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[Book Review of] *Rationing Health Care In America: Perceptions and Principles of Justice*, by Larry R, Churchill

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BOOK REVIEW

Rationing Health Care In America: Perceptions and Principles of Justice

by Larry R. Churchill

(Notre Dame, IN, University of Notre Dame Press), 1987

This is a timely and important book. Churchill's purpose is to argue for certain principles of justice in health care allocation and to show the differing senses of self and society implied by various alternative theories of justice. The book is addressed to medical students, doctors, hospital administrators, and those in public policy positions.

Churchill begins by examining cost escalations in contemporary health care and limitations on access to the system. Given the virtually inexhaustible need for health care services and their inevitable scarcity even in an affluent nation, Churchill draws the obvious conclusion: We must ration health care. Moreover, we do already. At present health care in American is rationed by ability to pay, insurance status, disease, age, race, geography, and luck. Since the dominant factor influencing all these others is money in the marketplace, our present rationing appears invisible. Most people get what they need because they can pay for it. Those who can't pay for it often don't get what they need. The logic seems simple and straightforward, since it's a logic we accept throughout our economy. Rationing appears invisible because no bureaucrat, no system of explicit decision-making, has excluded people; they simply can't afford it. To most Americans this has the appearance of a fact of nature.

This view of health care rationing is tied to American individualism. We prize independence and privacy. We seek distance from one another. Our conception of freedom is essentially negative, a freedom *from* the interference of others. Above all, self-sufficiency is valued. Ironically, self-sufficiency in health care is so overly stressed that it often expresses itself in its extreme opposite when we are sick, namely, in an abject dependence on physicians and the health care system.

One of the strengths of Churchill's book is his use of concrete images to carry his argument. Thus Americans are not so much bound to these values because of adherence to abstract principles, but because of the captivating images in certain stories, heroes, and models.

One such image which dominates much of our thinking in health care is the parable of the Good Samaritan. In addition to the obviously positive dimensions of this story, there are other dimensions that tend to reinforce certain problematic American dispositions. First, the action of the Good Samaritan is supererogatory and the patient is wholly passive. There is no real concept of a right on the patient's part and very little ability to cooperate. The action of the Good Samaritan is also one-on-one. This fits well with therapeutic relationships in clinical practice, but is not useful for thinking about systemic issues. What would the good Samaritan do, for example, if there were four who needed his help and only one who could be helped? Or if helping this patient in need now meant not being able to help several others in need later? Finally, of course, the Good Samaritan story is about rescuing. This is the main narrative structure in most accounts of contemporary medicine. Health care is a rescue from an acute — usually life-threatening — episode. The Good

Samaritan story is about rescuing. This is the main narrative structure in most accounts of contemporary medicine. Health care is a rescue from an acute — usually life-threatening — episode. The Good Samaritan story tells us little about individual wellness, disease prevention, or how to design a system to keep great numbers of people healthy.

Churchill also examines some philsophical theories of justice. He describes the theories of John Locke and of contemporaries Robert Nozick and John Rawls. He criticizes each for their own commitments to individualism, the assumption that the interests of individuals are prior to and precede in importance those of the community. These are not unusual criticisms in the cases of Locke and Nozick; the latter is an extreme individualist. But Churchill finds the same problem at the root of John Rawls's thought, even though he admits that Rawls may have something more to say to us than the others. The Rawlsian self on Churchill's account is a "thin rational self, calculating its self-interest in a timeless asocial, indeed presocial, existence of dispassionate ignorance."

Churchill then turns to a description of a more socially-based alternative in the ethical theory of 18th century thinker Adam Smith. Best known for his *Wealth of Nations,* which championed capitalism, Smith also developed an ethical theory based fundamentally on human sympathy. The moral sense of sympathy fits us by nature for social life together. It provides the capability and the affective basis for justice.

Churchill believes that there is a moral right to health care. We all become ill and we are all subject to death. Diseases are seldom directly related to human merit. And health care in many cases offers effective treatment. Churchill articulates a right to health care based on human need. "A right to health care based on need means a right to equitable access based on need alone to all effective care society can reasonably afford." The use of need as a criterion is an expression of our social solidarity based on our natural sympathy. Reference to what society can afford places a limit on the scope of the right.

With this theory of justice and conception of a right to health care, Churchill moves to an explicit discussion of rationing. The American and British experiences are compared. Churchill calls for an accessible and universal system of primary care physicians and other health care providers. At this level "relatively pure equity must reign." For more extensive access to health care services the norms of utility — the greatest good for the greatest number — must be used explicitly. He offers a priority ranking for these services: 1) very expensive therapies which sometimes affect cure or remission, 2) very expensive therapies of ambiguous benefit, and 3) elective procedures which satisfy personal desires or correct minimal burdens. Churchill believes that with sophisticated technological assessment and careful use of the principle of utility, we can make intelligent judgment about which services citizens ought to have a right to, beginning with those of the first priority ranking.

Churchill's writing is exceptionally clear. His use of examples is effective. The target audience of this book would be well served by reading it. His discussion of our Good Samaritan tradition and individualism in America is especially thoughtful and to the point.

But there are some shortcomings which must be pointed out — two theoretical and one practical. At the theoretical level, Churchill's treatment of Rawls seems unfair. Certainly, Rawls does use individual self-interest as a device to articulate a theory of justice. However, this is not Rawls's conception of the self. Instead this is a hypothetical model, a rational construction used to determine the details of justice in an imaginary situation demanding unanimity and freedom from bias. I doubt that Rawls or any of his followers intends this device of "original persons" negotiating behind a "veil of ignorance" as a theory of the human self. These hypothetical contractors are heuristic tools, not representatives of the real relationships among persons in communities.

The second theoretical problem is the alternative put forward by Churchill. While sympathy is an important dimension of our moral life, it has two fundamental flaws when used as a basis for ethical obligation. First is the simple fact that many people are not especially sympathetic to the plight of others. Churchill makes this very point in the beginning of his book: Sympathy is blunted by the distances people create between themselves. Therefore, the natural limitations of sympathy would tend, on this account, to limit our sense of obligation to others. Appeal to sympathy is unpersuasive to the

unsympathetic, unless there are grounds for an additional claim that they *ought* to be sympathetic. But this raises the second problem, a difficulty which David Hume, Scottish contemporary of Smith's, pointed out. Simply because we feel or fail to feel a certain sentiment does not of itself imply the necessity to act in any certain way. An *ought* cannot be derived from an *is;* or, at the least, its derivation is far more difficult conceptually than Churchill makes out. To illustrate this point, imagine someone, say Nietzsche, reading Churchill's account and reacting with the "wrong" ought: "Yes, some of us do tend to feel sympathy, but this is a character flaw, a sign of human weakness. We ought not to." It is unclear what Smith's or Churchill's response could be to this challenge.

The practical shortcoming follows from the expectations that a reader might bring to this book. Although Churchill does a good job of discussing the principles involved in rationing health care and the theories of justice and of the self which stand behind them, there is little practical direction in this book. Readers who are following the legislative innovations in the Oregon Medicaid program, for example, and who are looking for a detailed analysis of rationing will find little assistance here.

Despite these reservations, Churchill's book is a welcome addition to our discussions of justice and health care distribution. It is a reminder of some of the American cultural dispositions which stand in the way of creating a more equitable system. This book moves our discussions about American health care forward and it deserves wide readership.

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