POLITICAL ACCOUNTABILITY IN HEALTH CARE RATIONING: IN SEARCH OF A NEW JERUSALEM

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INTRODUCTION

In June 1989 the Oregon Legislative Assembly approved a package of bills that will ration health care for thousands of the state's poor and uninsured population. In doing so it started a national debate that shows no signs of abating. Over the last two years, health care providers, talk show hosts, scholars, print and media journalists, social advocacy groups, and public policymakers around the nation have ruminated on the necessity, practicality, and morality of health care rationing.[1]

Clearly the prospect of withholding health services that might reduce or eliminate human suffering or save human life is an anathema to some very fundamental American values. In addition, there is a sense of moral and political discomfort over the fact that rationing, as it is now proposed in Oregon and contemplated elsewhere, would primarily apply to the working and non-working poor and not to the middle and upper-classes.

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[1] *See* Lawrence D. Brown, *The National Politics of Oregon's Rationing Plan*, HEALTH AFF., Summer 1991, at 28; Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF., Summer 1991, at 7; Michael J. Garland & Romana Hasnain, *Health Care in Common: Setting Priorities in Oregon*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 16 (describing Oregon Health Services Commission's process of prioritizing health services); David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-effectiveness Meets the Rule of Rescue*, 265 JAMA 2218 (1991) [hereinafter *Health Care Priorities*] (describing Oregon's priority-setting process); David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, HASTINGS CENTER REP., Supp. May-June 1991, at 11 [hereinafter *Priority-Setting Exercise*] (describing Oregon's prioritization); William B. Stason, *Oregon's Bold Medicaid Initiative*, 265 JAMA 2237 (1991); H. Gilbert Welch & Eric B. Larson, *Dealing with Limited Resources: The Oregon Decision to Curtail Funding for Organ Transplantation*, 319 NEW ENG. J. MED. 171 (1988) (discussing Oregon's decision to extend Medicaid funding rather than to continue an organ transplant program); Alan L. Otten, *Local Groups Attempt to Shape Policy on Ethics and Economics of Health Issues*, WALL ST. J., May 25, 1988, at 27 (discussing the ethical and economic issues of health care rationing).

It is in part because of this latter prospect that rationing has sensitized students of public policy and political theory to questions that are often taken for granted in the policy literature. One of these is the subject of this article: namely, how do we make certain that the rationing process is an accountable one?[2] This concern is of special interest to students of American politics and democratic theory because "it is of the essence of democracy that the government should be accountable to the people."[3]

The generic problem for democratic theorists, from James Madison and John Stewart Mill to the present, has been how, specifically, does society ensure that those who make public policy do so in the public interest. This potential dilemma is what Mill called the "grand difficulty" of politics.[4] Although the "difficulty" is a general one, it takes on a rather special significance when the policy involves values that are as cherished as those of good health and access to medical care. Indeed, implicit in the very framing of the question about political accountability in this symposium is the notion that rationing health care is a unique area of public policy. There is a sense here that some extraordinary political or moral imperative requires that particular attention be paid to accountability in the allocation of health resources. After all, it hardly seems likely that the editor of a collection of essays on, for example, transportation policy or agricultural subsidies, would feel compelled to highlight, as this symposium does, the issue of political accountability.

Why, then, do we pay particular attention to, or make extraordinary provisions for, ensuring accountability in health care rationing? In this Article, I argue that the putative uniqueness of the policy values involved in health care rationing places an unusual—and probably unnecessary—burden on those who seek to insure accountability in the process. In addition to the high value placed on health care in America, the political and moral unpalatability of rationing and the intrinsic ambiguity of the concept of accountabili-

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[2] Although I will suggest later that the term "accountability" is anything but unambiguous, for the present I will rely on a fairly traditional definition: Political accountability refers to the exercise of popular control, typically through elections, over public officials and the actions for which they are legally and morally answerable. In this article, my concern will be with those who make the laws rather than those who administer them (i.e., bureaucratic accountability).

[3] J. ROLAND PENNOCK, DEMOCRATIC POLITICAL THEORY 268 (1979).

[4] CAROLE PATEMAN, PARTICIPATION AND DEMOCRATIC THEORY 32 (1970) (quoting Mill).

ty make the burden of ensuring accountability in health care rationing more onerous. None of these problems, however, has dissuaded proponents of rationing to search for and find a New Jerusalem of political accountability in the form of "participatory democracy." In Oregon, the one sustained application of participatory democracy to rationing suggests that, although this approach may be useful as a *supplement*, it is unlikely to *replace* other more traditional methods of citizen control over public policy.

Before proceeding further, I want to make clear which aspects of the health care rationing issue I will not discuss in this Article. First, I neither accept nor reject the need for rationing health care in America. Although this issue lies at the very heart of the national debate, I will leave it to others in this symposium and elsewhere to resolve this point.[5] At least one state believes rationing is necessary and thus has moved the issue from the status of a hypothetical, academic question to a pressing political debate. Second, for the purposes of this discussion, I assume the term "rationing" means a deliberately designed policy to allocate scarce health resources among individuals, rather than the implicit health care rationing that occurs daily in this country. Third, I do not question the ability of policymakers to devise a fair and effective rationing scheme. However consequential this issue might be in the overall debate, it is peripheral to health care rationing from the perspective of democratic theory.[6] Finally, I will not enter into the "is health care a right?" debate which, it seems to me, is central to the initial decision to ration, but not to devising a strategy for political accountability.[7]

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[5] *See, e.g.*, Daniel Callahan, *Rationing Medical Progress: The Way to Affordable Health Care*, 322 NEW ENG. J. MED. 1810, 1813 (1990) (asserting that Americans should ration health care).

[6] For a further discussion of this point, see PAUL T. MENZEL, STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE (1990); James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1981); Charles J. Dougherty, *Setting Health Care Priorities: Oregon's Next Steps*, HASTINGS CENTER REP., May-June 1991, at 1; *Health Care Priorities*, *supra* note 1, at 17-18; *Priority-Setting Exercise*, *supra* note 1, at 11.

[7] *See* 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 11-47 (1983) (detailing an ethical framework for access to health care); Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55, 59-78 (1984); Michael A. Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J.L. & HEALTH 1, 3-7 (1988-89); Charles Fried, *Equality and Rights in Medical Care*, HASTINGS CENTER REP., Feb. 1976, at 29; David Mechanic, *Rationing Health Care: Public Policy and the Medical*

Having said all this, I will now consider the difficulties confronting policymakers in any effort to create a rationing program that effectively holds political leaders answerable to their constituents.

I. "HEALTH CARE, THOUGH, IS DIFFERENT."[8]

The difficulty begins with the fact that political accountability requires, among other things, an attentive, well-informed public, which is capable of both understanding political issues and evaluating its own interests in light of proposed public policies. Unfortunately, the conventional wisdom among normative and empirical theorists is that the average citizen is supremely ill-equipped in these regards.[9]

This characterization is perhaps most applicable in the case of health care; citizen ignorance flourishes in an environment of limited and inaccessible information, resulting in the inability of lay people to evaluate health care policies.[10] Given the mysteries of modern medicine and the esoteric vocabulary used by its practitioners, it is hardly surprising that most people feel quite inadequate evaluating the performance of either the health care they receive personally or the health care policies proposed by government.

One could argue, of course, that in terms of its incomprehensibility and inaccessibility, health care is no different from many other technology-based public policies. Health care, however, has a uniquely personal aspect. The aphorism that "if you have your health, you have everything," and the empirical evidence on the importance that Americans attach to good health, suggest that health care occupies a special, if not unique, place in our value system and produces extraordinary political circumstances.[11] One

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Marketplace, HASTINGS CENTER REP., Feb. 1976, at 34.

[8] MENZEL, *supra* note 6, at 117.

[9] Giovanni Sartori, a keen student of democratic theory asks: "What is the information base of public opinion?" GIOVANNI SARTORI, THE THEORY OF DEMOCRACY REVISITED 103 (1987). His response does not bode well for citizen control over a rationing policy. "Here the answer is crushingly, throughout mountains of evidence, of a similar tenor: The state of inattention, non-interest, sub-information, perceptive distortion, and, finally, plain ignorance of the average citizen never ceases to surprise the observer." *Id.*

[10] *See* Rand E. Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401, 1409-10 (1981).

[11] Ten years ago the Gallup Poll asked Americans what they deemed most important to them personally. The two most frequently mentioned social values were a good family life (by 82% of the respondents) and good physical health (81%). *See Intangibles Valued More Than Belongings*, GALLUP REP. NO. 198, March 1982, at 3, 5,

consequence of all this is that the health care policy environment is one in which effective citizen control is rendered particularly difficult.[12]

It would seem that rational policy choice and effective citizen evaluation—both essential ingredients in any process of political accountability—are unusually diminished or inhibited by feelings of vulnerability and anxiety accompanying the contemplation of personal illness. There is then a perception that the personal stakes of illness, and the consequent need for health care access, are extraordinary. Mary Ann Bailey has noted that "[f]or most people, health care is special because of its importance in preventing pain and suffering, preserving the ability to pursue a normal life plan, providing information and relieving worry, and reflecting a community's concern for its members."[13] Paul Menzel states the point somewhat differently: "[I]llness touches on the most universal and mysterious human experiences of birth, death, and the contingency of life . . . ."[14] Thus, health care enjoys a special place of importance not simply because it helps alleviate or eliminate pain and suffering, but because it may be instrumental to our achieving most of what we want out of life.

The sense of incompetence and vulnerability that most of us feel in the face of illness is reinforced by a sense of impotence. We are beginning to recognize that a good deal of morbidity and premature mortality is self-inflicted, the result of irresponsible life-style choices that are by-and-large controllable. The view, however, still prevails that most ill health is the result of random, biological forces, over

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[12] Not everyone agrees that health care should enjoy a special place in public policy considerations. David Friedman, for example, argues that:

> It is often claimed that health care is special because it is a 'need' whereas most other things are only 'wants.' This seems to reduce either to the assertion that health care is a need because it is necessary for life, and life is infinitely valuable relative to other desirable things, or that it is a need because the kind and amount of health care which an individual requires is a matter of objective fact, to be determined by experts, rather than a matter of preferences. The claim that life is infinitely valuable, while rhetorically satisfying, is difficult to defend, whether as a proposition about how people do act or about how they should act.

David D. Friedman, *Comments on "Rationing" Medical Care: Processes for Defining Adequacy*, *in* THE PRICE OF HEALTH 185, 186 (George J. Agich & Charles E. Begley eds., 1986).

[13] Mary Ann Baily, *Rationing Medical Care: Processes for Defining Adequacy*, *in* THE PRICE OF HEALTH, *supra* note 12, at 165, 165.

[14] MENZEL, *supra* note 6, at 122.

which we have no control and which pose potentially fatal or at least debilitating consequences.

Because health is so highly valued yet largely misunderstood by the general public, any attempt to deliberately limit access to health care is certain to create substantial burdens on efforts to insure citizen control over such a rationing policy. Americans, historically, do not take well to rationing of any sort.[15] When it comes to rationing health care, there is a special dilemma: Americans have difficulty "in being able to think about [health care] rationing as a moral activity at all."[16] The initial problem here is an obvious one. Although rationing is designed to equitably and impersonally impose limits on health services available to *all* people within a certain category (for example, Medicaid recipients), it will still be viewed largely in terms of denying individual, identifiable human beings—as opposed to statistical "persons"—care that may lead to the prolongation of life or diminution of suffering. Saying "no" to those in need of health care is neither a congenial exercise nor consistent with prevailing cultural values and attitudes toward the sanctity of human life.[17]

Rationing, then, will place most Americans in a morally uncomfortable position. This situation is exacerbated by the highly technical nature of the process. The Oregon plan, for example, involves prioritizing over 700 condition/treatment pairs. Priority is based partially upon a highly technical and somewhat abstract calculation of how each relates to quality of well-being (QWB) associated with the nature of the condition and the quality of life resulting from providing or denying treatment.[18] Specifically, Oregon adopted an approach called "quality-adjusted life year" (QALY) that incorporates both the quality of life and the effect on life expectancy from treating particular conditions.[19]

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[15] *See, e.g.*, Stephen W. Sears, *Sorry, No Gas*, 30 AM. HERITAGE 4, 5-17 (1979) (describing America's Gasoline rationing program in the 1940s).

[16] LARRY R. CHURCHILL, RATIONING HEALTH CARE IN AMERICA: PERCEPTIONS AND PRINCIPLES OF JUSTICE 32 (1987); *see also* Karen Hansen, *The Ethical Dilemma of Health Care*, ST. LEGISLATURES, Oct. 1989, at 9, 11 (examining whether people have a right to health care).

[17] *See* Norman Daniels, *Why Saying No to Patients in the United States Is So Hard: Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENG. J. MED. 1380 (1986); Blumstein, *supra* note 6, at 1352-54.

[18] *See* Hadorn, *Priority-Setting Exercise*, *supra* note 1, at 11-12.

[19] *See id.* at 11. For extensive background on the process of developing the Oregon plan, see OREGON HEALTH SERVICES COMMISSION, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE *passim* (1991) [hereinafter

The sophisticated and esoteric nature of this approach raises the fundamental question of how well prepared the average citizen is to judge the relative merits of treating, say, acute urticaria (number 657 on the Oregon priority list) versus candidiasis (number 658).[20] Some, like David Hadorn, believe that the Oregon proposal is an improvement over the more traditional, rationing-type health care choices that citizens are asked to judge (for example, the funding of organ transplants versus neonatal programs or increased spending on Medicaid versus school lunch programs). They believe that even though most people are ill-equipped to evaluate the efficacy of specific *programs*, they have an experiential basis for judging health *outcomes*.[21]

Any rationing plan, whether based upon the prioritization of programs or outcomes, will sorely test the ability and willingness of citizens to judge the morality and efficacy of a public policy that represents a rejection of the most fundamental of American values. Blumstein has summarized the problem:

> Pragmatically, formulating standards is difficult because of the variety of problems and nuances that inevitably arise in the medical services context. More importantly, there is the specter of government openly renouncing the widely held belief in the sanctity of human life and publicly acknowledging that society is unwilling to expend the funds necessary to preserve human life and health.[22]

One can hardly imagine a less auspicious set of circumstances for citizens to evaluate public policy and to judge those who make it.

II. WHO IS ACCOUNTABLE TO WHOM, FOR WHAT, AND WHEN?

Thus far I have suggested that health care in general, and rationing in particular, provide an unusual array of problems that may make it difficult for citizens to hold public officials answerable for the consequences of rationing. The problem is exacerbated by

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OREGON HEALTH SERVICES COMMISSION].

[20] *See* OREGON HEALTH SERVICES COMMISSION, *supra* note 19, app. J.

[21] *Priority-Setting Exercise*, *supra* note 1, at 11. Hadorn concludes: "Everyone has been ill at one time or another and has experienced at least temporary periods of disability. Most people are in a position to recall what care can do, and therefore can offer opinions about various states of health that are better informed than their opinions about programs." *Id.* at 15.

[22] Blumstein, *supra* note 6, at 1371.

the fact that accountability is itself an elusive and complex concept. Above, I defined political accountability as the exercise of popular control over public officials for the actions they have taken or have caused to be taken.[23] This definition is, however, both conceptually and behaviorally inadequate. "Accountability" may be used in one of at least three ways to define the relationship among people, policymakers, and public policy.

First, political accountability is sometimes defined in narrow, legal terms, or what Leon Hurwitz calls "the state as defendant."[24] This definition envisions a system of redress available to citizens who believe they have been wronged by the state. In the case of rationing, this presumably might involve the right of a citizen to sue either the government, or health care providers as agents of the government, for a harm that allegedly resulted from the denial of a medical service not covered under a rationing plan. Oregon legislators, for example, clearly had this definition in mind when they exempted health care providers from "criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding" under the state's rationing law.[25]

Legal challenges to a state for harm resulting from the unavailability of a medical procedure that is not covered under a rationing plan might be based upon the claim that health care is an entitlement and to refuse services because of rationing is a denial of due process. It should be noted, however, that the courts have not been especially sympathetic to such pleas.[26]

If the idea of the "state as defendant" defines accountability narrowly, a second interpretation, namely "moral accountability,"

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[23] *See supra* note 2.

[24] For the development of the state as defendant as a legal principle, see LEON HURWITZ, THE STATE AS DEFENDANT: GOVERNMENTAL ACCOUNTABILITY AND THE REDRESS OF INDIVIDUAL GRIEVANCES (1981); John H.W. Hinchcliff, *The Limits of Implied Constitutional Damages Actions: New Boundaries for Bivens*, 55 N.Y.U. L. REV. 1238, 1243-48 (1980) (discussing the scope of the implied damages action for remedying violations of individual rights).

[25] OR. REV. STAT. § 414.745 (1991).

[26] *See* James F. Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899, 912-16 (1982).

broadens accountability considerably.[27] This particular construction posits a set of implicit, rather than explicit, moral obligations which government has toward its citizens, but which may not be part of its legal responsibilities.[28] For example, discussions of rationing often involve a reference to a "decent minimum" or "adequate level" of health care that each citizen should enjoy, despite the fact no such standard exists or has any legal status. The implication here is that the state has a moral, if not legal, obligation to provide a certain level of care that common sense or medical wisdom has identified as the point below which the well-being of a person would be jeopardized.

The claim that government has a moral responsibility toward its citizens is typically limited to areas in which human health, welfare, or safety is endangered. Hence, we speak of holding the Nazis morally accountable for the Holocaust, the Johnson and Nixon administrations for the war in Vietnam, or local officials for failure to adopt or enforce safety codes. Rarely do we speak of holding public officials morally accountable for the consequences of a capital gains tax, a highway beautification program, or changes in zoning policy.

Because the concept of a moral obligation of government is both more imprecise and highly charged than, say, that of legal responsibility, it is more difficult to identify who is to be held morally accountable and for what. Public law routinely specifies legal responsibility, but rarely moral responsibility. In addition, there are some practical limitations to ascribing moral accountability. As Dennis Thompson has noted: "Because many different officials contribute in many ways to decisions, and policies of government, it is difficult even in principle to identify who is morally responsible for political outcomes."[29] Thompson calls this "the problem of

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[27] For a discussion of the distinction between legal and moral accountability, see Dennis F. Thompson, *Moral Responsibility and the New York City Fiscal Crisis, in* PUBLIC DUTIES: THE MORAL OBLIGATIONS OF GOVERNMENT OFFICIALS 266, 266-67 (Joel L. Fleishman et al. eds., 1981); John Ladd, *The Ethics of Participation, in* PARTICIPATION IN POLITICS 98, 116-118 (J. Roland Pennock & John W. Chapman eds., 1975).

[28] *See* H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 211-30 (1968).

[29] Dennis F. Thompson, *Moral Responsibility of Public Officials: The Problem of Many Hands*, 74 AM. POL. SCI. REV. 905, 905 (1980). Moral responsibility is also sometimes thought of as the obligation that citizens have to one another. This interpretation is very much a part of the "participatory democracy" model advocated and practiced in Oregon, and to which I will return shortly. Thus, in referring to the series of public meetings held in Oregon to gauge community values on health issues, two members of Oregon Health Decisions, the guiding light of citizen involvement in Oregon

many hands," and it underscores the difficulty of applying typically vague notions of morality to judgments about responsibility.

The third and most common use of political accountability has already been mentioned—namely popular control through what Madison called "the restraint of frequent elections."[30] Thus, public officials who fail to fulfill campaign promises, or to anticipate constituent concerns, presumably will be held answerable by the voters for their actions. Or, as Madison noted with regard to the House of Representatives, it "is so constituted as to support in the members an habitual recollection of their dependence on the people." Just how effective this control is in practice is open to considerable doubt. Empirical evidence indicates that voters rarely throw incumbents out of office, and that elites do not always hold views identical to those whom they represent.[31]

Whichever meaning or meanings one attaches to the notion of accountability, it is necessary to specify *to whom*, and *for what* we expect public officials to be answerable. It is more than a mere exercise in pedantry to suggest that the answers to these questions are neither self-evident nor inconsequential. In the context of health care rationing, simply saying policymakers must be answerable to the people for a fair and effective rationing program is at the very least superficial and perhaps even misleading and/or undesirable depending upon the stated aims of the policy itself.

In the first place, although policymakers are theoretically answerable to "the people," not all of the people are equally affected by, or concerned about, each policy. In the case of rationing, health care providers, insurance carriers, social advocacy

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rationing, commented that: "Because of these meetings we can confirm that there is a pervasive concern that we, the entire American community, should hold ourselves accountable for the fairness, prudence, and common welfare created by our health care institutions and practices." Garland & Hasnain, *supra* note 1, at 17. *See also* Dougherty, *supra* note 6, at 3 (discussing the values at stake in prioritizing health care).

[30] THE FEDERALIST No. 57, at 344 (James Madison) (Isaac Kramnick ed., 1989).

[31] *See, e.g.*, Stephen D. Shaffer & George A. Chressanthis, *Accountability and U.S. Senate Elections: A Multivariate Analysis*, 44 W. POL. Q. 625 (1991) (examining the extent to which senators are held accountable to voters); *see also* Eric M. Uslaner & Ronald E. Weber, *Policy Congruence and American State Elites: Descriptive Representation versus Electoral Accountability*, 45 J. POL. 183, 185-93 (1983) (examining the extent of congruence between the public and three elite groups: county political leaders, state legislators, and state bureaucrats). For a more theoretical discussion of the problem of relying on elections as the chief instrument for insuring elite accountability, see NORMAN P. BARRY, AN INTRODUCTION TO MODERN POLITICAL THEORY 200-230 (1981).

groups, and health maintenance organizations all lay claim to a special interest in the process and outcome of any policy that will determine health resource allocations. The poor, who are likely to bear the burden of any rationing scheme, also have a special interest in health resource allocations. Assuming for the moment that some forum of accountability beyond that which is provided by "the restraint of frequent elections" or of routine legislative oversight is desirable, then it will be necessary to specify who among the population has a genuine interest in participation in the process of insuring answerability in the formation and implementation of health care rationing.

The belief that those who are most directly affected by rationing should be accorded a special role in ensuring elite accountability is not shared by everyone. Indeed, some would argue that responsibility for the determination and consequences of a rationing scheme can best be achieved when the entire community has a sense of ownership and obligation for rationing. This, as I will document below, is an essential part of the participatory democracy model adopted in Oregon.

This community responsibility requirement arises from both practical and ethical considerations. In practical political terms, the broader the constituency that identifies with rationing, the more likely it is that popular oversight will be effective in holding policymakers answerable for the content and consequences of health resource allocation decisions. From an ethical perspective, social justice and common vulnerability dictate that health care rationing should be a product of community involvement. This position is advanced by Larry Churchill: "A just health care system, whatever its final shape, requires a recognition of our sociality and mutual vulnerability to disease and death."[32] Health care, in this view, is a public good, and therefore the responsibility for any allocation decisions must be assigned to the entire community.

The question of *to whom* a rationing policy should be made accountable inevitably raises the question: *for what* should policymakers be held accountable? One way to answer this question is to ask another: What are the goals of rationing for which we want to hold policymakers responsible? The problem here, of course, is that there are several, often incompatible, aims. For example, rationing assumes scarce resources. In the case of health care, this

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[32] CHURCHILL, *supra* note 16, at 135.

scarcity refers not to medical personnel or equipment, but to the ability or willingness of the public sector to pay for the care of all those who are unable to pay for themselves. This is what Callahan calls "the simple" and "true proposition" about health care in America: "that we cannot have everything we want in health care."[33]

Implicit in this view of rationing is the idea that by limiting access to certain medical care procedures, we will be able to save money and to reallocate the savings in order to purchase care for those who are currently denied access. The difficulty with this is that it is unclear if we are to hold public officials accountable for saving money *and* expanding access, or just in expanding access. What if a rationing program results in universal access but ends up costing the taxpayers more money? Have public policymakers behaved responsibly?

There are other problems in specifying the goals of rationing. Access to health care is an instrumental value rather than a goal in itself. Access to health care should presumably lead to, among other things, decreased premature mortality, prolongation of life, reduction in human pain and suffering, and, perhaps, increased economic productivity. Some of these things, of course, are almost impossible to measure. But what about those that we can measure? What if mortality and morbidity rates do not decline? Is this something for which we want to hold public officials accountable? The calculation of goal achievement in expanding access is further complicated by the fact that access to health care is just one of many factors that may reduce morbidity, premature mortality rates, and human suffering. Other, non-medical factors include improved nutrition, housing, education, and job opportunities.

Unless we are willing to stipulate that social justice, in the form of universal access to a decent minimum or adequate level of health care—not equal access in the sense "that whatever is available to any shall be available to all"[34]—is the principle aim of rationing, then it will be quite difficult to judge whether or not policymakers have acted responsibly.

The difficulty, however, does not stop here. Do we want to judge political accountability merely in terms of outcomes and consequences, or in terms of process as well? Would proponents of

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[33] Daniel Callahan, *Allocating Health Resources*, HASTINGS CENTER REP., Apr.-May 1988, at 14, 18.

[34] Fried, *supra* note 7, at 30.

rationing be satisfied if access were expanded to all the uninsured, but in a way in which the poor, or health care providers, were not consulted in the formulation of the program? One might argue, for example, that given the uncertain and complicated nexus between health care and health, the most that we should hold public officials accountable for is the nature of the process of rationing (for example, publicity, opportunities for participation, and provisions for correcting policy performance, etc.), perhaps the altruism of their intentions, but not the consequences of their actions.[35]

Whether we want to hold public officials answerable for process or consequence, or both, we must also specify from whose perspective we are making such a judgment. A rationing plan that expanded access to all the uninsured, but reduced provider compensation or the role of private insurance carriers, will be evaluated quite differently depending on one's perspectives and goals. It is unrealistic to assume that because rationing involves the noble social value of guaranteeing access to the multitudes, that somehow principles of democratic "neutrality" or "undistorted communications," a Habermasian term, will prevail over interest group politics.[36] Rationing will become heavily politicized and will require, as much as any other issue of public policy, some structural guarantees to ensure that the process or its content remain accountable. The problem, as I have suggested, is in deciding *how* this will occur, *who* will be involved, and for *what* shall government be held answerable?

The difficulty, as some advocates of health care reform see it, is that existing mechanisms for holding officials responsible for their actions are inadequate, especially given the stakes involved in rationing. As a result, there has been renewed interest in examining the effectiveness of existing structures of accountability and searching for possible alternatives to these. It is this debate that I now address.

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[35] For a discussion that emphasizes the importance of participation in judging accountability, see Ladd, *supra* note 27, at 116-18.

[36] For the canonical source on the "corruption" of politics by client groups, see THEODORE J. LOWI, THE END OF LIBERALISM: THE SECOND REPUBLIC OF THE UNITED STATES 42 (2d ed. 1987).

III. PARTICIPATORY DEMOCRACY AND HEALTH CARE RATIONING

The "grand difficulty" of holding political elites answerable for their actions has become the grand frustration of American political theory. The problem begins with a widespread "realization, even in liberal democratic circles, that direct, participatory democracy is an impossibility in large societies."[37] If true—and I will return to this assertion shortly—the claim casts doubt upon one of the most fundamental tenets of democratic theory. John Dewey wrote that "[t]he keynote of democracy as a way of life may be expressed as the necessity for the participation of every mature human being in formation of the values that regulate the living of men together."[38] The burden for classical democratic theory here is that public policy becomes less the expression of popular preference, directly acted upon through public action, and more an elite choice which is largely removed from popular influence. Explanations or justifications for the fact that the elites, not the masses, govern range from the structural, such as the fact that power in any large scale organization will inevitably be concentrated in the hands of the few, to the empirical point that few people have the time, skills, or inclination to participate in politics even in its least demanding form—elections.[39]

The challenge for modern democratic theory, then, has been to accommodate political accountability within a structure of elite rule. This challenge has been met by offering alternatives to direct rule. Two in particular merit brief consideration. The first already has been mentioned in passing and is perhaps the most cherished of all, namely electoral accountability. This view suggests that the masses no longer directly make public policy—if they ever did outside the

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[37] KENNETH PREWITT & ALAN STONE, THE RULING ELITES 184 (1973).

[38] THOMAS R. DYE & L. HARMON ZEIGLER, THE IRONY OF DEMOCRACY: AN UNCOMMON INTRODUCTION TO AMERICAN POLITICS 9 (5th ed. 1981) (quoting John Dewey, *Democracy and Educational Administration*, SCHOOL AND SOCIETY, Apr. 3, 1937).

[39] Many scholars have identified the inevitable reliance on elites, not the masses, to govern. *See, e.g.*, C. WRIGHT MILLS, THE POWER ELITE 242-68 (1956) (theorizing that government is an automatic machine, regulated by a balancing of competing interests which are difficult to disturb); GAETANO MOSCA, THE RULING CLASS 103-19, 329-37 (Hannah D. Kahn trans., 1939) (detailing the history and theory of the ruling class); Uslaner & Weber, *supra* note 31 (examining the merits of the theses of descriptive representation and accountability). For a discussion of voting behavior, see GERALD M. POMPER, ELECTIONS IN AMERICA: CONTROL AND INFLUENCE IN DEMOCRATIC POLITICS 129-37, 240-43, 246-52 (1968); SARTORI, *supra* note 9, at 108-10, 133-41.

New England town meeting. Rather, they choose those who do make it.

In his classic formulation of the issue, Joseph Schumpeter argued that political decisions are arrived at through a process "in which individuals acquire the power to decide by means of a competitive struggle for the people's vote."[40] Thus, voters have the opportunity to periodically reward policymakers for faithfully reflecting popular wishes, or punishing them for ignoring those wishes. Political leaders are held accountable by anticipating citizen preferences and reactions. According to Jack Walker:

> The average citizen still has some measure of effective political power under this system, even though he does not initiate policy, because of his right to vote (if he chooses) in regularly scheduled elections. The political leaders, in an effort to gain support at the polls, will shape public policy to fit the citizens' desires. By anticipating public reaction the elite grants the citizenry a form of indirect access to public policy making . . . .[41]

The difficulties with assuring accountability through electoral representation were noted earlier.[42] To reiterate and elaborate on the point: low rates of voter turnout, split-ticket voting, citizen ignorance about incumbent and challenger policy positions, political elite ambiguity on their policy preferences, the absence of a disciplined party system, the division and fragmentation of political power, and often, partisan control between levels of government and among branches of government are just some of the problems that weaken the theory and practice of electoral accountability. It is hardly surprising that not everyone takes comfort from this alternative to direct democracy.[43]

The widespread indictment of the American voter as uninformed and uninvolved has led to an alternative view that tries to accommodate a more passive and less well-informed citizenry than is required by either direct democracy or electoral representation. At the heart of this theory, called pluralist democracy, is the recognition "that in a complex, urban, industrial society, individual

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[40] JOSEPH A. SCHUMPETER, CAPITALISM, SOCIALISM, AND DEMOCRACY 269 (3d ed. 1947).

[41] Jack L. Walker, *A Critique of the Elitist Theory of Democracy*, *in* APOLITICAL POLITICS: A CRITIQUE OF BEHAVIORALISM 199, 201 (Charles A. McCoy & John Playford eds., 1967); *see also* POMPER, *supra* note 39, at 64-67 (discussing the influence of elections on shaping government policy).

[42] *See supra* notes 8-10, 30-31 & 37-39 and accompanying text.

[43] *See* PREWITT & STONE, *supra* note 37, at 203-09.

participation in decision making is not possible and has inevitably and necessarily given way to interaction—bargaining, accommodation, and compromise—among leaders of institutions and organizations in society."[44]

Individual interests, according to pluralists, are articulated, pursued, and protected by the leadership of the social, economic, and political organizations and institutions to which Americans belong in great numbers. Through the various tools at their disposal (for example, lobbying, electioneering, litigation, and public relations), interest groups help bring the concerns of their members to policymakers, influence policy choices, and ultimately hold leaders responsible for the consequences of their actions. Thus, "[g]overnment is held responsible not by individual citizens but by leaders of institutions, organized interest groups, and political parties."[45] Pluralists do not view group membership and activity as replacing voting and elections, but rather as a supplement to them. Of course for those who do not vote on a regular basis, or who do not vote in a "rational" manner (voting for those who most closely reflect their own policy choices), group membership becomes the only opportunity for citizen influence.

Although pluralist democracy may be the most widely accepted view of American democracy among academics today, it is also among the most widely criticized. Scholars have taken pluralism to task for many of its descriptive and prescriptive assertions and implications, but only two of these merit discussion here.[46]

First, not all people belong to interest groups and, in fact, the least well educated and the least affluent are also the least likely to belong. In the context of health care rationing, this means that those who are most likely to be affected by rationing, such as the working and non-working poor, are the least likely to be represented by interest groups. As E.E. Schattsneider remarked a number of years ago: "The flaw in the pluralist heaven is that the heavenly

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[44] DYE & ZEIGLER, *supra* note 38, at 13.

[45] *Id.*

[46] For critiques of pluralism, see DYE & ZEIGLER, *supra* note 38, at 13-16; LOWI, *supra* note 36, *passim*; PREWITT & STONE, *supra* note 37, at 215-20; Charles W. Anderson, *Political Design and the Representation of Interests*, 10 COMP. POL. STUD. 127 (1977); William E. Connolly, *The Challenge to Pluralist Theory*, *in* THE BIAS OF PLURALISM 3 (William E. Connolly ed., 1969) (arguing that the conventional pluralistic interpretations of American politics are defective empirically, normatively and ideologically); Donald W. Keim, *Participation in Contemporary Democratic Theories*, *in* PARTICIPATION IN POLITICS, *supra* note 27, at 1.

chorus sings with a strong upper-class accent. Probably about 90 percent of the people cannot get into the pressure system."[47]

Second, even if they are represented, not all groups have equal resources, access, or influence; the playing field is anything but level in interest group politics. It is not unreasonable to predict, for example, that in the context of health care rationing the health provider industry will have more political influence than advocates for the poor or the poor themselves. In fact, as argued below, this is precisely what happened in Oregon.[48] These and other criticisms have led many to conclude, as Charles Anderson has, that "[i]nterest group pluralism does not provide a sufficient basis for a *policy* of interest representation. It is not plausible as a model of institutional design in a democratic society."[49]

A theoretical effort to reconcile elite rule and popular accountability is the Platonic notion of an enlightened elite that has internalized the norms of civic virtue, tolerance, and other democratic values.[50] The modern incarnation of this idea is based upon some rather convincing empirical evidence that these values are more prevalent among the nation's political leadership than its electorate.[51] Among the reasons for the contrast between elite and mass values are that the members of the elite are better educated, more likely to be exposed to civil libertarian ideals, and more likely to interact with others committed to these ideals. By extension it is assumed that among the internalized values of the elite is that of acting responsively and responsibly. In this modern version of noblesse oblige, political accountability emerges from an elite culture that incorporates an attentiveness to citizen needs and preferences.

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[47] E.E. SCHATTSNEIDER, THE SEMISOVEREIGN PEOPLE: A REALIST'S VIEW OF DEMOCRACY IN AMERICA 35 (1960).

[48] *See infra* notes 81-85 and accompanying text.

[49] Anderson, *supra* note 46, at 137.

[50] *See* PREWITT & STONE, *supra* note 37, at 188-97 (discussing the enlightened elite).

[51] For *the* classic work on this subject, see SAMUEL A. STOUFFER, COMMUNISM, CONFORMITY, AND CIVIL LIBERTIES: A CROSS-SECTION OF THE NATION SPEAKS ITS MIND 26-27 (1955) (finding that community leaders are more likely than the average person in the population to respect the civil rights of those of whom they disapprove). *See also* HERBERT MCCLOSKY & ALIDA BRILL, DIMENSIONS OF TOLERANCE: WHAT AMERICANS BELIEVE ABOUT CIVIL LIBERTIES 418-27 (1983) (finding that leaders in a democratic society are more likely than the average citizen to honor and protect the liberties of others).

How comfortable should we feel relying on the ethos of democratic elitism to guarantee political accountability? As an empirical matter, it appears we ought to feel uncomfortable with this reliance. A number of observers have found "the record of the elite is not promising."[52] The Platonic ideal requires a greater degree of selflessness, self-restraint, and self-abnegation than the record will support. The post World War II era, from McCarthyism to Vietnam to Watergate to Iran-Contra, hardly leaves one comforted by the prospect of elites guarding the hen house of democracy. The Platonic model also emphasizes procedural concerns, such as elections, tolerance, and free speech, but not substantive ones.[53] Thus, although this model might well produce an elite that is accountable to the masses in terms of protecting procedural rights, it is less clear that they would, for example, respond to popular demand for an adequate level of health care for all.

IV. PARTICIPATORY DEMOCRACY REDUX

Scholarly concern over the apparent ineffectiveness of electoral representation, pluralist democracy, and democratic elitism to insure popular control over public policies has led to a search for a democratic alternative. Ironically enough, the quest has led some back to "the people." The idea here, hardly a new one, is that citizens should be reinserted into the process of directly making public policy in their own communities. The irony, of course, is that each of the theories of democracy reviewed above was a response to the charge that the classical democratic ideal of citizen participation was unrealizable. Walker has stated: "The concept of an active, informed, democratic citizenry, the most distinctive feature of the traditional [democratic] theory, is the principal object of attack. On empirical grounds it is argued that very few such people can be found in Western societies."[54]

After years, really centuries, of being relegated by democratic theorists to the essentially defensive role of controlling (holding accountable) the political elite, advocates of participatory democracy want to place citizens back in the business of actually making policy. Advocates of participatory democracy argue that the preconditions

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[52] PREWITT & STONE, *supra* note 37, at 193; *see also* DYE & ZEIGLER, *supra* note 38, at 20-23 (noting that although elites are more committed than the masses to democratic values, "they frequently abandon these values in crisis periods.").

[53] *See* PREWITT & STONE, *supra* note 37, at 196-97.

[54] Walker, *supra* note 41, at 199-200.

for such a venture, namely knowledge, time, a sense of civic—as opposed to private—obligation, and a geographically manageably sized community, all thought to be absent, have simply been stifled. People *want* to become involved, if for no other reason than disillusionment with politicians. In addition, citizens are better educated, more knowledgeable about, and capable of engaging in, community-wide decision making than at any time in history. Benjamin Barber, a major and influential proponent of participatory democracy, or what he calls "strong democracy," argues that people are naturally drawn to political activity, possess civic virtue, and have the ability to make reasonable, rational, and selfless choices.[55]

Barber is not a Pollyanna who believes that citizen self-government will replace representative government. Rather, he argues the participation will be a matter of degree, albeit a qualitatively important degree: "Active citizens govern themselves directly here, not necessarily at every level and in every instance, but frequently enough and in particular when basic policies are being decided and when significant power is being deployed."[56]

Barber argues that strong democracy renders the issue of political accountability largely irrelevant. Although it may still be necessary to ensure accountability in administration of policy, he contends that when the people become the decisionmakers, that is "self-government by citizens rather than representative government in the name of citizens," the need for external control over public policymaking disappears.[57] In fact, Barber argues that the whole concept of accountability has perverted and eviscerated true democracy:

> It may also explain the civic climate—the political style—of passive distrust that has made America at once a bastion of private rights and a graveyard of public action. When the citizenry is a watchdog that waits with millennial patience for its government to make a false move but that submits passively to all other legitimate

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[55] *See* BENJAMIN R. BARBER, STRONG DEMOCRACY: PARTICIPATORY POLITICS FOR A NEW AGE at xiv (1984) (claiming that "strong democracy is the only viable form modern democratic politics can take, and that unless it takes a participatory form, democracy will pass from the political scene along with the liberal values it makes possible"). For another, somewhat less sanguine, discussion of participatory democracy, see C.B. MACPHERSON, THE LIFE AND TIMES OF LIBERAL DEMOCRACY 93-115 (1977) (arguing that more participation in our present political system is not only desirable but possible).

[56] BARBER, *supra* note 55, at 151.

[57] *Id.*

> governmental activity, citizenship very quickly deteriorates into a latent function.[58]

According to advocates of strong democracy, America will only regain the spirit and content of democracy by again placing its faith, and political power, in the hands of the people, or, in Barber's words, in "unmediated self-government by an engaged citizenry."[59] Barber's ideas were put to a test, at least partially, in Oregon as it prepared for rationing and it would therefore be useful to review that experience for the insights it provides into the utility of participatory democracy as a means of achieving political accountability.

Oregon is in many respects an ideal setting for such a noble experiment. Active citizen involvement in policymaking has a long and cherished tradition in the state. It was in Oregon, in the early part of this century, that the initiative and referendum were first introduced.[60] In addition, Oregonians embrace and exemplify a "moralistic" political subculture in which "both the general public and politicians conceive of politics as a public activity centered on some notion of the public good and properly devoted to the advancement of the public interest."[61]

This spirit and tradition are embodied in a grass-roots, nonprofit, citizens' advocacy group, Oregon Health Decisions (OHD), which played an important role in engaging Oregonians directly in the process of setting health care priorities in the state's rationing plan. OHD, which traces its origins to the 1982 Governor's Conference on Health Care for the Medically Poor, includes as one of its goals, "[t]o promote the involvement of the general public in the process

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[58] *Id.* at 220.

[59] *Id.* at 261. Americans had a brief, but politically important, flirtation with limited participatory democracy in the form of Community Action programs during Lyndon Johnson's War on Poverty. These programs were intended to encourage "maximum feasible participation" by citizens in federal antipoverty programs. *See* LOWI, *supra* note 36, at 226. For less than glowing evaluations of those experiences, see *id.* at 211-26; Howard I. Kalodner, *Citizen Participation in Emerging Social Institutions*, *in* PARTICIPATION IN POLITICS, *supra* note 27, at 161. Participatory democracy actually has a rather interesting pedigree. The idea was introduced into the lexicon of American politics in 1962 in the "Port Huron Statement" of the radical Students for a Democratic Society (SDS). It was then coopted, much to the chagrin of SDS, by the Johnson anti-poverty program. *See* MILTON VIORST, FIRE IN THE STREETS: AMERICA IN THE 1960S at 191 (1979).

[60] MICHAEL BARONE & GRANT UJIFUSA, THE ALMANAC OF AMERICAN POLITICS 1990, at 1002 (1990).

[61] DANIEL J. ELAZAR, AMERICAN FEDERALISM 115-22 (3d ed. 1984).

of clarifying the health related values of Oregonians and to apply these values to health policy processes."[62]

In 1984 and 1988, OHD conducted a series of community meetings around the state that engaged Oregonians in discussions about public values on bioethical issues, and in particular, health care priorities.[63] These meetings culminated in a Citizens' Health Care Parliament, which approved resolutions that reflected the health care values and priorities of Oregonians—or at least of those who participated in the process.[64] OHD has become the model for other state organizations. In 1985 the federal Office of Health Planning, Department of Health and Human Services commissioned a guide for citizen-based bioethical groups.[65]

Oregon Health Decisions (OHD), and its peripatetic founder, Dr. Ralph Crawshaw, were well known and highly respected in the state. The idea of citizen involvement in setting health care priorities, with which OHD had been identified and had experience, appealed to state political leaders, especially the chief architect and guiding light of the health reform plan, state Senate President (and physician) John Kitzhaber.[66] Kitzhaber and other legislators had taken a great deal of political heat, and suffered a good deal of genuine personal anguish, in December 1987 when a seven-year boy from Portland had died of leukemia. The boy's mother, who was unemployed, learned that the state had ceased funding organ transplants earlier that year as a way of saving dwindling state Medicaid funds. The death of the young boy,[67] and the appearance before a state legislative committee in January 1988 of friends and relatives of three transplant candidates,[68] brought uncomfortable national attention to the state. As a result of this experience, Senator Kitzhaber, who became the focus of much of this attention, decided that if the state had to ration health care for the poor, which he believed it did, then those decisions should be built upon a social and political consensus.[69] This consensus was vital to the

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[62] 1989 OREGON HEALTH DECISIONS LONG RANGE PLAN: 1989-1994, at 2.

[63] *See id.* at 1-2.

[64] *See id.* at 2.

[65] *See* 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 7.

[66] Telephone interview with Mark Gibson, Executive Assistant to Oregon Senate President John Kitzhaber (Feb. 20, 1992).

[67] *See* Nat Hentoff, *Saving the Most Lives for the Buck*, VOICE, May 31, 1988, at 34.

[68] *See* Patrick O'Neill, *Attempt to Expand Transplant Aid Fails*, OREGONIAN, Jan. 29, 1988, at E1.

[69] *See* OREGON STATE SENATE, DISCUSSION PAPER ON SENATE BILL 27, at 7 (1989).

political and social legitimacy and acceptance of any health resource allocation plan.

The Basic Health Services Act,[70] as the rationing law came to be known, created an eleven-member Health Services Commission (HSC),[71] which was to "actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions."[72] The Commission was to accomplish consensus building in the prioritization of health services in three ways. First, it would hold a series of eleven public hearings around the state allowing interested parties to express their views.[73] Second, it authorized OHD to conduct the kind of community meetings it had held previously.[74] Finally, the HSC commissioned a statewide telephone survey of 1000 Oregonians.[75] The results of the survey were then formally incorporated into a mathematical cost/utility or "net benefit value" formula that included data on expected outcomes of given treatments for hundreds of health conditions.[76]

After some initial data collection and methodological problems, which produced a medically and politically unacceptable initial prioritization list, the HSC ultimately submitted to the legislature a list of 709 medical condition/treatment pairs.[77] On June 30, 1991, the Oregon Legislative Assembly approved a budget that would allow the state to fund health services to the Medicaid population through number 587 on the priority list.[78]

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[70] OR. REV. STAT. §§ 414.705-.750 (1990).

[71] *Id.* § 414.715(1).

[72] *See id.* § 414.720(2).

[73] *See* Fox & Leichter, *supra* note 1, at 20.

[74] *See id.* Ultimately, forty-seven forums, attended by over 1000 Oregonians, were held around the state during which time participants filled out a questionnaire soliciting their opinions on the relative importance of certain health situations and categories, and engaged in group discussions of values related to health. *See id.*

[75] *See id.* at 21. To conform to the principle of incorporating community values in the prioritization process, the commission used a modified version of the Quality of Well-Being Scale: "Respondents were asked to rate thirty-one health situations from 0 (a situation that is 'as bad as death') to 100 (a situation that describes 'good health')." *Id.*

[76] *Id.*

[77] *See* OREGON HEALTH SERVICES COMMISSION, *supra* note 19, app. J.

[78] The HSC submitted the list of 709 condition/treatment pairs to a public accounting firm for an actuarial analysis. The firm calculated the monthly per capita cost for each of the 709 health treatments. Their report provided the legislature with ten threshold models of services ranging from providing all medicaid recipients with coverage for 200 of the 709 services (at a per capita monthly cost of $87.12) to all 709 services ($145.15 per capita). The Legislative Assembly authorized the expenditures

How closely did this procedure conform to the sort of "strong democracy" advocated by Barber? First, there is evidence suggesting that community values figured prominently in commission deliberations and the outcome. For example, Amy Klare, one of the four consumer representatives on the HSC, reported that although some members, including herself, felt that the high value assigned to preventive services by Oregonians in the community forums dictated that such services receive a high priority, some of the physician members were less convinced about the relative utility of, say, nutritional supplements and dental check-ups.[79] In the end, however, the force of expressed community values prevailed, and preventive health services appeared high on the list.[80]

Other evidence, however, paints a less favorable picture of the process. In our study of the Oregon rationing experience, Daniel Fox and I found that the process tended to be dominated not by the people who would be most directly affected by rationing, namely the poor, but rather by health care interests.[81] For example, although OHD had hoped to attract a cross-section of Oregonians to the community meetings, this did not turn out to be the case. Of the slightly more than 1,000 people who attended, almost seventy percent were mental health and other health care workers.[82] Although the term *workers* is not defined, over one-third of the participants had incomes of $50,000 or more and two-thirds were college graduates.[83] Few of those attending were "poor."[84] In addition, the health service industry's presence and influence were substantial during the legislative hearings on the rationing package, and health care providers were in the majority on the eleven-member HSC: there were five physicians, one public health nurse, one social worker, and four "consumers of health care."[85]

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of funds to cover 587, or about 80%, of the services on this list. *See* OREGON HEALTH SERVICES COMMISSION, *supra* note 19, app. I, at 37-44 & exhibit 28-A. For a complete account of the rationing story, see Fox & Leichter, *supra* note 1.

[79] Telephone interview with Amy Klare, Commissioner, Health Services Commission (March 18, 1991).

[80] *See id.*

[81] *See* Fox & Leichter, *supra* note 1, at 24-25.

[82] *See* ROMANA HASNAIN & MICHAEL GARLAND, HEALTH CARE IN COMMON: REPORT OF THE OREGON HEALTH DECISIONS COMMUNITY MEETINGS PROCESS 29 (1990).

[83] *See id.* at 29.

[84] *See id.* at 30.

[85] *See* OREGON HEALTH SERVICES COMMISSION, *supra* note 19, at 3.

Finally, it is important to note that all of the direct citizen participation took place *after* the initial, and critical, decision to ration health care had been made by the political leadership; there was no formal solicitation of community sentiment or exercise in participatory democracy on the actual decision to ration. Similarly, most of the critical decisions involving the legislation—for example, the composition of the HSC, the methods for gauging community sentiment, the determination of whose views to solicit, the commitment to an "adequate level of health care," the limitation on physician liability, and the decision to fully reimburse health care providers for the services they would provide under Medicaid—were decided in the normal legislative process of interest group lobbying, bargaining, and compromise. In short, the Oregon legislation resembles the paradigm of participation in a liberal, pluralist democracy. In this process, as Schumpeter and others correctly predict,[86] the medical professional played a key role.

Having said this, however, there is little doubt in my mind that the process of rationing health care in Oregon was far more open to public scrutiny and involvement than is typically the case in policymaking. In this sense, and in this way, those involved in the process, including leading health professionals, other community influentials, and the legislature *are* more politically accountable for explicitly rationing health care services in the state. But Kitzhaber and his staff assert that they have gone further: Oregon, they claim, is "hold[ing] *society accountable for the rationing of health services to the poor through its legislature.*"[87]

As I have suggested above, given the socially and economically narrow range of that involvement, this claim may be a bit presumptuous. Nevertheless, it is revealing of the philosophy behind community involvement that the focus here is on societal rather than political accountability. The Oregon leadership wanted citizens to *buy into* and have a *sense of ownership of* health rationing in the state. Benjamin Barber would, I suspect, be at least partially pleased by Oregon's experiment in "strong democracy."

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[86] *See supra* notes 40-45 and accompanying text.

[87] Memorandum from Oregon Senate President's Office to Daniel Fox and Howard Leichter (December 26, 1990) (on file with author).

CONCLUSION

Does, or indeed should, the Oregon effort to engage citizens in the rationing of health care provide a model for other states? Can Oregon's experiment, however far short it might fall of Barber's ideal, work in other places? There are two points that I would make in this regard. First, as suggested above, Oregon is in many respects an ideal laboratory for an experiment in quasi-strong democracy. The state has a tradition of innovation and plebiscitarian democracy—it is relatively small and socially homogeneous—and it was fortunate to have an existing organization in the form of Oregon Health Decisions that had the experience, leadership, and respect necessary to engage in such an exercise. These conditions are not unique to Oregon—a number of states now have grass-roots, bioethical groups modeled after OHD—but they are not widespread.[88]

Second, no one can or would claim that Oregon has come up with a successful alternative to existing mechanisms of political or social accountability. The problems identified in this Article, which are generic to any attempt to ensure that public policy serves the public interest, remain. Physicians in Oregon, for example, define accountability differently than do representatives of the Oregon Health Action Council, an umbrella organization representing more than seventy labor, senior citizen, minority, and low income groups. Resource differentials among groups in our pluralist society remain a reality of life that efforts at participatory democracy are unlikely to erase.

Is the Oregon approach an improvement over relying strictly on elections, or interest group representation, or elite guardianship of the commonweal? In my judgement it is. How much of an improvement is open to question. In any event, this experiment should be viewed as a supplement to, rather than a replacement of, the admittedly flawed system of accountability that prevails in this country.

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[88] *See* Otten, *supra* note 1.