavorable medical result occurred, and a patient could successfully claim omission of a material risk by the physician who had altered patient consent so as to cause damages, the physician was potentially liable for considerable amounts of money damages.

A "conflict of interest" exists when a person's obligations to another person or group are at least in part at odds with, or are irreconcilable with, that person's own self-interest (Morreim 1995, page 459). Such conflicts are legion in any society, but when one's obligations to others are so imbued with the public interest, and there is a radical inequality between the parties owing to a large gap in knowledge and relevant experience, and to the resulting vulnerability of the disadvantaged party, the obligation to others goes beyond a duty not to defraud them and is recognized as a "fiduciary" duty. Such a duty has been owed by physicians to their patients from time immemorial, being essentially one of trust, of holding the patient's interests in trust and promoting them even above their own at times. It is principally the fiduciary duty to patients which accounts for the paternalism of the past and its embers which continue to smolder. A fundamental tension is
clearly operant here, one of more recent vintage. If one purports to hold physicians to the strict letter of their fiduciary duty as that duty has long been understood while at the same time demanding the firm recognition of patient autonomy with informed consent as its centerpiece, one of the two must give way to a degree or a *de jure* fiction will be allowed to fester. Changes in the practice of medicine in the last quarter century have also recast the dominant form of the conflict of interest between physician and patient; as we have noted, the formerly prevalent fee-for-service mode carried only the relatively minor danger to the patient that unnecessary procedures would be performed, whereas under the now dominant managed care mode, the greater danger to the patient is that potentially beneficial procedures will be denied. Thus are the essential battle lines drawn and physicians, now more than ever, are caught in the middle between the unprecedented medical demands of patients and the unprecedented demands for accountability by private insurance companies and the Government. To some, the choice is beginning to appear as that between an unacceptable risk of legal liability to the patient and an unacceptable risk of becoming a professional pariah in the eyes of their fellow physicians, hospitals, the Government, and private insurance companies.

Physicians have been balancing the needs of the patients in their overall patient mix, and within as well as between patients in various diagnostic categories. Increasingly, in the past twenty-five
years, with the dawn of managed care in the private sector and the P.P.S. for Medicare, practices known as "hoarding," "poaching," and "fudging" have come to characterize the professional response to irreconcilable pressures. As care has become more standardized (guidelines), oversight more common (utilization review), and overall patterns of patient diagnosis-treatment have come under closer scrutiny (physician profiles), physicians have been correspondingly less able to simply shift costs between and among patients. As cost emphasis has migrated from micro-concerns with what is being done for the individual patient to macro-concerns with what is being spent on the population served, the conflict between purportedly applicable standards and the realities of actual practice has been exacerbated.

Noting the changed circumstances of resource availability and allocation, Mehlmann and Massey see the relative inability (as well as the non-requirement) of physicians to shift costs between patients and the limits on how far anyone can expect physicians to go in sacrificing their own interests as pointing to two incompatible alternatives: 1. Eliminating the physician prerogative of refusing to treat patients who are unable to pay their fees. 2. Eliminating the fiduciary duty owed by physicians to their patients a la Oregon (Mehlmann and Massey 1994, page 302). Concerning the Oregon Plan, the authors state:
This provision not only absolves physicians of liability for malpractice for failing to act reasonably, substituting the legislature's notion of reasonableness for the norms of the profession, but it also protects physicians from liability for breaches of their fiduciary duty to make a heroic effort to provide services to patients despite resource limits . . . has the effect of eliminating physicians' entire fiduciary duty with regard to unfunded services . . . by enabling citizens to abandon patients who cannot pay. (Ibid., page 303)

Surprisingly, in our view, Mehlmann and Massey opt for a self-styled Rawlsian solution in calling for a legislative enactment forbidding services not available to those in the public tier to be provided to anyone, on grounds that otherwise resources will be shifted from the worst off to others. We have shown the moral unacceptable of such an encroachment on the second tier. It is unacceptable in a way parallel to the Clinton Plan provision forbidding the provision of services in the second tier which are available in the first tier. While we do not agree with the solution offered here, the article accurately pinpoints the issue of physician standards and the virtual inevitability of a change in those standards. Even Nancy Jecker, who opposes age-based rationing and favors restricting some services not available in the first tier (Jecker and Pearlman 1994, pages 121-142), advocates "maximally-restricted" advocacy over "minimally-restricted"
advocacy in seeking a balance between traditional patient advocacy and burgeoning social responsibility on the part of physicians. She declares:

Although this objection rightly notes that social obligations can and should be broadly conceived, it wrongly claims that physicians' social responsibilities can be fully met outside the clinical encounter . . . situations in which two or more patients cannot have all their entitlement to care met due to limited medical resources. A dilemma arises in such cases if the parties concerned are all equally entitled to their share of the relevant resources. It would not arise if their rights were ranked in some order of priority. (Jecker 1990, pages 136-137, emphasis supplied in last three instances)

Even from a more narrowly conceived legal perspective it is clear to some that the doctrine of informed consent will come under increased pressure. An article by Frances Miller on the evolving legal aspects of informed consent can serve to sharpen the moral issues at stake as well (Miller 1992, pages 37-71).

The area discussed in broadest terms is the relation between the denial of health care and informed consent. Miller notes that lawsuits against insurance companies are now being joined by suits against doctors, on grounds of the alleged failure to deliver a reasonable standard of care due to economic pressures. Though not formally acknowledged by the medical profession, "customary
practice" has been altered somewhat by the pressures of limited resources and the managed care which administers them, yet the legal standard is becoming more patient-based. Miller sees the only real way out to be disclosure by physicians on two fronts:

1. Disclosure to the patient of the risk of not undergoing a treatment deemed not to be covered. 2. Disclosure to the patient of the economic conflict of interest giving rise to the denial (*Ibid.*, pages 70-71). Once again, Oregon's approach to conferring immunity on physicians in such situations is mentioned with approval, along with the Oregon requirement that the physician disclose "medically necessary" treatment.

We support the conferring of immunity in this fashion on physicians in the public tier. Where society has, through its representatives, imposed limitations and restrictions on coverage in that tier, physicians should not be held liable for "expert" interpretations they have reasonably relied upon but which have proven erroneous. This is especially true if both disclosures suggested by Miller have been made to the patient. It would be reasonable to hold the provider (i.e., the subject institution) liable for such mistakes, but the potential measure of damages would be best left to Congressional enactment. However, we concede that this change might alter the physician-patient relation in intangible ways as well. It would be too sanguine to deny that patient trust could be diminished, even though the disclosures would represent
information honestly given, information not often now disclosed. It is hard to define "bedside rationing," with much precision, but the term generally is used to refer to the sort of implicit rationing so long prevalent in England but much more covertly practiced here to the point where its existence is sometimes falsely denied. The case against bedside rationing is invariably couched in terms of lost trust and a general weakening of the bonds between physician and patient.

The premises of the argument against bedside rationing rest upon two questionable preliminary propositions, both of which are rooted in a longstanding tradition which has, alas, undergone substantial changes in recent years. The unitary standard of care is no longer the monolithic guide it once was, and the practice of bedside rationing has become an increasingly common aspect of that evolving standard, yet those who are horrified by the "prospect" of bedside rationing at least implicitly assume things are much as they once were. As Mark Hall has aptly and succinctly put it: "Because economic resources are limited, some form of health care rationing is inevitable. . . . The fundamental decision we must make in fashioning a sensible approach to rationing is whether to ration through incentives (i.e., bedside rationing) or through rules" (Hall 1997, page 315). Hall would have the physicians bear complete responsibility for rationing by internalizing the necessary constraints and implementing them through bedside rationing, but
we believe it is preferable instead to minimize this burden through explicit rules of rationing which are "externally" imposed. This is in no small measure because it is unrealistic for a system which has steadily progressed toward a reliance on externally prescribed standards of coverage, and correspondingly away from the internalized standards of bedside rationing, to suddenly reverse itself on this matter. In addition, a system reliant primarily on external standards can more easily and efficiently implement the limitations and restrictions on coverage which are an integral part of a Q.A.L.Y.-driven, priority-based system of allocation. However, a certain amount of bedside rationing is ineliminable and has long been a part of medical practice. As Eddy cogently put it:

A third point is that we have already been making these types of choices for decades. That is, despite our perceptions that we are maximizing the care we give to personal patients, we already make choices that fail to do that. Medicine is filled with indications, thresholds, and limits that are based on implicit judgment that some amounts of benefit are just too small to be worth the cost. . . . Although the choices will become more explicit and intense in the future, appreciation of this long tradition should help relieve some of the discomfort. (Eddy 1994-1, page 1795)

If the bond between physician and patient would be indeed weakened by the required disclosures suggested here, this
unfortunate effect is more than counterbalanced by the following considerations: 1. These disclosures are more in keeping with the doctrine of informed consent and the dramatic increase in patient autonomy which gave rise to it. 2. The disclosures represent an ongoing and increasingly inevitable change in the traditional unitary standard of care. 3. The disclosures are a further example of the call for greater transparency which underlies much of our project. 4. The disclosures may well be necessary to minimize the potential legal liability of physicians. 5. The trust between physician and patient which has long existed was nonetheless built with paternalistic foundations which have been largely superseded. 6. Patients will probably adjust to these changes somewhat better than many observers believe.

The unitary standard of care should be bifurcated to reflect changes already somewhat in place. Following the lead of Haavi Morreim, who borrowed heavily from the Oregon experience, we propose the standard be modified to reflect a division between a standard which is unvarying with regard to each patient, one of medical expertise, and a standard which reflects the priorities of care which are in place, one of resource use. Such a transformation would serve to recognize changes which have come, and which will continue to come, while continuing the more essential aspects of the physician-patient relation as before. This would also serve to complete the shift from a paternalistic model to
an autonomy-based model for health care. Indeed this would underscore the subsidiary emphasis on getting patients to see more clearly that they have to accept the consequences of the informed choices they have made. To continue with the present standard, or to attempt to implement an "equalizing" standard to otherwise carve out a unitary standard by either placing everyone in the first tier (equalizing "downwardly") or in the second tier (equalizing "upwardly"), is to be blind to present realities, to deny the moral right to seek medical care in a second tier, or to project spending at unrealistically high levels, respectively. These options are all unacceptable and their weaknesses all point to the need for a divided standard. To make explicit that which is becoming more implicitly clear can only bring the standard into a closer agreement with practice; this in turn will make necessary adjustments that much easier.

IX. Concluding Remarks

Our main goal in Part Three has been to outline a system of rationing to implement the universal health care coverage we are advocating. This goal entails both the need for comprehensive cost controls which would counterbalance the increased costs arising from universal coverage and a defense of these controls against a variety of criticisms. As in any other area of public life, a blueprint for substantial change inevitably becomes a lightning rod for
criticism levied by defenders of the status quo. Since, to some degree, we are suggesting a redistribution of publicly-funded health care resources, there will unavoidably be those who would not fare as well under the proposed changes as they are at present; however, in doing this, we would be violating no fundamental moral rights of anyone and, at the same time, would be achieving greater equity and efficiency in the distribution of these resources. We recognized in Part One that we could properly claim only that a new, well-designed system of rationing was morally "preferable" if its positive consequences were clearly to outweigh its negative consequences while, at the same time, violating the fundamental rights of no one. We believe the contours of our proposal can be fairly said to have met this burden.

Our argument to dislodge major aspects of the status quo depends on fleshing out the remnants of the fee-for-service mechanism, identifying the aspects of increased patient autonomy which have actually fanned the fires of the health care crisis by continuing attitudes engendered by that mechanism and by uncritically embracing the tenets of a technological utopia, exposing the burgeoning "medicalization" of our society fed by a scientific community so conditioned to the nomological and the somatic that our humanity is all too often relegated to the background, and by recognizing some of the entrenched constituencies reflexively opposed to change. The attitudes engendered by these forces of
reaction and entitlement have fostered a hostile climate for any proposed system of rationing. Opposition to denial of medically beneficial care, strong in individual cases or classes of cases, becomes immeasurably greater when this is suggested on a system-wide basis. Even under conditions of absolute scarcity, there is widespread resistance to considerations of medical efficiency. When conditions of relative scarcity, which are all but universal in the U.S. outside of organ transplants and emergency care, are applicable, the merits of saying "no" become even harder for people to appreciate. Yet the attitudes so widely prevalent here have been revealed by us to be the product of the vestigial fee-for-service mechanism, of fortuitous economic conditions which are no longer applicable, of a misplaced analogy derived from "danger invites rescue" situations, and of a pervasive belief that a person's fundamental worth or value is somehow under attack if that person is denied potentially beneficial medical care and especially if others are deemed to be receiving it "instead."

Overcoming such deeply-rooted patterns of belief is one of the main tasks before us. In a sense they represent a dense underbrush which must be cleared away to allow for an edifice to be constructed on the same site. Perhaps the greatest source of encouragement has come from the example of Oregon a decade ago. Even with resources amounting to only a small fraction of that available to our national government, a single state of modest size
has produced an alternative plan for Medicaid recipients which rations medical care instead of people, which has abandoned the bloated rubric of "medical necessity" in favor of a discrete list of covered condition-treatment pairs, and which realized the necessity of moving from a needs-based system to a more balanced one where medical benefit and costs are also major factors so that many more people can be provided medical care. Without benefit of the Oregon experience, there would be fewer commentaries in support of these major elements of health care reform. Placed in a much larger portfolio with an admixture of additional policies and procedures at the national level, these seminal reforms can provide much of the basis for the major overhaul envisaged here. We have proposed that all existing Federal health care programs be eliminated in favor of the system presented in these pages. The transition pains of some of those now in the public tier are de minimis in comparison to the prospective social benefits of this consolidation. While relatively few current recipients would be provided coverage which is less deep than at present, much broader coverage would bring ten of millions of people now uninsured or underinsured into the fold. Sharp reductions in inefficiencies, waste, and fraud would produce savings to help offset cost increases due to this greater access. By shifting the focus of health care somewhat away from acute care to primary care and from curing to caring in a more general way, we can
achieve further savings while improving the general health of the population in the long run, our primary goal from a medical standpoint.

The move away from the current system to one featuring explicit rationing involves not only the recognition of obstacles to the new system but the affirmative establishment of sound reasons for adopting and implementing it. Section VI of this Part, entitled "The Rocky Road to Rationing," is aptly named. Even if one recognizes the need for a comprehensive system of rationing, conceptual variances, impressive counterexamples, and stubborn intuitions are among the roadblocks on the way to such a system. Largely because of these counterexamples and the intuitions instilled in their conclusions, we are not advocating a system of rationing based entirely on considerations of efficiency.

We have tempered the clarion call for greater efficiency for other reasons as well: 1. Any system here generating a single canonical number in each instance will be somewhat more precise on the surface than in fact. 2. The views of the community at large and of discrete segments of the medical community are the indispensable bridge between the qualitative and quantitative dimensions of the system. 3. A measure of caution should characterize any such change which breaks significant new ground. We have been compelled to allow considerations of fairness to make encroachments into our Q.A.L.Y.-based efficiency model. As
Daniels reminded us in his seminal article on unresolved rationing problems, where services are not divisible in terms of money, prospective losers have plausible claims, and distributive principles are too general to decide among claimants or classes of claimants, allocation problems will be exceedingly difficult to "resolve" (Daniels 1994, page 27). Here, even the terms "best outcome," "aggregation" of benefits, or "fair chances" can lack a clear meaning in use. Where we disagree most with commentators such as Daniels and Kamm is their almost complete failure to take costs into account. Even in intrinsically problematic cases, benefit must be related to cost in our view. This widespread reluctance to explicitly consider costs, except in terms of aggregate measures, undoubtedly reflects one of the more "stubborn intuitions" which remain with us. We believe our position is a fair compromise, especially given our studied flexibility concerning the elderly, the handicapped, and the poor, where we have opened the door a bit wider in the name of "need" and "fairness."

We have called for substantial changes in the unitary standard of care owed by physicians to their patients. The proposed changes here are certainly revolutionary in purely formal terms, but the nominal standard has increasingly been deviated from in practice in recent years. This is due primarily to the far-reaching changes which have driven this project and the increasingly loud chorus for reform in general, but also stems from the partially
fiction-like character of any standard both univocal and intangible. The "growing pains" spawned by the proffered formal changes would be all too real, unfortunately; however, in the long run, the benefits seem to clearly outweigh the unavoidable transition problems, again given the more realistic nature of the proposed modified standard. The pervasive uncertainties of the present situation virtually guarantee meaningful change is on the way. In our view, these changes should reflect a clean break with the outdated aspects of the current standard. Only then can the new standard approximate the current dynamic of providing medical care.

Throughout Part Three, we have had to be mindful of the need to play the cards dealt to us in Parts One and Two in an appropriate way. The major elements of our proposal are universal coverage, explicit rationing, and a second tier. While our primary goal is to put in place a system of universal coverage, this cannot be achieved without more efficient cost controls. All things considered, this cannot be achieved without rationing, rationing which must be in large measure explicit if the desirable transparency, openness, and public awareness are to attach. Showing the moral permissibility of both a system of universal coverage and of explicit rationing was the point of departure while showing their moral preferability was the exclamation point. Their moral permissibility and moral preferability in turn were subject to a
condition precedent: no inherent moral right could be violated in the process. Our moral excavation in Part One found only one such right— the right to pursue health care in a second tier, which was in effect an extension of the most fundamental moral right of all, i.e., the right to a basic level of physical security concerning one’s person and the general freedom to be at large. At the same time, the excavation failed to find such a right to health care. Importantly, a legal right to health care, which we advocate, is a perfect fit because of the positive nature of any claim to health care. Such a right lends itself to frequent changes, multitudinous tradeoffs, and the ministrations of politically-motivated interest groups, unlike inherent moral rights, which leave far less room for such matters. This distinction between the inherent moral right to health care and its legal counterpart is central to much of our analysis. The requisite boldness of our plan, its flexibility, and its emphasis on long-term perspective all depend on this distinction. These are the attributes necessary for the health care reforms needed in this Millenium. Bound by solidarity, tempered by responsibility, and inspired by freedom, we can achieve no less.
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