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# National Health Care Reform: Welfarism Out of Context

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# NATIONAL HEALTH CARE REFORM: WELFARISM OUT OF CONTEXT

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## I. INTRODUCTION

> *This health care system of ours is badly broken, and it is time to fix it.*[1]
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> *And we have three prime — three things we're trying to achieve. The Republicans, and I think Mrs. Clinton's group, likewise. First of all, we're trying to get everybody covered in America. Secondly, we're trying to hold down the costs. And thirdly, we want to maintain the quality, make sure the quality, the improvements that the great American health care system have seen, which is the best system in the world for those who can afford it. We want that same best system for everybody.*[2]

In modern times, public policy makers have assumed a role at the bedside. Judges hold hearings in hospital rooms to decide

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1. *The Clinton Health Plan; Clinton Text: "This is Our Chance . . . Our Journey"*, L.A. TIMES, Sept. 23, 1993, at A8 (President William Clinton's Speech on Health Care Reform) [hereinafter President Clinton's Speech].

2. *Health Care Crisis Gets Ideological Responses* (National Public Radio broadcast, Aug. 17, 1993) (statement of Senator John Chafee).

whether life-saving treatments will be provided, withheld, or withdrawn. Legislators enact public health measures to eradicate diseases that formerly afflicted millions. The President of the United States proposes that Congress adopt a national health care delivery system, hereinafter a "communal system,"[3] to provide the benefits of modern medicine to all Americans.

Policy makers unavoidably bring their own emotions and individual ethical principles to these matters affecting the universal human experiences of suffering and death. In addition, policy makers are obliged to abide by another set of ethical

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3. Communal systems vary in their particulars, but typically they share five characteristics: a plan for health care delivery that is designed and regulated by government, guaranteed universal or nearly universal coverage regardless of ability to pay or health status, coverage of a more or less comprehensive range of governmentally defined health care benefits, legal limitations of some sort on expenditures for health care, and compulsory funding for the health care delivery plan. *See generally* UNDERSTANDING UNIVERSAL HEALTH PROGRAMS: ISSUES AND OPTIONS (David A. Kindig & Robert B. Sullivan eds., 1992) [hereinafter UNDERSTANDING UNIVERSAL HEALTH PROGRAMS].

The major health care reform bills currently pending in Congress exhibit some or all of these features. *See* H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993) (plan of President Clinton) (providing for federal funding and regulation; coverage of all but illegal aliens; standard acute-care package with prescription drugs, with some mental and home health; government sets annual national limit on expenditures; mandatory employer/employee premium payments) [hereinafter Clinton Plan]; S. 1807, 103d Cong., 2d Sess. (1994) (plan of Senator Phil Gramm) (providing system designed by federal government but with minimal regulation; uninsured induced to buy coverage through tax credits; minimum benefits vary according to coverage; voluntary funding); H.R. 1200 & S. 491, 103d Cong., 1st Sess. (1993) (plan of Representative Jim McDermott) (establishing single governmental payer system; all Americans covered by 1995; extensive package, including acute care, set by American Health Security Standards Board; government sets national spending limit tied to prior budget year plus gross domestic product (GDP); financed by payroll tax); H.R. 3222 & S. 1759, 103d Cong., 1st Sess. (1993) (plan of Representative Jim Cooper) (creating National Health Board; Private Health Care Standards Commission defines health benefits, which Congress can amend; no global budget; voluntary participation and funding); H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (plan of Senator John Chafee) (creates National Benefits Commission (NBC) and state regulated Health Insurance Purchasing Cooperatives; universal coverage by the year 2000; two packages chosen by NBC: one catastrophic, the other more comprehensive; financing limited to $25 billion per year; small businesses must offer coverage).

Communal systems currently in place in other countries exhibit most of these characteristics. *See, e.g.*, Jonathan E. Fielding & Pierre-Jean Lancry, *Lessons From France — "Vive la Difference,"* 270 JAMA 748 (1993) (comparing the French health care system and reform proposals in the United States); Bradford L. Kirkman-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany,* 265 JAMA 2496 (1991) (describing key characteristics of the systems in place in the Netherlands and Germany).

principles: the principles of justice that establish what is ethically right with respect to the governance of society.

This Article examines these principles of justice. What principles should guide public policy decisions in the realm of universal experiences? In particular, what principles of justice should guide public policy makers contemplating reform of the national health care delivery system?

Most participants in the public policy debate explicitly assert or implicitly assume that the principles of welfarist consequentialism, or "welfarism,"[4] should guide policy makers. Welfarism

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4. In his September 22, 1993 Speech on Health Care Reform, President Clinton spoke in the language of welfarism, entreating political leaders and the nation to support him in an effort to rationally construct a superior system of health care delivery for the nation. President Clinton's Speech, *supra* note 1, at A8. He admonished them that the effort was not just desirable, but ethically required:

> This health care system of ours is badly broken, and it is time to fix it. . . . We have to preserve and strengthen what is right with the health care system, but we have got to fix what is wrong with it. . . . Both sides, I think, understand the literal ethical imperative of doing something about the system we have now.

*Id.*

Scanlon asserts that welfarism reflects the dominant mode of modern reasoning about the demands of justice. T. M. Scanlon, *Contractualism and Utilitarianism*, *in* UTILITARIANISM AND BEYOND 103, 103 (Amartya Sen & Bernard Williams eds., 1982) [hereinafter UTILITARIANISM AND BEYOND].

> [Utilitarian welfarism] occupies a central place in the moral philosophy of our time. It is not the view which most people hold; certainly there are very few who would claim to be active utilitarians. But for a much wider range of people it is the view towards which they find themselves pressed when they try to give a theoretical account of their moral beliefs. Within moral philosophy it represents a position one must struggle against if one wishes to avoid it.

*Id.* For a discussion of "welfarist consequentialism," see Amartya Sen & Bernard Williams, *Introduction* to UTILITARIANISM AND BEYOND, *supra*, at 3-4.

The most common variant of welfarism is utilitarianism. Classical utilitarianism was developed by liberal British reformers Bentham, Mill, Sidgwick, and Edgeworth. John C. Harsanyi, *Morality and the Theory of Rational Behaviour*, *in* UTILITARIANISM AND BEYOND, *supra*, at 40. As Harsanyi described these reformers:

> Basically, both in politics and in ethics, they fought for reason against mere tradition, dogmatism, and vested interests. In politics, they conceived the revolutionary idea of judging existing social institutions by an impartial rational test, that of social utility, and did not hesitate to announce it in clear and unmistakable terms if they felt that many of these institutions had definitely failed to pass this test. Likewise, in ethics, they proposed to subject all accepted moral rules to tests of rationality and social utility.

*Id.* See also Taylor's description of classical utilitarianism as a product of its

holds that the choice of a public policy is "just" if the consequences of that public policy maximize social welfare.[5]

This Article concludes, however, that welfarism cannot succeed in guiding policy makers to just choices in the context of national health care delivery. In explaining why welfarism fails, this Article notes ethical principles embedded in the historical experience of doctors ministering to patients. These are principles that welfarism cannot accommodate and that a successful theory of justice must accommodate. Determining appropriate principles of justice for application in this context is a demanding task, and an important one, as this nation and others continue to struggle with health care delivery reform proposals.[6] This Article proposes a beginning.

Part II of this Article assumes that welfarism is a valid theory of justice as applied to issues of national health care delivery, and accepts the social welfare goals identified by participants in

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time, a time when rationalism supplanted theology as the dominant mode of inquiry into matters of justice and individual ethics. Charles Taylor, *The Diversity of Goods, in* UTILITARIANISM AND BEYOND, *supra*, at 129.

5. Sen & Williams, *supra* note 4, at 4. This approach, focusing on the social welfare maximizing consequences of policy measures, also characterizes some methods of public policy analysis that seek to describe an efficient result rather than necessarily to prescribe what justice requires. Frank Hahn, *On Some Difficulties of the Utilitarian Economist, in* UTILITARIANISM AND BEYOND, *supra* note 4, at 187. As Hahn wrote:

> The economic theory of public policy is relentlessly utilitarian: policies are ranked by their utility consequences. . . . The utilitarian stance of Welfare Economics has proved very powerful in the following sense: it has given precise arguments why one policy under precisely stated conditions was to be preferred to all others available.

*Id.*; *see also* Robert Sugden, *Welfare, Resources, and Capabilities: A Review of* Inequality Reexamined *by Amartya Sen*, 31 J. ECON. LIT. 1947, 1948-51 (1993) (discussing problems with revealed preference welfarism as a viable theory of normative as opposed to positive economics). For a discussion of utilitarian welfarism as coinciding with a natural rights theory of justice, see generally David Friedman, *Should Medicine Be a Commodity? An Economist's Perspective, in* RIGHTS TO HEALTH CARE 259 (Thomas J. Bole & William B. Bondeson eds., 1991) [hereinafter RIGHTS TO HEALTH CARE].

6. Numerous commentators have proposed a variety of approaches to this task. *See generally* Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37 (1993) (drawing upon ethical principles of the medical profession); NORMAN DANIELS, JUST HEALTH CARE (1985) (proposing a life opportunity based account); CHARLES J. DOUGHERTY, AMERICAN HEALTH CARE: REALITIES, RIGHTS, AND REFORMS 23-132 (1988) (drawing upon principles of a number of different theories of justice); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICAL BIOMEDICAL & BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 11-46, 183-97 (1983) [hereinafter PRESIDENT'S COMM'N] (drawing upon a number of different theories).

the public policy debate. Part II then analyzes whether welfarism requires policy makers to adopt a communal system, and concludes that it does not. Part III questions whether welfarism succeeds as a theory of justice applied in this context, and concludes that it does not. In addition, Part III concludes that successful principles of justice must emerge from the context of health care delivery.

## II. WELFARISM AND COMMUNAL SYSTEMS: THE BEST WAY TO FIX THIS SYSTEM?

> *Now, people may disagree over the best way to fix this system.*[7]

### A. *Introduction*

Most participants in the public policy debate regarding national health care delivery not only agree that welfarism should guide policy makers in their choice of just public policy, but they also agree upon the social welfare goals of just public policy.[8] They agree that just public policy should assure broad access to health care that is low in cost and high in quality.[9]

Debaters disagree, however, about which public policy measures will achieve these social welfare goals.[10] The discussion

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7. President Clinton's Speech, *supra* note 1, at A8.

8. "[W]e agree with President Clinton's concepts; we believe in coverage; we believe in security, savings, responsibility — all the six things he talked about. But I think to tell anybody it's going to be easy would be a mistake." *Sen. Robert Dole Interviewed About Health Care Reform* (CNN News broadcast, Sept. 23, 1993). "'Fixing the system won't be easy,' [Vice President Al Gore] warned. 'But the American people have demanded that we fundamentally reform a system that costs too much, wastes too much, and serves too few. We must make the system work better for real people with real problems.'" Charles Marwick, *Physicians Tell Washington "You Want Our Help"*, 269 JAMA 1920 (1993); *see also Alternative Plans: Gaining Support at the WH's Expense,* HEALTH LINE, Oct. 18, 1993, *available in* LEXIS, Nexis Library, HLTLNE File; David Lauter & Edwin Chen, *Health Care for All — Three Plans Compete,* L.A. TIMES, Nov. 11, 1991, at A1 (Senator John D. Rockefeller IV stating Americans are angry about the health care system and want it changed); Mitchell Locin & Carol Jouzaitis, *"Our Work has Just Begun,"* CHI. TRIB., Jan. 26, 1994, at 1 (Senator Dole arguing for a modest proposal that offers "greater access to health care for all"). *See also supra* notes 1-2.

9. *See, e.g.,* David M. Eddy, *What Care is "Essential"? What Care is "Basic"?*, 265 JAMA 782 (1991); Kevin Grumbach et al., *Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal*, 265 JAMA 2549 (1991); David U. Himmelstein et al., *A National Health Program for the United States: A Physicians' Proposal*, 320 NEW ENG. J. MED. 102 (1989); George D. Lundberg, *National Health Care Reform: An Aura of Inevitability is Upon Us*, 265 JAMA 2566 (1991).

10. A number of vastly different proposals for national health care reform

below analyzes the relative merits of a communal system and of alternative reform proposals as means for achieving these widely agreed upon goals.

### B. *Access to Health Care*

Welfarist proponents of a communal system generally assert that because a communal system guarantees universal access to health care, and because access to health care contributes to social welfare, policy makers should adopt a communal system.[11] Access to health care is not, however, something that, *in and of itself*, contributes to welfare in the sense that access to food, housing, or entertainment may contribute to welfare.[12] Rather, access to health care is instrumental in furthering other goals that may contribute to welfare. These goals may include: improved health status for those obtaining access;[13] benefits to others because improved health status enables individuals to fulfill their family, work, and community obligations;[14] improved security regarding the ability to obtain health care services;[15] benefits to others because improved security enables individuals to make life changes, such as taking jobs in which their talents are better applied, without fear of loss of health benefits;[16] and a reduced incidence of "free riders" who impose costs upon others by obtaining health care services and failing to pay for the services.[17]

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have garnered significant support; none has garnered majority support. *Compare* Eddy, *supra* note 9 (designing a system to take care of basic and essential needs); Grumbach et al., *supra* note 9 (proposing a plan for more benefits for more people at a low cost to the consumer); *with* Himmelstein et al., *supra* note 9 (urging the adoption of a national health care program similar to Canada's).

11. *See, e.g.*, Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491 (1991).

12. The hypochondriac is an exception. Hypochondriacs experience pleasure not generally recognized by others in obtaining health care services.

13. *See* Friedman, *supra* note 11, at 2493 ("It is . . . not unreasonable to assume that medical indigence is associated with lack of care and poorer health status.").

14. President Clinton, Address Before Congress upon Delivering the Health Security Act of 1993 to Congress, U.S. NEWSWIRE (Oct. 27, 1993), *available in* LEXIS, Nexis Library, USNWR file.

15. President Clinton's Speech, *supra* note 1, at A8.

16. This failure to make beneficial life changes arises because of the phenomenon commonly referred to as "job lock." Job lock has been defined as "unsatisfied people staying in jobs just to maintain health coverage." Kevin Anderson, *Workers Staying Put For Benefits*, USA TODAY, Sept. 27, 1991, at 4B.

17. For a discussion of the free-rider problem, see Allen E. Buchanan, *Rights, Obligations, and the Special Importance of Health Care, in* RIGHTS TO HEALTH CARE, *supra* note 5, at 169, 177-81.

Guaranteed universal access is of highly questionable instrumental value in achieving the first and second goals — improving individuals' health status and consequent benefits to others — for two reasons. First, guaranteed universal access reduces or eliminates some but far from all barriers to *actual access* to health care, and may introduce barriers to actual access as well. Second, actual access is itself of limited instrumental value in improving *health status.*

With respect to the first point — the efficacy of guaranteed universal access in assuring actual access to health care — guaranteed universal access does reduce or eliminate two practical barriers to actual access: inability to pay and poor health status.[18] Reducing or eliminating these barriers likely would improve somewhat the actual access of many uninsured Americans.[19] However, other practical barriers to actual access would remain. Lack of medical facilities may reduce actual access to health care for many individuals. For example, there may be no doctors or hospitals within a two-hour drive or bus-ride of their homes; or if there are nearby hospitals, they may not offer appropriate specialized services, such as neonatal intensive care units or burn centers.[20] Even if appropriate health care services

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18. Inability to pay prevents some Americans from purchasing comprehensive private health insurance coverage. This, in turn, forces these Americans to pay for health care services directly if they can, obtain charity care if it is available, or obtain coverage through a governmental program such as Medicaid if they qualify. *See* Friedman, *supra* note 11.

Poor health status prevents some Americans from purchasing comprehensive health insurance coverage even though they could afford to do so. This is because insurers refuse to provide coverage, or refuse to provide comprehensive coverage, to individuals with prior or current health problems. Insurers refuse to provide coverage because these individuals could submit costly claims against the insurer in the future in connection with these pre-existing conditions. *See* Mark V. Pauly, *A Primer on Competition in Medical Markets, in* HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE 27, 51-56 (H.E. Frech III ed., 1988) [hereinafter HEALTH CARE IN AMERICA].

19. Grumbach et al., *supra* note 9. Experience with the Medicaid program, which provides coverage for some of the poorest Americans, suggests that simply eliminating inability to pay as a barrier results in significantly greater access to health care. Friedman, *supra* note 11, at 2493; *see* Social Security Amendments of 1965, § 121, Pub. L. No. 89-97, 79 Stat. 286, 343 (1965) (codified as amended at 42 U.S.C. §§ 1396-1396u (1988 & Supp. IV 1992)).

20. *See* Frances H. Miller & Graham A.H. Miller, *The Painful Prescription: A Procrustean Perspective*, 314 NEW ENG. J. MED. 1383, 1385 (1986) (explaining BNHS division into regional centers to provide specialized services); Robert Pampalon, *Health Discrepancies in Rural Areas in Québec*, 33 SOC. SCI. & MED. 355, 359 (1991) (study of rural health care in Quebec clearly shows a progressive decline in health status as people live farther from urban centers); R. Burciaga Valdez et al., *Improving Access to Health Care in Latino*

are available within a reasonable distance, individuals may not avail themselves of the services for a variety of reasons. For example, they may lack information or understanding about the availability or desirability of the services,[21] they may have communication problems due to language barriers,[22] they may lack ready access to transportation or child care,[23] or they may be so overwhelmed with problems of day-to-day living that health care takes low priority.[24] Some doctors and hospitals may apply disproportionate resources to the treatment of select patients, regardless of the theoretical entitlement of all patients. For example, age, class, race, and gender biases may lead to differential treatment.[25] The diverse practical factors that determine actual as opposed to theoretical access to health care are daunting, and the ability of policy makers to affect them is limited.[26]

Guaranteed universal access may also introduce barriers to actual access to health care. Budget constraints imposed under communal systems may require the imposition of restrictions on access. For example, lengthy waits for access to some health care services are common under communal systems.[27]

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*Communities,* 108 PUB. HEALTH REP. 534 (1993). In 1981, there were 2033 areas of the United States officially designated as Health Manpower Shortage Areas. PRESIDENT'S COMM'N, *supra* note 6, at 84. Within these areas, there were 16 million Americans deemed "underserved." *Id.*; *see also* Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us,* 247 SCI. 418, 421 (1990) (considering the British experience in rationing health care); Emily Campbell et al., *Allocating Medical Resources and Medicaid: Raising the Issues from a Psychological Jurisprudential Perspective,* 60 UMKC L. REV. 665, 700-01 (1992) (explaining that an individual's gender and race are among the factors that affect one's access to health care).

21. Valdez et al., *supra* note 20, at 534; *see also* Pat Swift, *Health Care Crisis is Evident in Some Frightening Numbers,* BUFF. NEWS, Feb. 19, 1994, at L7 (citing ignorance as a reason many women fail to get preventive care).

22. Barbara M. Aved et al., *Barriers to Prenatal Care for Low-Income Women,* 158 W.J. MED. 493, 493 (1993); Eli Ginzberg & Miriam Ostrow, *Beyond Universal Health Insurance to Effective Care,* 265 JAMA 2559, 2560 (1991); Valdez et al., *supra* note 20, at 534.

23. On the average, of people with no insurance, 25% must travel more than 30 minutes, whereas only 18% of people with insurance travel more than 30 minutes for medical care. PRESIDENT'S COMM'N, *supra* note 6, at 85; *see also* Valdez et al., *supra* note 20, at 538 ("[A]bout 10 percent of Latinos report lengthy, time-consuming travel to reach a health care facility.").

24. *See Black Women with AIDS Lack Access to Treatment, Research,* 8 AIDS ALERT 145 (Sept. 1993); *see also* Valdez et al., *supra* note 20, at 538 ("[Some Latinos] forego seeking medical care because of household, job, or family responsibilities.").

25. *See* Ginzberg & Ostrow, *supra* note 22, at 2560; *see also* Robert Baker, *The Inevitability of Health Care Rationing: A Case Study of Rationing in the British National Health Service, in* RATIONING AMERICA'S MEDICAL CARE: THE OREGON PLAN AND BEYOND 208, 217-21 (Martin A. Strosberg et al. eds., 1992) [hereinafter RATIONING AMERICA'S MEDICAL CARE].



26. *See* Valdez et al., *supra* note 20, at 539-41.

27. *See* Ronald S. Bronow et al., *The Physicians Who Care Plan: Pre-*

Guaranteed universal access pursuant to a communal system is not the only and not necessarily the most effective means of improving actual access to health care. Other policy measures could reduce or eliminate inability to pay and poor health status as barriers to actual access. For example, the state or federal governments could provide publicly-funded vouchers for the purchase of health insurance,[28] and reformed insurance regulations could prohibit insurance companies from refusing to provide coverage or placing limitations upon coverage based on poor health status.[29] Policy measures to reduce or eliminate other practical barriers to access do not bear any necessary

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*serving Quality and Equitability in American Medicine,* 265 JAMA 2511, 2511 (1991) ("In the Canadian System, . . . [p]atients' needs take a backseat to budget constraints."); 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, 1381 (1986) (reporting budget constraints in Great Britain have decreased access to some beneficial care); John K. Iglehart, *Canada's Health Care System Faces its Problems,* 322 NEW ENG. J. MED. 562, 562 (1990) (reporting Canadians are demanding better access in the face of a large budget deficit); see also *infra* part II.C. for a discussion of cost containment under communal systems.

28. Such measures could supplement or supplant the current system of Medicaid, which provides subsidized health care for some poor individuals, and charity care primarily provided through hospitals and neighborhood health centers. Other measures could include increased direct provision of subsidized health care services, as well as the elimination of regulatory measures that cumulatively have the effect of pricing health insurance beyond the ability of low income individuals to pay for it. For a discussion of the effects of a voucher system, see generally Nancy K. Rhoden, *Free Markets, Consumer Choice, and the Poor: Some Reasons for Caution in* RIGHTS TO HEALTH CARE, *supra* note 5, at 213, 213-38. For a discussion of a wide variety of state initiatives to improve access, see IMPROVING ACCESS TO HEALTH CARE: WHAT CAN THE STATES DO? (John H. Goddeeris & Andrew J. Hogan eds., 1992) [hereinafter IMPROVING ACCESS TO HEALTH CARE].

29. The National Association of Insurance Commissioners, the Health Insurance Association of America, and Blue Cross and Blue Shield have proposed such regulations. Paul Cotton, *Preexisting Conditions "Hold Americans Hostage" to Employers and Insurance,* 265 JAMA 2451, 2452 (1991). *But see* Pauly, supra note 18, at 51-56.

> The purpose of insurance is to pool risky events so that each person can pay a certain premium, *equal to the expected loss he faces,* rather than face the probability distribution with the same expected or average value but much larger variability. If people are risk averse, they will gain by choosing the certain loss over the risky loss. They will always be able to afford the insurance as opposed to bearing the loss. Among a set of people with the same expected loss at the beginning of a time period, insurance redistributes wealth away from those who are lucky enough to stay well to those unlucky enough to get sick. But it does not, and should not be expected to, redistribute from those known to be well at the beginning of the period to those known to be sick at the beginning of the period.

*Id.* at 52 (emphasis original).

relationship to adoption of a communal system. These policy measures could target particular practical barriers, as by providing transportation assistance[30] or information about the availability of health care services.[31]

With respect to the second point — the limited contribution of actual access to the goal of improved health status — improvements in actual access do yield some improvements[32] in health status.[33] However, certain known factors affect health status far more significantly. In addition, other poorly understood factors also correlate far more strongly with health status.

Known factors that affect health status to a greater degree than actual access to health care are public health measures and individual behaviors. Public health measures include the purification of water, disposal of sewage, and the promotion of

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30. PRESIDENT'S COMM'N, *supra* note 6, at 43 (proposing provision of transportation for those in rural settings requiring specialized services that are not locally available).

31. Valdez et al., *supra* note 20, at 540.

32. Andrew B. Bindman et al., *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 JAMA 2899 (1990); Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome*, 265 JAMA 374 (1991); Mark B. Wenneker et al., *The Association of Payer with Utilization of Cardiac Procedures in Massachusetts*, 264 JAMA 1255 (1990).

In Alabama, infant mortality rates dropped considerably, primarily due to improved access to prenatal care for pregnant women and follow-up care for newborns. PRESIDENT'S COMM'N, *supra* note 6, at 54-55. Women who had no health coverage or only Medicaid coverage had significantly more advanced breast cancer on initial diagnosis than women with private health insurance coverage. John Z. Ayanian et al., *The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer,* 329 NEW ENG. J. MED. 326, 329 (1993).

However, as one commentator has noted, "[D]espite heroic treatment, technological advances, and widespread involvement of many groups in health care, current life expectancy for adults has changed very little since the turn of the century. Most of the change in life expectancy is attributable to decreases in infant mortality." Robert M. Kaplan, *The Connection Between Clinical Health Promotion and Health Status: A Critical Overview,* 39 AM. PSYCHOL. 755, 763 (1984). Furthermore, universal guaranteed coverage under the British National Health Service does not appear to have affected the gap in health status between socio-economic classes. JULIAN LEGRAND, THE STRATEGY OF EQUALITY: REDISTRIBUTION AND THE SOCIAL SERVICES 126 (1982).

33. Improvements in health status may be defined differently. Improved health status may be measured by gross indicia, such as mortality and morbidity statistics, or may be measured according to finer criteria, such as success in saving low birth weight infants. George J. Schieber & Jean-Pierre Poullier, *International Health Spending: Issues and Trends,* 10:1 HEALTH AFF. 106, 116 (1991). Access to health care may improve health status as measured by some indicia, but not by others.

vaccinations.[34] Individual behaviors include using seat belts and refraining from smoking.[35]

Other factors correlate strongly with health status for reasons that are poorly understood. Health status correlates very strongly with wealth, and may correlate with educational status and employment status as well.[36] Whether these factors are proxies for differences in individual behaviors or for other factors known to affect health status directly is unknown.[37]

Thus, a number of factors — some understood, some not — determine health status. Actual access is but one among many of these factors and not necessarily the most significant.

Assuming that improved health status and the consequent benefits to others are important social welfare goals, a welfarist analysis might guide policy makers to reject policy measures aimed at improving actual access in favor of alternative policy measures more strongly correlated with improvements in health. For example, rather than devoting social resources to improved access to health care, policy makers could choose to devote

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34. ANDREW HARPER, THE HEALTH OF POPULATIONS: AN INTRODUCTION 69-70 (1986); *see also* Edward S. Golub, *Defeating Disease: Public Health Remedies vs. Biomedical Quick Fixes*, OMNI, Sept. 1993, at 4 (discussing public health responses to the AIDS epidemic); *see generally* DAN E. BEAUCHAMP, THE HEALTH OF THE REPUBLIC: EPIDEMICS, MEDICINE, AND MORALISM AS CHALLENGES TO DEMOCRACY (1988) (providing a historical and philosphical background to American public health initiatives); LOUISE B. RUSSELL, IS PREVENTION BETTER THAN CURE? 10-40 (1986) (examining preventive health measures such as vaccinations).

35. *See* Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207 (1993) (noting the socioeconomic factors that contribute to death in the United States).

36. *See* Jack M. Guralnik et al., *Educational Status and Active Life Expectancy Among Older Blacks and Whites*, 329 NEW ENG. J. MED. 110, 115 (1993) (raising socioeconomic status may have a more significant effect on health status than improving poor lifelong health practices); *see also* James C. Hurowitz, *Toward a Social Policy for Health*, 329 NEW ENG. J. MED. 130, 131-32 (1993) (noting that studies show there is a correlation between higher income and longevity and good health and there may be a correlation between education and employment status and health); McGinnis & Foege, *supra* note 35, at 2210-11 (concluding low income and educational status are two factors that contribute to death in the United States). Although death rates have declined in the United States during the past 30 years, for those Americans whose educational levels and income have not risen, mortality rates remain high. Gregory Pappas et al., *The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986*, 329 NEW ENG. J. MED. 103, 107 (1993).

37. Marcia Angell, *Privilege and Health — What Is the Connection?*, 329 NEW ENG. J. MED., 126, 126 (1993) (noting scientific confusion over the exact correlation between privilege and health); *see also* McGinnis & Foege, *supra* note 35, at 2211 (discussing the socioeconomic factors that contribute to death in the United States).

these resources to improving educational attainment or reducing unemployment.[38]

With respect to the third and fourth goals — improving security and the consequent benefits to others — the effects of universal guaranteed access under a communal system would be mixed. Guaranteed universal access would improve the security of those Americans who otherwise would be uninsured,[39] and of those who are insured but fear loss of coverage if they lose

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38. Of course, the ability of policy makers to accomplish such goals is limited. The ability to improve actual access to health care services is also limited, however, and improved actual access likely affects health status far less.

39. Most Americans are insured under private insurance group or individual plans, self-insured plans of employers, or government plans including Medicaid Title XIX (providing coverage of some poor persons) and Medicare Title XVIII (providing coverage for most elderly persons). *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395-1396u (1988 & Supp. IV 1992)). A patchwork of regulations provide limited assurance of coverage upon termination of employment or leave from employment. *See* Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986) (codified as amended at 29 U.S.C.A. §§ 1161-1167 (1988 & Supp. IV 1992)); Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3, 107 Stat. 6 (1993). Other regulations assure coverage in the event of emergencies. *See* COBRA, *supra* (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. IV 1992)). Current estimates indicate that approximately 37 million Americans are uninsured for some period of time in every year. Many others are "underinsured" in the sense that they have coverage only for a limited range of health care expenses and must pay for or obtain charity care for other expenses. *See* PRESIDENT'S COMM'N, *supra* note 6, at 49-182; *see also* John A. MacDonald, *Americans' Wish List for Health Care Focuses on Security, Cost,* HARTFORD COURANT, Jan. 16, 1994, at A1; *see also* Friedman, *supra* note 11, at 2492.

The insecurity endured by some uninsured Americans is, however, a matter of choice. *See* John Holahan & Sheila Zedlewski, *Expanding Mecidaid to Cover Uninsured Americans,* 10:1 HEALTH AFF. 45, 49 (1991) (5.9% of the population that are under the age of 65 and incomes at least 300% above poverty level do not purchase insurance). The choice not to purchase insurance is not irrational from the perspective of some uninsured individuals. These individuals may choose to self-insure after weighing and balancing private insurance premium costs and their ability to set aside funds to assure a similar level of coverage. Others may choose not to make any provision for health care costs because they are healthy and the chances of needing costly care are low, or because they are willing to rely upon the assistance of relatives or charity care. Entitlements to emergency treatment and charity care under the current American health care system, or assistance available from friends or family may provide sufficient, if not perfect, security. Furthermore, for persons with modest assets, safeguarding these assets through the purchase of insurance is a far less worthwhile undertaking than for persons with substantial assets. The failure to purchase insurance, however, does impose costs on others. *See infra* notes 54-63 and accompanying text for a discussion of free riders.

their jobs, change jobs,[40] or their employer changes or eliminates insurance coverage.[41] For individuals who are insured, guaranteed access would increase their willingness to make life changes that may benefit others, such as taking new jobs that better use their skills without fear of losing their coverage.[42]

Secure access to health care is an elusive goal, however. Expanding secure access to health care must come at some expense.[43] The expense may be in the form of increased taxes,[44] decreased quality of care,[45] decreased choices regarding providers of health care,[46] decreased innovation,[47] decreased provision of

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40. Three out of ten Americans report they or a member of their family stayed in jobs, though they preferred to leave, because of fear of losing health coverage. Anderson, *supra* note 16, at B4. In a poll by the Employee Benefit Research Institute, 81% of the respondents believed changing jobs should not bring with it a change in health insurance. Matthew P. Schwartz, *Public Supports Clinton's Main Reform Goals: Poll,* NAT'L UNDERWRITER, Oct. 4, 1993, at 42. A later poll by the same institute indicated 18% of workers surveyed had turned down new jobs or stayed in jobs, solely because of their desire to retain health care benefits. Stephen H. Dunphy, *The Newsletter,* SEATTLE TIMES, Feb. 22, 1994, at D1.

Frustration with job lock has been a major force in the push for health care reform. *See* Anderson, *supra* note 16, at B4 ("[W]hen nearly one-third of the population . . . feels frustrated by the health-care system in as personal a way as job lock, the impetus for sweeping change is deep-seated."); *see also* Schwartz, *supra,* at 42 (reporting that portability of health care benefits from one job to another is a critical component of President Clinton's plan).

41. *See, e.g.,* Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993) (holding that a reduction in coverage for individuals with Acquired Immune Deficiency Syndrome (AIDS) does not violate Employee Retirement Security Act of 1974 (ERISA)).

42. The life changes that security permits also include quitting employment and other acts that may cause a net loss to other members of society. *See supra* note 16.

43. Some assert that savings in unnecessary administrative costs and unnecessary or cost-ineffective health care services can subsidize expanded actual access under a communal system. However, as discussed *infra* part II.C, administrative "savings" come at some expense as well, and determining what are unnecessary and cost-ineffective services, and then assuring their elimination, are challenging tasks.

44. Under the Clinton Plan, *see supra* note 3, § 7111, a "sin tax" on cigarettes subsidizes part of the expansion. To the extent this tax reduces consumption of cigarettes, thus improving health status, a net savings would be realized. To the extent smokers substitute other unhealthy habits, or cigarette smuggling leads to increased crime, these savings may not be realized.

45. Obvious quality problems have arisen, for example, in Germany with respect to the blood supply. Nicola Clark, *Blood and Irony: Did Price Controls Spread AIDS?,* WALL ST. J., Nov. 11, 1993, at A14.

46. Iglehart, *supra* note 27, at 562 (reporting that Canada is struggling to maintain consumers' free choice of doctors).

47. *See* Patricia M. Danzon, *Hidden Overhead Costs: Is Canada's System Really Less Expensive?,* 11:1 HEALTH AFF. 21, 37 (1992). The Canadian system

targeted services for the poor,[48] reduced access to certain kinds of health care,[49] or some combination of these results.

Communal systems typically absorb much of the expense of secure access by restricting access to certain kinds of health care services.[50] Although these barriers to access are of little consequence to most individuals, these barriers may result in the denial of important or life-saving health care services for those relatively few who are seriously ill.[51] Thus, for those who are relatively healthy, a communal system may assure secure access to health care services they are unlikely to require; for those who are seriously ill, a communal system may reduce secure access to health care services they likely will require.

Communal systems also may absorb some of the expense of assuring secure access by reducing the provision of health care services specifically and effectively targeted to the poorest Americans. The net effect may be a redistribution of secure access from the poorest to the somewhat less poor and the middle class.[52]

Assuming improved security and the consequent benefits to others are important social welfare goals, alternative public policy measures could improve the security of all at least to

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spends less on research and development in part because it relies on the research and development taking place in the United States. *Id.*; Baker, *supra* note 25, at 213 (noting severe problems with lack of innovation under the BNHS).

48. *See* LEGRAND, *supra* note 32, at 31.

49. *See, e.g.*, THOMAS HALPER, THE MISFORTUNES OF OTHERS 155 (1989). The United Kingdom's program of denying renal dialysis may allow the country to live within its means; however, it may also mean "the innocent and helpless may be left with the highest price to pay." *Id.* at 155; *see also* Baker, *supra* note 25, at 212 (regarding lengthy waiting lists for surgery and other acute care under the BNHS).

50. Baker, *supra* note 25, at 212 (citing systemic bias under the BNHS against acute care, nursing home care, emergency care, and tertiary care).

51. *See, e.g.*, Herrick Peterson, *Does U.S. Health Care Need a Dose of Canadian Medicine?*, BUS. & HEALTH, Nov. 1991, at 34, 39 (noting that Canadian citizens faced such a long wait for cardiac surgery that the Government contracted with hospitals in Seattle to perform 400 procedures in one year). *But see* Raisa B. Deber, *Canadian Medicare: Can it Work in the United States? Will it Survive in Canada?*, 19 AM. J.L. & MED. 75, 82 (1993) (arguing that Canada's waiting list problem has been exaggerated by American commentators). Lack of innovation under a communal system may aggravate the negative health consequences to the seriously ill. *See* Baker, *supra* note 25, at 213.

52. The goal of the BNHS was to assure secure access to health care according to need rather than wealth. The effect of the BNHS, as with other social insurance measures, has been to redistribute resources to the middle class to the detriment of the poorest. LEGRAND, *supra* note 32, at 28; *see also* Baker, *supra* note 25, at 217-21; *infra* part III.D. (discussing expansion of access to cover the relatively less poor under the Oregon Plan).

some degree. Providing vouchers and prohibiting refusals of coverage because of poor health status could improve security without necessarily reducing the access of those who are sickest or poorest.[53] However, any policy measures that have the effect of expanding secure access must come at some expense.

With respect to the fifth goal — reducing the incidence of free riders who fail to pay for health care services they obtain[54] — the conclusions are again mixed. Communal systems match a compulsory funding mechanism with an assured reimbursement mechanism, thus eliminating uncompensated care.[55] However, assured reimbursement means that the costs of previously uncompensated care are redistributed. This redistribution may recast the free rider problem in the form of increased taxes,[56] decreased reimbursement rates,[57] or reductions in access or quality.[58]

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53. *See supra* note 28 and accompanying text. Assuming the vouchers permitted the purchase of only limited health insurance benefits for the poorest, security would be relatively better for the well-to-do and relatively worse for the poorest. For a discussion of the effects of a voucher system, see Rhoden, *supra* note 28, at 226-38; see also *infra* part III.D. for a discussion of rationing of health care benefits to Medicaid recipients under the Oregon plan.

54. Those Americans who do not have health insurance, or sufficient health insurance to cover all of their health care costs, often fail to pay some or all of the costs of obtaining health care from health care providers. Health care providers cope with this situation in part by cost-shifting: they increase their charges to patients with more generous private or governmental insurance coverage. Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J.L. & MED. 21, 30 (1993). In recent years, private insurers increasingly have refused to bear the cost shift, denying full payment of charges submitted. Also, government payers have both refused to bear the cost shift and, further, ratcheted down their payments to the point that reimbursement levels are below the costs of providing care in some cases. Friedman, *supra* note 11, at 2492 (indicating that physicians hesitate to treat Medicaid patients for this reason). This undercompensation by government programs generates further cost-shifting, imposing a tax-by-cost-shift upon others who obtain and pay for health care services. The consequences, especially for rural and urban hospitals caught in the reimbursement squeeze, have been devastating. *See* Robert A. Carolina & M. Gregg Bloche, *Paying for Undercompensated Hospital Care: The Regressive Profile of a "Hidden Tax,"* 2 HEALTH MATRIX 141, 144-46 (1992) (describing the regressiveness of the cost-shift "tax"); *see also* Friedman, *supra* note 11, at 2493-94 (describing the difficulties for hospitals with many uninsured patients and few insured patients to whom costs can be shifted).

55. This is considered an important feature of the German health care system. For a detailed discussion of the German system, see Jeremy W. Hurst, *Reform of Health Care in Germany*, 12:1 HEALTH CARE FIN. REV. 73 (1991); *see also* Kirkman-Liff, *supra* note 3, at 2496-97 (reporting the German system has eliminated free rider problems).

56. Albert Warson, *Canadian Health System Running a Fever*, MOD. HEALTHCARE, Feb. 14, 1994, at 78, 78-80 (describing Canadian budget constraints on health care).



57. Generally, Canadian physicians are paid on a fee-for-service basis.

Assuming that the elimination of free riders is an important social welfare goal,[59] alternative public policy measures could achieve similar results, recasting the free rider problem in a variety of ways. If the purchase of health insurance were subsidized through the provision of vouchers[60] and made mandatory,[61] this would eliminate most of the free-rider problem.[62] Alternatively, targeted policy measures could assure reimbursement to particular hospitals and other health care providers serving disproportionate numbers of nonpaying patients.[63]

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Deber, *supra* note 51, at 83. Because limited fee-for-service payments provide incentives for physicians to practice on a volume-driven basis, the Canadian provinces are pursuing methods for capping total physician payments. *Id.*

58. Canadian hospitals are reimbursed based on an annual "global budget." Peterson, *supra* note 51, at 34. The hospital receives this lump sum through periodic payments, with the hospital determining the distribution of such funds. *Id.* Once the budget is established, if a hospital wants to add a service, it must cut another area. *Id.* at 34-35; *see* Danzon, *supra* note 47, at 34; *see also* Himmelstein et al., *supra* note 9, at 102 ("In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement."); *infra* notes 74-77 (discussing effects of price controls).

59. Numerous businesses suffer problems with customers who do not pay. The distinction lies in the obligations imposed by law upon hospitals to provide health care services regardless of patients' ability to pay. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986) (codified as amended at 42 U.S.C. § 1395dd(c)(1) (1988 & Supp. IV 1992)); Hospital Survey and Construction (Hill-Burton) Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291 to -291*o*-1 (1988)). *But see* Pauly, *supra* note 18, at 65. Pauly stated:

> Much of uncompensated care is simply a natural consequence of doing business on a credit basis. Once subsidies for the poor are set at socially appropriate levels, any remaining problem of uncompensated care would not really be a problem of public policy; it would be a problem of the private business of hospitals.

*Id.*

60. *See supra* note 53.

61. The purchase of health insurance either could be made mandatory or could be made mandatory only if an individual failed to pay for health care rendered on one or more occasions. The provision of some other evidence of financial responsibility could be permitted in lieu of evidence of the purchase of health insurance. Such a scheme would accord with the rationale that justifies requiring motorists to purchase automobile insurance or provide other forms of proof of financial responsibility for the benefit of innocent third parties who suffer personal injury or property damage by the negligent acts of these motorists.

62. Some individuals might not use their vouchers to purchase insurance coverage or might incur expenses not covered by their insurance.

63. Pauly, *supra* note 18, at 65-66 (arguing that direct subsidies to the poor would be preferable). "[T]he absence of information on what health care the poor need most — and the sneaking suspicion that hospitals are singularly inappropriate to provide it — makes it hard to favor direct transfers to hospitals." *Id.* at 64.

In sum, communal systems and noncommunal systems can address the five access goals by a variety of policy measures. Policy measures designed to achieve these goals always encounter practical problems and always come at some expense, typically absorbed in the form of trade-offs against other access, cost, or quality goals.

### C. *Costs of Health Care*

Federal and state policy makers, business leaders, and broad segments of the American public find common cause in favoring health care reform that promises to achieve the goal of cost containment.[64] Proponents of communal systems assert that the current American health care system suffers from two major cost containment problems. The first problem cited is that Americans spend too much money on health care services as opposed to other goods and services. Commentators commonly attribute this "macroallocation problem" to: private and governmental insurance plans that encourage overuse of benefits,[65] the advent of expensive high technology equipment,[66] the aging of the population with consequent increased demand for treatment of the illnesses of aging,[67] over-charging by health care

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64. Poll results indicate that this is the most important goal for most Americans. Richard Benedetto, *Skepticism Grows Over Quality, Cost and Choice*, USA TODAY, Nov. 1, 1993, at 2A (USA Today/CNN/Gallup poll indicating 56% say costs will go up under Clinton's plan); *Clinton Says Health Plan Alterations Inevitable*, SAN FRANCISCO EXAMINER, Mar. 3, 1994, at A14 (citing poll determining that public has "little appetite for new taxes, even to pay for health care reform"); MacDonald, *supra* note 39, at A1 (reporting concern about increased cost is the "rock bottom" reason people oppose Clinton's plan). For a discussion of the strong interest of business leaders in cost control, see Richard A. Knox, *Cost of Care Leaves Many in US Seeking Better Way*, BOSTON GLOBE, May 14, 1991, at N/F1.

65. Problems with health insurance coverage cited include overuse of health care services because of the incentives of the health care provider and the consumer to draw upon the common fund to their mutual benefit in the short-term, but with ever escalating costs in the long-term. *See* Pauly, *supra* note 18, at 29, 36-38; *see generally* Garrett Hardin, *The Tragedy of the Commons*, 162 SCI. 1243 (1968) (applying economic theory of public goods misuse to population control).

66. Jeff Goldsmith, *Chronic Illness and the Technologic Transformation of American Health Care*, *in* UNDERSTANDING UNIVERSAL HEALTH PROGRAMS, *supra* note 3, at 42; Pauly, *supra* note 18, at 33-34; Dale A. Rublee, *Medical Technology in Canada, Germany, and the United States*, 8:2 HEALTH AFF. 178 (1989).

67. Edward L. Schneider & Jack M. Guralnik, *The Aging of America: Impact on Health Care Costs*, *in* UNDERSTANDING UNIVERSAL HEALTH PROGRAMS, *supra* note 3, at 35.

providers and insurers,[68] and high administrative costs.[69] The second problem cited is that Americans spend too much on inefficient health care services that are not worth their costs. Commentators commonly attribute this "microallocation problem"[70] to private and governmental insurance plans that encourage overuse of benefits,[71] and to inefficiencies introduced by high technology, treatment for the elderly, over-charging, and high administrative costs.[72] Proponents of communal systems assert that adoption of a communal system is necessary to solve both the macroallocation and the microallocation problems.[73]

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68. Sources of over-charging cited include hospitals and insurance companies. *See* Robert C. Evans, *Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control, in* UNDERSTANDING UNIVERSAL HEALTH PROGRAMS, *supra* note 3, at 224, 225.

69. *Id. But see* Danzon, *supra* note 47 (arguing that administrative cost savings under a communal system may be illusory because costs are saved at the time and expense of the patient).

70. Health care services may be considered "not worth their costs" according to a number of methods of analysis. Cost-benefit analysis considers the value of one undertaking as opposed to another in terms of the benefits to be achieved in comparison to the costs. Cost effectiveness refers to whether one course of treatment intended to yield a given result is cheaper than another course of treatment. *See generally* ALAN L. SORKIN, HEALTH ECONOMICS: AN INTRODUCTION (3d ed. 1992). Other efforts to express the concept of whether health care services are worth it are numerous. *See, e.g.*, Eddy, *supra* note 9; Robert M. Kaplan, *A Quality-of-Life Approach to Health Resource Allocation, in* Rationing America's Medical Care, *supra* note 25, at 60, 60-75.

71. *See supra* note 65.

72. For a discussion of the perplexities of devising and applying cost-effectiveness and related criteria for measuring whether health care is "worth it," see Lisa Scott, *Looking Beyond Cost*, MOD. HEALTHCARE, Feb. 28, 1994, at 36-40; *see also* Rolla Edward Park et al., *Physician Ratings of Appropriate Indications for Three Procedures: Theoretical Indications vs. Indications Used in Practice,* 79 AM. J. PUB. HEALTH 445, 449 (1989) (noting that "[p]atients should know that a substantial percentage of procedures are performed for indications about which expert physicians disagree"); John E. Wennberg et al., *Hospital Use and Mortality Among Medicare Beneficiaries in Boston and New Haven*, 321 NEW ENG. J. MED. 1168 (1989); Steven H. Woolf, *Practice Guidelines: A New Reality in Medicine,* 150 ARCHIVES INTERNAL MED. 1811, 1812-17 (1990) (describing various entitites involved in developing practice guidelines); *supra* note 5.

73. The current American health care system reflects no comprehensive design to limit expenditures on health care, although temporary limited efforts were undertaken as part of the wage and price controls of the Nixon administration. ODIN W. ANDERSON, HEALTH SERVICES IN THE UNITED STATES: A GROWTH ENTERPRISE SINCE 1875, at 205-06 (1985).

Piecemeal efforts by federal and state governments have included various payment schemes designed to achieve overall savings, such as Medicare's Diagnosis Related Groups, and efforts to limit hospital rates and restrict capital construction projects by health care institutions, such as hospital rate

Communal systems address the macroallocation and microallocation problems by a variety of devices. First, to limit overall spending on health care, communal systems impose expenditure limits, consisting either of limits on the reimbursement of services, overall budget caps, or both.[74] However, price controls, price ceilings, and other similar devices generate responses in regulated entities that threaten the effectiveness of these devices.[75] In addition, to the extent these devices are effective, they typically generate distortions,[76] including reductions in access, quality, or both.[77]

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review programs and certificate of need programs. Pauly, *supra* note 18, at 56-59. Efforts by private insurers have included the imposition of deductibles and copayments, restrictions imposed upon providers by insurance company utilization review administrators, and incentives to economize imposed by risk-sharing health maintenance organization (HMO) arrangements. *See* Pauly, *supra* note 18, at 40-44; *see also* Clark C. Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers, in* HEALTH CARE IN AMERICA, *supra* note 18, at 221-56. *See generally* ANDERSON, *supra*; WARREN GREENBERG, COMPETITION, REGULATION, AND RATIONING IN HEALTH CARE (1991). For a discussion of cost containment approaches under communal systems, see Brian Abel-Smith, *Cost Containment and New Priorities in the European Community*, 70 MILBANK Q. 393 (1992); Evans, *supra* note 68, at 224.

74. *See supra* notes 56-58. Although communal systems in other industrialized countries currently struggle with health care cost inflation comparable to that in the United States, Miller & Miller, *supra* note 20, at 1385; Warson, *supra* note 56, at 78, they have been successful in limiting the percentage of Gross Domestic Product (GDP) expended on health care services to levels significantly lower than in the United States. In 1991, other communal systems spent approximately 6 to 11% of GDP (France 9.1%, Canada 10%, Germany 8.5%) on health care in contrast to 13.4% in the United States. Fielding & Lancry, *supra* note 3, at 748. These cost figures are not directly comparable, however. For example, cited statistics for Canada's system often include percentage of Gross National Product (GNP) spent on health care: in 1970, both Canada and the United States spent 7% of GNP, yet by 1988 Canada's spending had increased to only 8.5% of GNP compared to 11% in the United States. BEAUCHAMP, *supra* note 34, at 239. Analysts often note Canada's slow rate of increased health expenditures, but fail to note Canada's high rate of GNP growth, the denominator in the percentage. *Id.* In essence, it could be argued, Canada's increasing health care expenditures are merely being overshadowed by its rapidly rising GNP. *Id.* For a discussion of various "apples to apples" and "oranges to oranges" comparisons of health care spending among nations, see Schieber & Poullier, *supra* note 33, at 106.

75. *See* STEPHEN BREYER, REGULATION AND ITS REFORM 68-69, 210-12, 250-53 (1982). With respect to limits imposed upon health care providers, in practice, physicians and hospitals have proved adept at frustrating these limits by altering their practice patterns. In Germany, the numbers of visits and lengths of hospitilization have increased in response to the constraints on reimbursement. Hurst, *supra* note 55, at 76.

76. In a recent letter to President Clinton printed in the Wall Street Journal,

Second, communal systems address macroallocation and microallocation problems through targeted measures aimed at cited causes of overuse or misuse of health care benefits. For example, a communal system may ration access to high technology equipment and promote preventive care to achieve greater cost effectiveness.[78] The elderly may be discouraged from using expensive

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> 562 economists pointed out that the fee schedules, annual spending caps and limits on insurance premiums and drug prices do, in fact, constitute price controls, which historically and in other countries have led to shortages, rationing and economic disaster. They may "appear to reduce medical spending, but such gains are illusory. . . . We will instead end up with lower-quality medical care, reduced medical innovation and expensive new bureaucracies to monitor compliance. These controls will hurt people and they will damage the economy."

Joan Beck, *Clinton Health Plan: Terminal Case of Wishful Thinking*, CHI. TRIB., Jan. 23, 1994, at P3; *see also* DAVID D. FRIEDMAN, PRICE THEORY 390-400 (1986). Consumers of drugs in the United States currently subsidize the price controls on drugs in other countries. Pharmaceutical companies "cost-shift" to the U.S. market. *Pharmaceuticals: GAO Finds Drug Prices Higher in U.S.*, HEALTH LINE, Feb. 3, 1994, *available in* LEXIS, Nexis Library, HLTLNE file.

77. *See* Jerome C. Arnett, Jr., *Canada's Single-Payer Health Scheme a Singular Failure*, WALL ST. J., Aug. 6, 1993, at A11 ("[D]ogs at York Central Hospital in metropolitan Toronto were able to get CAT scans immediately while humans were put on a waiting list."); Bronow et al., *supra* note 27, at 2511 ("In the Canadian System . . . [p]atients' needs take a backseat to budget constraints."); Daniels, *supra* note 27, at 1381 (1986) (reporting budget constraints in Great Britain have decreased access to some beneficial care); Iglehart, *supra* note 27, at 562 (reporting Canadians are demanding better access in the face of a large budget deficit); C. David Naylor, *A Different View of Queues in Ontario*, 10:2 HEALTH AFF. 110, 110-11 (1991) (queues for nonemergency treatments are a form of rationing).

78. For example, in France, for a hospital to get expensive equipment such as a magnetic resonance imager (MRI), the hospital must obtain governmental permission. Fielding & Lancry, *supra* note 3, at 754. This approval is based upon several factors, including quantified proof of need and proof that the hospital's current revenues are sufficient to pay for the equipment and the servicing of the equipment. *Id.* The number of MRIs in France in 1991 was 1.23 MRIs per 1 million people compared to 3.8 (in hospitals alone) in the United States in 1990. *Id.* In addition, "Canada has appreciably slowed the diffusion of six major forms of technology: open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extracorporeal shock-wave lithotropsy, and magnetic resonance imaging (MRI)." Iglehart, *supra* note 27, at 565 (footnote omitted).

Much emphasis in the public policy debate has been placed upon the concept of a basic benefits package pursuant to a communal system that would emphasize preventive care. As numerous commentators have noted, preventive care may be desirable, but it is not necessarily cost-effective and it is likely to increase rather than decrease overall costs of health care. *See generally* Kaplan, *supra* note 32, at 761-63 (noting that in spite of increased emphasis on preventive care, there has been virtually no increase in life

life-extending care.[79] Drug prices and insurance premiums may be price controlled.[80] Administrative costs may be reduced by replacing most private insurance companies with a single governmental payer.[81]

These communal system policy choices regarding how much should be spent on health care services as opposed to other goods and services, and regarding which health care services are worth their costs, implement value judgments.[82] Because communal systems are governmentally directed, they can implement these value judgments fairly effectively.[83] In some cases, however, communal systems will make mistakes in their efforts to implement these value judgments.[84] In other cases, reasonable people may disagree about the value judgments.[85]

Assuming that the goals of reducing the macroallocation and microallocation problems are important social welfare goals, the marketplace is the major alternative mechanism for achieving them.[86] However, the marketplace achieves these goals only after redefining them. If, in a properly functioning market place, consumers choose to spend their dollars on health care services,

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expectancy for adults since the 1900s); Robert M. Kaplan, *Behavioral Epidemiology, Health Promotion, and Health Services*, 23 MED. CARE 564, 565-77 (1985) (reviewing evidence for cost-effectiveness of preventive care); RUSSELL, *supra* note 34, at 76 (concluding that "screening and treating hypertension adds to medical expenditures"); PETR SKRABANEK & JAMES MCCORMICK, FOLLIES & FALLACIES IN MEDICINE 83-102 (1990).

79. For a discussion of restrictions on renal dialysis for the elderly under the BNHS, see Baker, *supra* note 25, at 218-21. *See also* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 177-91 (1978) (comparing allocation of renal dialysis units for the elderly in Italy, the United States, and England).

80. *See supra* note 76 (discussing price controls as a means of cost shifting by current communal systems to the American health care system); *see also MacNeil/Lehrer NewsHour* (Public Television broadcast, Feb. 8, 1994) (discussing the limitation of insurance costs under the Clinton Plan).

81. *See* Evans, *supra* note 68, at 224, 229-30.

82. For a discussion of the difficulties encountered in attempting to match cost-effective measures with emotional values, see David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 JAMA 2218 (1991); *see also* David M. Eddy, *What's Going on in Oregon?*, 266 JAMA 417 (1991).

83. These may be subject to evasions and distortions that are unanticipated or beyond control. *See supra* notes 69-70.

84. For example, preventive care may not be cost-effective, hence promotion of preventive care fails to achieve the goal that the communal system values. *See supra* note 72.

85. For example, reasonable people may disagree about the cost effectiveness of expensive life-extending care for the elderly and others. *See supra* notes 73, 75.

86. Mixed approaches might implement some communal system measures, such as defining benefit packages, and some marketplace measures. *See, e.g.*, H.R. 3222 & S. 1759, 103d Cong., 1st Sess. (1993) (plan of Rep. Jim Cooper).

then the sum of their choices constitutes the proper macroallocation of societal resources to health care services. If, in a properly functioning marketplace, consumers choose to spend their dollars on particular health care services that are worth their costs to those consumers, then this choice constitutes the proper microallocation of the consumers' resources to particular health care services. Thus, from the perspective of free market economics, macroeconomic and microeconomic problems arise only if the marketplace is not functioning properly. The value judgments to be implemented would be those of consumers through their actions in the marketplace rather than those of the designers of a communal system pursuant to the political process.[87]

Proponents of the marketplace recognize that a variety of imperfections distort the proper functioning of the marketplace. The principal causes cited are: tax-favored treatment of health insurance premiums;[88] insurance coverage of health care expenses;[89] and failures of consumer information.[90] Some market imperfections are inevitable in an imperfect world.[91] However, some could be reduced. For example, eliminating tax-favored treatment of insurance premiums would improve the functioning of the marketplace somewhat and, hence, would reduce marketplace macroallocation and microallocation problems.[92] However, this improvement would come at the expense of those who previously enjoyed the benefit of the tax subsidy.

In sum, communal systems and market systems are alternative mechanisms for implementing value judgments regarding cost containment goals. Both mechanisms entail trade-offs among

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87. *See generally* Pauly, *supra* note 18, at 35-36.

88. *See generally* Paul J. Donahue, *Federal Tax Treatment of Health Care Expenditures: Is It Part of the Health Care Problem?, infra* this volume, at part II.A.

89. *Id.* parts III.C. and III.D.

90. *See supra* note 79; *see also supra* note 61.

91. *See, e.g.,* Pauly, *supra* note 18, at 30-31, 44-51 (discussing the problem of imperfect information).

92. *See generally* James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981); Clark C. Havighurst, *Competition in Health Services: Overview, Issues and Answers,* 34 VAND. L. REV. 1117, 1135-39 (1981); Havighurst, *supra* note 73, at 229-54 (explaining failures of insurance company competition); Pauly, *supra* note 18, at 29-31, 44-51 (explaining problems with consumer information and problems with tax-favored treatment of insurance that encourages overspending on health insurance, and problems with overuse of health care services encouraged by health insurance); Charles D. Weller, *'Free Choice' as a Restraint of Trade in American Health Care Delivery and Insurance,* 69 IOWA L. REV. 1351, 1376 (1984) (explaining failures of health care provider competition).

cost, access, and quality goals, and both face practical problems in achieving implementation of their cost containment goals.

### D. *Quality of Health Care*

Participants in health care reform debates are in general agreement that the quality of health care available in the United States to patients who have access to it is the best in the world by nearly every measure.[93] Proponents of communal systems generally do not dispute that the current health care system delivers very high quality health care to most Americans. Instead, they argue that good or better quality care at equal or lesser cost can be provided to all under a communal system.[94]

To determine how well a health care system ensures quality of care, one must specify indicia of quality and their relative importance. Commentators propose a variety of indicia of health care quality,[95] including that the care: improves gross measures of mortality and morbidity;[96] relieves suffering;[97] is rendered in accordance with standard medical practices;[98] achieves good outcomes;[99] is delivered in comfortable and convenient circumstances by sensitive and considerate health care providers;[100] is

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93. Marlene Cimons, *Clinton Plan's Preventive Care Sparks Healthy Debate*, L.A. TIMES, Sept. 12, 1993, at A1; DOUGHERTY, *supra* note 6, at 3.

94. *See, e.g.*, Grumbach et al., *supra* note 9; Himmelstein et al., *supra* note 9, at 102.

95. *See* Kathleen N. Lohr et al., *Issues in Measuring and Assuring Quality of Care for Health Care Reform*, 270 JAMA 1911 (1993) (highlighting readily available and accurate ways to assess quality of care).

96. *See* James S. House et al., *Age, Socioeconomic Status, and Health*, 68 MILBANK Q. 383, 385, 398 (1990).

97. *See* Pauly, *supra* note 18, at 59-66; *see also* Schieber & Poullier, *supra* note 33, at 116 (noting that some refined outcome measures, such as infant mortality by birthweight, suggest that the United States is achieving superior quality results in return for higher expenditures).

98. *See, e.g.*, Paul R. Fortin, *Quality Assurance in Canada: Does Insurance Affect Assurance?*, 19 J. RHEUMATOLOGY 11, 11 (1992) (noting Canadian quality assurance efforts have traditionally emphasized satisfactory structures and delivery of care, while American quality assurance efforts stress outcomes); Bradford Kirkman-Liff & Gunter Neubauer, *The Development of Quality Assurance in the German Health Care System*, QUALITY R. BULL., Aug. 1992, at 266.

99. *See* Paul M. Ellwood, *Shattuck Lecture—Outcomes Management: A Technology of Patient Experience*, 318 NEW ENG. J. MED. 1549 (1988) (urging physicians to use outcomes management to achieve better quality of life outcomes for their patients); William L. Roper et al., *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197 (1988) (proposing a plan to improve health outcomes).

100. *See* AVEDIS DONABEDIAN, THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT (1980), *reprinted in* BARRY R. FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 14 (1991); *see also* John C. Mowen et al., *Waiting in the Emergency Room: How to Improve Patient Satisfaction*, 13 J. HEALTH CARE MARKETING 26 (1993).

something that consumers are willing to spend their money for;[101] and is rated "satisfactory" by the majority of consumers.[102]

Proponents of communal systems often emphasize the first and last of these indicia: mortality and morbidity statistics[103] and majority consumer satisfaction.[104] However, there are numerous determinants of health status as measured by mortality and morbidity statistics. Although health care certainly is one of these determinants, it likely is not the primary determinant.[105] In addition, majority consumer satisfaction may reflect the fact that most consumers are relatively healthy most of the time and hence have no occasion to be dissatisfied with aspects of health care that only the sickest have occasion to consider, such as timely access to high technology care or access to expensive treatments that offer relatively low likelihood of cure or amelioration of disability or discomfort.[106]

With respect to achieving quality care according to other indicia, communal systems facilitate a targeted and uniform approach. For example, if governmental decision-makers determine that preventive health care is of high quality because it relieves suffering by treating illnesses sooner rather than later, then a communal system's benefit package and physician incentive package can encourage preventive treatments by primary physicians rather than acute care by specialists.[107] The preference of many individuals to obtain acute care as needed rather than

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101. *See* Havighurst, *supra* note 92; Pauly, *supra* note 18, at 58; Weller, *supra* note 92, at 1387.

102. Chris Adams, *Health Plan not Wanted by All: Many Satisfied With Own Policy*, TIMES-PICAYUNE, Jan. 23, 1994, at A1; Iglehart, *supra* note 27, at 565 (noting that the public support level of Canada's health care plan is very high).

103. *Canada & Germany: Models for U.S. Health Care?*, HEALTH LINE, Mar. 18, 1993, *available in* LEXIS, Nexis Library, HLTLNE file. *See also* SORKIN, *supra* note 70, at 21-22.

104. An international survey evaluating consumer satisfaction across 10 countries' health care systems found German citizens' satisfaction ranked third in the percent of consumers who felt only "minor changes" would be needed in their systems. Hurst, *supra* note 55, at 82. In 1990, French citizens were surveyed about their health system with the following responses: 10% wanted a complete system overhaul (compared to 30% of Americans) and 40% indicated fundamental changes needed to be made (compared to 60% of Americans). Fielding & Lancry, *supra* note 3, at 748; *see also* Iglehart, *supra* note 27, at 565 (survey indicating that 87% of Canadians are "very" or "somewhat" satisfied with the Canadian system); Joel Havemann, *Diagnosis: Healthier in Europe,* L.A. TIMES, Dec. 30, 1992, at A1 (citing a 1990 Harvard School of Public Health survey indicating only 10% of Americans believe their "health care system works pretty well").

105. *See supra* notes 34-37.

106. *See supra* text accompanying note 51.

107. Eddy, *supra* note 82.

preventive care on a routine or timely basis, as well as the preference of physicians to specialize, will pose practical problems to implementation of this approach. Nonetheless, these measures will have some effect.[108] However, the governmental decision-makers may be mistaken regarding the efficacy of preventive care in relieving suffering.[109] Furthermore, reasonable people may disagree about the relative importance of different indicia of quality. For example, some may favor applying resources to achieve long-term improvements in relief of suffering that can be realized only through innovation and new technologies[110] rather than short-term improvements in access or cost that generate high consumer satisfaction.[111]

Communal systems allow fairly effective governmental implementation of quality assurance measures. Thus, the benefits, mistakes, and consequences of the priorities established by the communal system will be widely disseminated.

The current American health care system also generates benefits and mistakes and yields value judgments regarding priorities.[112] Policy measures to correct mistakes and adjust priorities could include, for example, the adoption of practice guidelines to encourage efficient practice styles that yield good outcomes.[113] Efforts to accomplish these goals will be imperfect given the enormous difficulties of informing and altering the practice patterns of doctors and other health care providers.[114] Such policy measures also will yield mistakes and generate disagreement regarding priorities.

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108. *See supra* note 66.

109. *See* RUSSELL, *supra* note 34, at 63 (stating screening tests may increase suffering because false-positive test results (those that incorrectly indicate a patient has a condition) may cause patients unnecessary risk and discomfort); *see also* Kaplan, *supra* note 70, at 575-77.

110. Baker, *supra* note 25, at 215-21.

111. Of course, it is impossible to measure the health status consequences of opportunities for the development of new technology that are foregone. There can be no "control society" in which resources are available as profit incentives for the development of new technology as opposed to applied to broader access or lower costs. The only comparison that can be drawn is between the United States and other developed nations that have adopted communal systems; generally, the United States yields more innovations. *See supra* note 47.

112. *See* Wennberg et al., *supra* note 72 (1989) (studying variations in clinical practice); John E. Wennberg et al., *Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?*, THE LANCET, May 23, 1987, at 1185, 1186-88 (same); *see also* Weller, *supra* note 92, at 1391 (discussing various practice styles, all of which result in the same outcomes).

113. For example, Maine has enacted established "practice parameters" as a safe harbor in medical malpractice actions. *See* FURROW ET AL., *supra* note 100, at 141.

114. *See supra* note 66.

In sum, the current American health care system yields high quality care, but at relatively high cost and with limited access. Communal systems broaden access and contain costs, and reorder priorities regarding quality in some cases. Both systems reflect trade-offs among quality, access, and cost goals. Both encounter practical problems in efforts to reorder priorities.

### E. *Conclusion: The System Will Not Fix*

Accepting welfarist principles, and accepting the social welfare goals commonly cited in the public policy debate regarding national health care delivery, the evidence does not support the conclusion that adoption of a communal system would best assure realization of these goals. Communal systems generally achieve certain goals, such as secure access, better than other goals, such as prompt access to expensive health care services. Particular communal system policy measures, such as global budgets, may achieve cost containment goals better than others, such as fee schedules. Noncommunal systems generally assure access to expensive life-extending care better than they assure broad access to care. Particular noncommunal policy measures, such as vouchers, may assure secure access better than others, such as measures to improve market price competition among insurers.

In short, modern health care delivery systems, whether communal or noncommunal, struggle with the same unavoidable trade-offs among competing goals and the same practical problems with devising particular policy measures that will be effective in achieving preferred goals. Communal systems do not transcend or evade these trade-offs or practical problems. A communal system cannot assure the broadest possible access to the highest quality health care services at the lowest cost. Hence, welfarism does not require adoption of a communal system as an all-purpose fix, a means of assuring the best system for everybody.

In fact, as the preceding discussion reveals, there is no best system for everybody. The apparent consensus upon the three social welfare goals that would define the best system is wholly illusory. Upon closer examination, these three goals fracture into numerous goals, each requiring a trade-off with one or more other goals if any is to be realized. There is no consensus regarding preferred goals in light of the trade-offs required.

Perhaps, then, policy makers should squarely face these trade-offs and determine preferred social welfare goals. They then could proceed to a more focused consideration of the relative instrumental merits of various communal system and noncommunal system policy measures in achieving these goals. Perhaps

welfarism would require adoption of a communal system if, for example, policy makers concluded that secure access for all to most health care services yielded more welfare benefits than access to expensive life-extending care for few. Thus, by a process of rational calculation of the consequences of adoption of a communal system or of alternative policy measures, policy makers could determine just public policy. This resort to welfarist principles cannot succeed, however, as discussed below.

## III. Welfarism as an Account of Justice in Three Health Care Contexts

*Both sides, I think, understand the literal ethical imperative of doing something about the system we have now.*[115]

### A. *Introduction*

Resort to welfarist principles to determine the demands of justice in the context of national health care delivery tempts policy makers for two reasons. First, welfarism invokes rationality as a means to determine the requirements of justice. Rationality in modern medicine and politics has been a powerfully effective weapon in the battle against suffering and death. The achievements of modern medicine for individual patients and of public health measures for communities attest to its force. A national health care delivery system promises the delivery of the benefits of modern medicine to the national community, a marriage of individual medicine and community health. Welfarist analysis appears well-suited to establishing the just terms of this marriage.

Second, welfarism holds out the promise of clear and definite answers to the question: what is ethically required of society in response to the suffering and deaths of its members? Clear and definite answers are especially appealing in this context.

A number of objections have been posed to the welfarist conception of justice, however. These objections are founded in conflicts with competing principles of individual ethics and justice, and in practical problems with applying welfarist analysis. These objections arise in applying welfarist principles to determine the content of individual welfare, to compare the welfare experiences of different individuals, and to calculate the maximization of social welfare.[116]

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115. President Clinton's Speech, *supra* note 1, at A8.

116. Problems of implementing effective policy measures to maximize social welfare, as discussed in part II, *supra*, also will give rise to objections. However, problems of implementation in a complex world will plague efforts to realize the commands of any theory of justice.

Welfarist analysis first requires that policy makers define the content of individual welfare.[117] For example, different welfarist theorists characterize individual welfare variously as the enjoyment of pleasures, or the satisfaction of actual, rational, or revealed preferences.[118] Some theorists exclude unacceptable kinds of pleasures or preferences, such as sadistic pleasures or preferences with respect to the conduct of other peoples' lives.[119]

Welfarism next requires a comparison and ranking of the welfare experiences of different individuals that result from proposed policy measures.[120] To compare and rank individual welfare experiences, policy makers must be able to know the different welfare experiences of individuals and must be able to rank them on a common metric.[121]

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117. For a critique of welfarist analysis on this point, see H. TRISTRAM ENGELHARDT, JR., BIOETHICS AND SECULAR HUMANISM: THE SEARCH FOR A COMMON MORALITY 107-09 (1991).

118. Harsanyi explained his conception of individual welfare as the satisfaction of true preferences as opposed to manifest or actual preferences:

> [An individual's] manifest preferences are his actual preferences as manifested by his observed behaviour, including preferences possibly based on erroneous factual beliefs, or on careless logical analysis, or on strong emotions that at the moment greatly hinder rational choice. In contrast, a person's true preferences are the preferences he *would* have if he had all the relevant factual information, always reasoned with the greatest possible care, and were in a state of mind most conducive to rational choice. Given this distinction, a person's rational wants are those consistent with his true preferences and, therefore, consistent with all the relevant factual information and with the best possible logical analysis of this information, whereas irrational wants are those that fail this test. . . . [S]ocial utility must be defined in terms of people's true preferences rather than in terms of their manifest preferences.

Harsanyi, *supra* note 4, at 55. For a discussion of alternative definitions of social welfare, see Peter J. Hammond, *Utilitarianism, Uncertainty and Information*, *in* UTILITARIANISM AND BEYOND, *supra* note 4, at 86-87; Harsanyi, *supra* note 4, at 54-56. For a discussion of persistent practical problems with all of these characterizations, see Sugden, *supra* note 5.

119. Harsanyi proposes to exclude from consideration "all clearly antisocial preferences, such as sadism, envy, resentment, and malice." Harsanyi, *supra* note 4, at 56; *see also* Hammond, *supra* note 118, at 87.

120. For a critique of welfarist analysis on this point, see Partha Dasgupta, *Utilitarianism, Information and Rights*, *in* UTILITARIANISM AND BEYOND, *supra* note 4, at 199, 205-06; John Rawls, *Social Unity and Primary Goods*, *in* UTILITARIANISM AND BEYOND, *supra* note 4, at 159, 159-61; *see also* Sugden, *supra* note 5, at 1950-51 (discussing the attempt in revealed preference welfarism to avoid problems with interpersonal comparisons of welfare).

121. Welfarist theorists argue that all human beings are enough alike, and sensible enough about how they are alike, to accommodate the modest demands of interpersonal comparison. Harsanyi argues "imaginative empathy" is required to make interpersonal utility comparisons:

> [A]ny interpersonal utility comparison is based in what I will call

Finally, welfarist analysis requires application of a formula to calculate the social welfare consequences of proposed policy measures.[122] The formula must aggregate in some fashion individual welfare experiences that result from policy measures to determine which policy measure maximizes social welfare. For example, classical utilitarianism calculates the maximization of social welfare by aggregating the units of pleasure and units of pain of all members of society that result from a particular policy measure. The policy measure that yields the greatest excess of pleasure over pain maximizes social welfare.[123] Other approaches calculate the maximization of social welfare by determining the policy measure that maximizes the welfare of the worst-off person, or by determining the policy measure that improves the welfare of any person without diminishing the welfare of any other person.[124]

The discussion below analyzes objections to the application of welfarism in three health care contexts. With respect to bioethical issues, policy makers generally reject welfarist approaches to determining the requirements of justice. In contrast, welfarism generally prevails in the context of public health issues. With respect to health care delivery issues, the contest between welfarist and nonwelfarist principles is unresolved. For reasons

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> the *similarity postulate*, to be defined as the assumption that, once proper allowances have been made for the empirically given differences in taste, education, etc., between me and another person, then it is reasonable for me to assume that our basic psychological reactions to any given alternative will be otherwise much the same. . . .
>
> In general, if we have enough information about a given person, and make a real effort to attain an imaginative empathy with him, we can probably make reasonably good estimates of the utilities and disutilities he would obtain from various alternatives. . . .
>
> In any case, utilitarian theory does not involve the assumption that people are very good at making interpersonal utility comparisons. It involves only the assumption that, in many cases, people simply *have* to make such comparisons in order to make certain moral decisions — however badly they may make them. If I am trying to decide which member of my family is in greatest need of food, I may sometimes badly misjudge the situation. But I simply *have* to make *some* decision. I cannot let *all* members of my family go hungry because I have philosophical scruples about interpersonal comparisons and cannot make up my mind.

Harsanyi, *supra* note 4, at 50.

122. For a critique of welfarist analysis on this point, see ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 259-61 (1981).

123. Sen & Williams, *supra* note 4, at 4.

124. *Id.* at 4 n.4 (discussing the Rawlsian Difference Principle as a method of calculating the maximization of social welfare). For a discussion of Pareto and Marshall efficiency, see Friedman, *supra* note 5, at 262.

discussed below, the application of welfarism should vary according to context, and welfarist principles should play only a limited role in determining the requirements of justice with respect to a national health care delivery system.

### B. *Welfarism and Bioethics*

Bioethical issues require policy makers to find just resolutions to tragedies involving the role of modern medicine in individual experiences of suffering and death.[125] Welfarism fails as a guide to the requirements of justice in this context.

In the context of bioethics, there is no consensus with respect to the goals of medical intervention, or with respect to acceptable means to achieve these goals. One individual resists death with all that modern medicine has to offer, the other surrenders to death without resort to life-extending procedures.[126] Preferences regarding goals and means in the context of bioethics are diverse.

In addition, individuals value highly their preferences regarding the goals and means of medical intervention. Bioethical tragedies pose stark choices between important goals, such as avoiding further suffering and avoiding death. The means employed by modern medicine are often highly intrusive upon personal privacy and upon the human body. These important goals and intrusive means arouse intense emotions and often implicate ethical principles. In choosing death rather than continued suffering, one individual feels terror, the other serenity.[127]

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125. *See, e.g.*, Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

> Petitioner, Elizabeth Bouvia, . . . seeks the removal from her body of a nasogastric tube inserted and maintained against her will and without her consent by physicians who so placed it for the purpose of keeping her alive through involuntary forced feeding. . . . Petitioner is a 28-year old woman. . . . Except for a few fingers of one hand and some slight head and facial movements, she is immobile. She is physically helpless and wholly unable to care for herself. . . . She is in continual pain. . . . She has on several occasions expressed the desire to die.

*Id.* at 298-300.

126. *See, e.g., In re* Quackenbush, 383 A.2d 785 (N.J. Morris County Ct. 1978). *Quackenbush* involved the visit of a judge to determine the competency of Mr. Quackenbush, a 72-year-old man, in light of Mr. Quackenbush's refusal to allow amputation of a gangrenous leg to avoid death: "He spoke somewhat philosophically about his circumstances and desires. He hopes for a miracle but realizes there is no great likelihood of its occurrence. He indicates a desire — plebian, as he described it — to return to his trailer and live out his life." *Id.* at 788.

127. *See, e.g.*, Public Health Trust v. Wons, 541 So. 2d 96, 98 (Fla. 1989) (upholding Mrs. Wons' constitutional rights of privacy and free exercise of religion to refuse a blood transfusion although the consequence would be death).

One believes that the relief of suffering is an ethical imperative, the other believes that suffering should be endured.[128]

Thus, in this context, preferences regarding goals and means are diverse and highly valued. Consequently, objections to welfarism apply with force as the public policy debate surrounding the use of anencephalic infants as organ donors illustrates.[129]

Anencephalic infants are born without all or most of the cerebral hemispheres, but with functioning brain stems.[130] Anencephalic infants invariably die soon after birth, usually within a day or two.[131] Although the absence of the cerebral hemispheres means that these infants cannot develop self-awareness and cognitive abilities, during their brief lives they display brain functioning not very different from that of newborns with normal brains.[132]

The other organs of anencephalic infants are often normal or near normal and, hence, potentially suitable for transplantation into other infants.[133] However, these other organs deteriorate during the normal dying process of anencephalic infants, thus rendering them no longer suitable for transplantation.[134]

At one time in the United States, anencephalic infants were sacrificed and their organs harvested for transplantation into

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128. *See, e.g., In re* Conroy, 486 A.2d 1209 (N.J. 1985). The *Conroy* court recognized differences in this regard: "Nevertheless, even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain he might experience." *Id.* at 1232.

129. *See generally* Jeffrey R. Botkin, *Anencephalic Infants as Organ Donors*, 82 PEDIATRICS 250 (1988); Thomas Leggans, *Anencephalic Infants as Organ Donors*, 9 J. LEGAL MED. 449 (1988) (advocating the use of organ transplants from anencephalic infants); Alan Shewmon et al., *The Use of Anencephalic Infants as Organ Sources: A Critique*, 261 JAMA 1773 (1989); Robert D. Truog & John C. Fletcher, *Anencephalic Newborns: Can Organs be Transplanted before Brain Death?*, 321 NEW ENG. J. MED. 388 (1989); James W. Walters & Stephen Ashwal, *Organ Prolongation in Anencephalic Infants: Ethical and Medical Issues*, 18 HASTINGS CENTER REP. 19 (Oct./Nov. 1988).

130. The cerebral hemispheres permit cognitive functioning; the brain stem is responsible for maintaining the functioning of the heart, lungs, and reflexes. Botkin, *supra* note 129, at 252-53; BARRY R. FURROW ET AL., BIOETHICS: HEALTH CARE LAW AND ETHICS 200 (1991).

131. *See* FURROW ET AL., *supra* note 130, at 200; Walters & Ashwal, *supra* note 129, at 19.

132. Some anencephalic newborns may respond preferentially to their mothers, and display consolability and the ability for conditioning and associative learning. Shewmon et al., *supra* note 129, at 1776.

133. Regarding limitations on the suitability of anencephalic infants as organ donors for a variety of practical reasons, see Shewmon et al., *supra* note 129, at 1774-75.

134. Botkin, *supra* note 129, at 251; FURROW ET AL., *supra* note 130, at 201.

other infants.[135] The circumstances surrounding the first transplantation of an anencephalic infant's heart are described as follows:

> Three days after [Christiaan Barnard's first human-to-human heart transplant], [Dr. Adrian] Kantrowitz performed the first human-to-human heart transplant in the United States. . . . [T]he donor was an anencephalic newborn. . . . [T]he infant was cooled by immersion in ice water, and the heart removed immediately after it ceased beating spontaneously. The recipient died six and one-half hours later, but Kantrowitz described the operation as "technically successful."[136]

Currently, sacrificing anencephalic infants in the United States likely would constitute murder.[137]

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135. Some hospitals instead permitted medical intervention to artificially sustain anencephalic infants during the dying process so that their organs remained suitable for transplantation after death. *See* FURROW ET AL., *supra* note 130, at 202; *see also* George J. Annas, *From Canada with Love: Anencephalic Newborns as Organ Donors?*, 17 HASTINGS CENTER REP. 36, 36 (Dec. 1987). Annas recounted a successful transplantation apparently involving medical intervention to preserve the organs of an anencephalic infant during the dying process:

> When ultrasound revealed that her fetus suffered from anencephaly [the mother] was presented with three options: induction of labor, cesarean section, or carrying the fetus to term. She and her husband decided to continue with their plans for natural childbirth, and to offer the child's organs for donation. . . . Baby Gabriel, named after the archangel who guards the gates of heaven, breathed without assistance throughout her first night of life. The following day she was transferred to Children's Hospital in Western Ontario, where she was placed on a mechanical ventilator while preparations were made for organ donation. . . . Leonard Bailey of Loma Linda, California, had a pregnant patient whose fetus had been diagnosed as suffering from hypoplastic left heart. . . . A decision was made to deliver that child prematurely by cesarean section to take advantage of the available organ. Baby Gabriel was pronounced dead in Canada and flown to Loma Linda, where death was confirmed. The heart transplant was performed and the recipient, named Paul, . . . has so far survived.

*Id.* at 36. Medical intervention raises issues similar to that of sacrifice but involving a less dramatic imposition upon the anencephalic infant. Instead of being killed, the infant's life is extended, possibly entailing the infliction of pain, some or all of which may be eased by the use of anesthetics. The debate regarding these practices has abated in part because opportunities for successful transplantation of anencephalic organs currently appear to be few in number. *See* FURROW ET AL., *supra* note 130, at 201-02.

136. *Anencephalic Donors: Controversy in the 1960s*, 17 HASTINGS CENTER REP. 38 (Dec. 1987).

137. *See* FURROW ET AL., *supra* note 130, at 201-02. Most statutory defi-

A welfarist account of justice might guide policy makers to enact policy measures expressly permitting[138] the harvesting and transplantation of organs from anencephalic infants.[139] Recipients of the organs could lead full and healthy lives instead of dying in infancy. Donor infants would die anyway in a matter of hours or days after the moment of sacrifice. Hence, the pleasure of recipients and their loved ones would outweigh any pain[140] of donors and their loved ones.[141]

The application of welfarist principles to determine the requirements of justice in the above situation proves problematic, however. First, with respect to determining the content of individual welfare, welfarism does not provide an obvious answer to the question of whether pleasure deriving from the sacrifice of another person is an acceptable pleasure that should be included in determining the content of individual welfare.[142] If this were an acceptable kind of pleasure, then the sacrifice of orphans, the elderly, or the ill would be permitted, assuming that in these cases the pleasure of organ recipients and their loved ones would be greater than the pain of donors and their loved ones.

Perhaps this strongly counterintuitive result would be avoided, however, if all pleasure and pain resulting from such a policy

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nitions of death are based upon the Uniform Determination of Death Act or otherwise adopt a standard that requires complete cessation of all brain function, including the functioning of the brain stem, or the complete cessation of all circulatory and respiratory function. Botkin, *supra* note 129, at 252. Because anencephalic infants have functioning brain stems, they are not dead. Hence, killing these infants likely would constitute murder.

138. Presumably, a welfarist policy would permit the sacrifice only if the parents consented and the hospital and medical personnel agreed to participate in the sacrifice. Requiring the sacrifice against the wishes of any of these individuals presumably would inflict so much harm that social welfare would not be maximized.

139. This would require amendment either of statutory definitions of death, *see supra* note 137, or of statutory prohibitions of the harvesting of organs for donation before the donor is dead, according to the Uniform Anatomical Gift Act as adopted in all 50 states. *Id. See also* Kathleen L. Paliokas, *Anencephalic Newborns as Organ Donors: An Assessment of "Death" and the Legislative Policy*, 31 WM. & MARY L. REV. 197, 201-34 (1989) (reviewing the legal status of anencephalic newborns).

140. Part III of this Article refers to pleasure and pain as characterizations of individual welfare, except when the characterization itself poses a problem to welfarist analysis. *See infra* part III.D.

141. A welfarist account might conclude to the contrary that a legal rule permitting sacrifice would yield disutility over time because it would invite disrespect for persons and ever-increasing encroachments on the security of individual life, or because of its impact on medical personnel who participate in sacrificing one person for the sake of another, or its effects upon society's trust in the medical profession. *See* Botkin, *supra* note 129, at 253.

142. *See* Harsanyi, *supra* note 4, at 56.

measure were properly accounted for. The widespread pain caused by awareness that one could, at any time, fall into a class subject to sacrifice for the benefit of others might outweigh the pleasure to relatively few organ recipients and their loved ones. Hence, the sacrifice of those capable of self-awareness would not be permitted. The sacrifice of anencephalic infants, on the other hand, would be permitted because they lack self-awareness.

This, however, would permit inclusion of pleasure derived from the sacrifice of those who have lost higher brain functioning as a result of illness or injury. Again, perhaps this strongly counterintuitive result would be avoided because of the pervasive fear such a policy would generate given that everyone is susceptible to illness and injury. Hence, sacrifice would be permitted only of those who had never experienced higher brain functioning, including anencephalic infants.[143]

Welfarist analysis offers no principled basis for excluding pleasure derived from the sacrifice of other persons in determining the content of individual welfare.[144] If such pleasure were included, and if permitting the sacrifice of anencephalic infants would yield more pleasure than pain, welfarism would guide policy makers to adopt a policy permitting such sacrifice.

However, in the context of bioethics, policy makers overwhelmingly reject this consequentialist reasoning.[145] Instead, pol-

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143. Alternatively, anencephalic infants could be declared nonpersons, according to criteria that declare those who never had higher brain functioning as nonpersons notwithstanding the fact that they are born of human stock. Then, perhaps the pleasure deriving from their sacrifice should be included because it entails the sacrifice only of a nonperson who is born of human stock. Although this might avoid federal constitutional (Fourteenth Amendment), state constitutional (due process or other provisions), and statutory (*e.g.*, murder) restrictions on sacrificing these infants, it would not provide, in itself, a reasoned basis for distinguishing these infants from other persons. Leggans, *supra* note 129, at 450. As the debate surrounding abortion reveals, defining who is a "person" for purposes of entitlement to constitutional and other legal rights is not merely a matter of logically applying a set of scientifically determined criteria. A "person" is that creation of human stock that other creations of human stock, with the power of decision, decide should not be killed or caused to suffer without justification.

144. Some welfarist theorists engraft individual rights as constraints on consequentialist reasoning. *See* R.M. Hare, *Ethical Theory and Utilitarianism*, *in* UTILITARIANISM AND BEYOND, *supra* note 4, at 23, 25-38; *see also* Harsanyi, *supra* note 4, at 61-62.

145. *See In re* Conroy, 486 A.2d 1209 (N.J. 1985). The court, regarding withholding or withdrawal of life-sustaining treatment from an incompetent patient, stated: "[W]e expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life, or the value of that life to others." *Id.* at 1232-33. Other informative decisions

icy makers recognize some individual rights that are not subject to compromise regardless of the welfare consequences to others.[146] These rights include constitutional and statutory protections of privacy and free exercise of religion, and common-law protection of rights to make decisions regarding medical treatment and other decisions.[147]

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include the majority decisions of the Missouri Supreme Court and the United States Supreme Court upon review upholding the power of the State of Missouri to require clear and convincing evidence of an incompetent person's desire that she not be sustained in a persistent vegetative state by the administration of life-sustaining hydration and nutrition. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 280-83 (1990); Cruzan v. Harmon, 760 S.W.2d 408, 425-26 (Mo. 1988). Dissenters on the Missouri Supreme Court and the United States Supreme Court both mentioned the social welfare consequences of sustaining a woman in a persistent vegetative state. *See Cruzan*, 497 U.S. at 354 (1990) (Stevens, J., dissenting); Cruzan v. Harmon, 760 S.W.2d at 427 (Mo. 1988) (Blackmar, J., dissenting). Justice Stevens' dissent stated: "Today the State of Missouri has announced its intent to spend several hundred thousand dollars in preserving the life of Nancy Beth Cruzan in order to vindicate its general policy favoring the preservation of human life." *Cruzan*, 497 U.S. at 354 (Stevens, J., dissenting). Justice Blackmar, in his dissent to the Missouri Supreme Court's opinion, expressly noted the welfarist concern:

> The absolutist position is also infirm because the state does not stand prepared to finance the preservation of life, without regard to the cost, in very many cases. In this particular case the state has Nancy in its possession, and is litigating its right to keep her. Yet, several years ago, a respected judge needed extraordinary treatment which the hospital in which he was a patient was not willing to furnish without a huge advance deposit and the state apparently had no desire to help out. Many people die because of the unavailability of heroic medical treatment. It simply cannot be said that the state's interest in preserving and prolonging life is absolute.

Cruzan v. Harmon, 760 S.W.2d at 429 (Blackmar, J., dissenting); *see also* FURROW ET AL., *supra* note 130, at 232-33 (discussing impact of *Cruzan* cases).

146. An example of legislative decision-making in the bioethical context that protects individual rights regardless of the welfare consequences to others is the approach to organ donation in the United States. Because of religious and other objections to removal of organs from dead bodies, all 50 state legislatures have adopted the Uniform Anatomical Gift Act (UAGA) requiring an affirmative agreement to donation in advance of death by the organ donor, or an affirmative agreement by relatives upon the death of the organ donor, rather than permitting the harvesting of organs from dead bodies in the absence of knowledge of the donor's objection. *See* Arthur J. Matas et al., *A Proposal for Cadaver Organ Procurement: Routine Removal of Cadaver Organs*, 10 J. HEALTH POL., POL'Y & L. 231 (1985).

147. Some state constitutions contain provisions protecting privacy. *See, e.g.*, FLA. CONST. art. I, § 23. In cases involving objection to the administration of blood transfusions, courts generally have been amenable to constitutional arguments founded in religious beliefs. *See, e.g.*, *In re* Osborne, 294 A.2d 372 (D.C. 1972). Examples of common-law judicial decision-making include

Policy makers draw upon ethical principles of the medical profession to guide them in establishing or giving content to these rights. The principle of *individual autonomy* directs doctors to honor their patients' preferences regarding the proper role of modern medicine in their lives.[148] The principle of *beneficence* directs doctors to further the best interests of their patients.[149] The principle of *fidelity* directs doctors to minister loyally to their patients rather than considering the needs or desires of others.[150]

These legal rights and the principles of medical ethics that inform them guide policy makers to respect individuals, their preferences and best interests, and to refrain from consideration of the interests of others. These principles of respect for individuals accommodate the diverse and highly valued preferences of individuals regarding the goals and means of medical interventions in their lives. For incompetent individuals, including anencephalic infants, these principles guide policy makers to honor the individuals' preferences, if they can be determined or, if they cannot, to honor the preferences they would hold in light of their own best interests and without regard to the interests of others.[151] Welfarist analysis does not incorporate

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Strunk v. Strunk, 445 S.W.2d 145, 149 (Ky. Ct. App. 1969), in which the Kentucky Court of Appeals determined that it would permit a kidney to be removed from an incompetent ward of the state for the purpose of transplantation into his brother, but only because the death of the incompetent's brother likely would be more emotionally and psychologically damaging to the incompetent than the operation to remove the incompetent's kidney.

148. *See In re* Conroy, 486 A.2d 1209, 1221 (N.J. 1985). For a general discussion of the principle of autonomy in medical ethics, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 67-113 (3d ed. 1989); VEATCH, *supra* note 122, at 190-213.

149. *See In re* Conroy, 486 A.2d 1209 (N.J. 1985). For a general discussion of the principle of beneficence, see BEAUCHAMP & CHILDRESS, *supra* note 148, at 194-249.

150. *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. (1993) [hereinafter UAGA]. The UAGA prohibits the physician or surgeon who attends an organ donor at death from harvesting the donor's organs for transplantation unless specifically requested to do so by the donor in a signed writing. *Id.* §§ 2(b), 2(d), 8(b). For a general discussion of the principle of fidelity in medical ethics, see BEAUCHAMP & CHILDRESS, *supra* note 148, at 341-57.

151. *See In re* Guardianship of Pescinski, 226 N.W.2d 180 (Wis. 1975), in which the court refused to permit tests to be performed upon an incompetent to determine if he would be a suitable donor for a kidney transplant to save the life of his sister:

> An incompetent particularly should have his own interests protected. Certainly no advantage should be taken of him. In the absence of real consent on his part, and in a situation where no benefit to him has been established, we fail to find any authority for the county court, or this court, to approve this operation.

*Id.* at 182.

these principles of respect for individuals. In the context of bioethics, involving diverse and highly valued preferences, this failure is especially problematic.

An additional problem with the application of welfarism in the bioethical context is a practical one. The problem arises in efforts to compare and rank the welfare experiences of anencephalic infants and other individuals. These comparisons and rankings are necessary if policy makers are to compute the net of pleasure and pain to all individuals resulting from the adoption of a policy measure permitting the sacrifice of anencephalic infants.

Efforts to compare and rank the welfare experiences of anencephalic infants and others are rendered hopeless, however, by the impossibility of knowing the nature and degree of pain experienced by infants lacking cerebral brain capacity who are deprived of a day or two of life. Policy makers might assume the pain to be miniscule, but cannot hope to know.[152]

Policy makers may believe they are better able to compare and rank the welfare experiences of the parents of the recipient and donor infants. In the context of bioethical tragedies, however, in which individual preferences are diverse, failures of knowledge are severe. For example, family members, who presumably know one another best, often confess failure in efforts to know what other family members would have chosen with respect to medical treatment decisions involving matters of life and death.[153] As a practical matter, welfarism is impossible to apply in a context in which problems with interpersonal comparisons are aggravated by the diversity of individual preferences regarding medical treatment.

A third problem arises with respect to the formula selected for calculating maximization of social welfare. If the formula merely aggregates pleasure and pain, justice may require permitting the sacrifice of anencephalic infants. If, instead, the formula assures that the worst-off member of society is as well

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152. "Often, it is unclear whether and to what extent a patient such as Claire Conroy is capable of, or is in fact, experiencing pain. Similarly, medical experts are often unable to determine with any degree of certainty the extent of a nonverbal person's intellectual functioning or the depth of his emotional life." *In re Conroy*, 486 A.2d at 1233.

153. *See, e.g.*, *In re* Westchester County Medical Ctr., 531 N.E.2d 607, 611 (N.Y. 1988). This is one of the reasons for the impetus to the use of living wills, durable powers of attorney, and other legal devices for instructing doctors and others regarding preferred medical treatment decisions in the event of an individual's incapacity. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring) (noting the "practical wisdom" of such devices); UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. (1987 & Supp. 1993).

off as possible, justice may require forbidding such sacrifice.[154] Although what is at stake is a matter of life and death, policy makers will not find guidance within the welfarist framework itself as to which formula should be applied. The choice ultimately requires resort to other ethical principles, such as principles founded in respect for individuals or egalitarianism.

Thus, policy makers do not and should not resort to welfarism to determine the requirements of justice with respect to bioethical issues. Welfarism cannot accommodate the diverse and highly valued preferences of individuals with respect to the role of modern medicine in their experiences of suffering and death. Justice in this context should be founded in respect for individuals as embodied in legal principles protecting individual rights and ethical principles of the medical profession.

### C. *Welfarism and Public Health*

In the context of public health, policy makers must determine the requirements of justice with respect to policy measures that improve the health status of members of the community by reducing or eliminating environmental threats to health. There is broad consensus upon the goals, and the importance of the goals, of public health measures. For example, nearly all can agree that access to purified water supplies is a desirable goal. Furthermore, nearly all can agree that the goal is an important one given the serious threats to health posed by contaminated water. In addition, there is broad consensus upon acceptable means to public health goals. Nearly all can agree, for example, that the means to the goal of purified water should be a governmentally designed and implemented water works.

There is consensus regarding the means to achieve public health goals for three reasons. First, most public health measures entail negligible intrusions upon the privacy and bodily integrity of individuals.[155] For most individuals most of the time, public health measures do not even intrude upon their consciousness. Second, public health measures have proved to be extraordinarily effective means to achieving the important shared goals of

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154. This assumes that the worst-off anencephalic infant would not be better off dead sooner.

155. Mandatory vaccination programs entail the most significant intrusions and have aroused the most opposition. *See* RUSSELL, *supra* note 34, at 10-30 (describing opposition to vaccination for smallpox and measles); *see also* Jacobson v. Massachusetts, 197 U.S. 11 (1905) (rejecting a challenge to an early mandatory vaccination ordinance). The nonintrusiveness of most public health measures contrasts with the intrusiveness of means in the bioethical context. *See supra* part III.B.

reducing threats to health status.[156] Third, governmental public health measures are necessary to solve economic problems that otherwise might deprive communities of the benefits of improved individual health status through reduced threats to health. These economic problems include the tendency of producers to underproduce public goods[157] and to overproduce goods with negative externalities.[158]

The public goods problem arises from the inability of producers to control who receives the benefits of the public goods they produce. Because consumers know they will receive the benefits of these public goods regardless of whether they pay for them, some will refuse to pay for them.[159] As a consequence, producers may underproduce or fail to produce public goods.

Public health measures solve public goods problems through governmental action.[160] For example, pure water and sanitation systems eradicate diseases. Producers of these systems cannot, however, control who receives the benefits of disease eradication. Everyone will benefit regardless of whether they pay. Hence, private producers might not provide these systems and, consequently, the community would not enjoy the benefits of disease eradication.[161] To solve this public goods problem, local govern-

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156. Several major causes of death have almost disappeared due to public health measures, such as the provision of pure water, the proper handling of sewage, and the promotion of vaccinations. Major causes of death that have almost disappeared include typhoid, diphtheria, and gastroenteritis. RUSSELL, *supra* note 34, at 1. The efficacy of public health measures in improving health status contrasts with the relative ineffectiveness of individual health care services. *See supra* part II.B.

157. Public goods are goods that yield positive effects upon other persons. FRIEDMAN, *supra* note 76, at 423 (distinguishing between positive and negative public goods).

158. Negative externalities are the negative effects of one person's acts upon other persons. *Id.*

159. *See id.* at 421-22. For example, all people in the United States benefit from the national defense. Nevertheless, each individual knows that, in the absence of compulsory taxation to support a national defense, that individual would receive the benefit of national defense regardless of whether the individual paid for it.

160. *Id.* at 420-22.

161. Similarly, immunizations benefit those who obtain vaccinations as well as those who do not. Producers of vaccines cannot control the benefit that the nonvaccinated enjoy from the reduction or eradication of contagious diseases. Hence, governmental measures promote and, in some cases, mandate immunization. RUSSELL, *supra* note 34, at 11, 26. Current means of promoting vaccination include measures designed to promote the production of vaccine by relieving manufacturers from potential tort liability for injuries caused by the vaccines. *See* National Childhood Vaccine Injury Act of 1986 (NCVIA), Pub. L. No. 99-660, 100 Stat. 3755 (1986) (codified as amended at 42 U.S.C. §§ 300aa-10 to 300aa-33 (1988 & Supp. IV 1992)) (intending to assure the

ments provide these systems and charge community members for the benefits.

Public health measures also potentially solve negative externalities problems. Producers tend to overproduce products with negative externalities because, in calculating the costs and benefits of production, producers take into account only their own costs. They fail to include costs imposed upon others, *i.e.*, the negative externalities.[162]

Public health measures solve negative externalities problems through governmental action as well. For example, regulations to protect the safety of workers force producers of negative externalities that threaten the health of others to internalize the costs of these negative externalities either by eliminating the negative externalities or by paying fees or fines.[163]

Thus, in the context of public health, there is consensus upon the goals of public health measures and their importance. In addition, there is consensus upon governmental public health measures as generally nonintrusive, highly effective, and necessary means to achieve public health goals. In this context, objections to the application of welfarism are few, and policy makers should apply the principles of welfarism to guide their policy choices.

Defining the content of individual welfare as consisting in the pleasure of improved health status through implementation of public health measures does not pose significant problems. Public health measures generally do not entail significant intrusions upon others nor intrusions on some that are not endured by all.[164] Hence, conflicts with principles of respect for individuals are unlikely to arise.

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availability of the diphtheria, tetanus, and pertussis (DTP) vaccine by establishing a compensation program in the event of injury or death). *See also* Jacobson v. Massachusetts, 197 U.S. 11 (1905) (upholding an ordinance requiring compulsory smallpox vaccinations).

162. FRIEDMAN, *supra* note 76, at 423.

163. *See, e.g.*, Occupational Safety and Health Act, Pub. L. No. 91-596, 84 Stat. 1590 (1970).

164. Individual rights are most likely to be tested by mandatory vaccination or similar measures, such as quarantine. *Jacobson*, 197 U.S. at 26 (stating if the survival of the community is at stake, individual objections cannot be accommodated unless they are based upon individual unsuitability for medical treatment). Policy measures such as mandatory helmet laws for motorcycle riders are akin to public health measures in that they affect the health of a broad segment of the community. However, these measures have as their primary goal the regulation of the conduct of others for their own good, rather than the reduction of negative externalities constituting health threats to the community, and these measures also are fairly intrusive. These measures arouse intense opposition founded in claims of violation of individual rights. *See* BEAUCHAMP, *supra* note 34, at 121-22.

Comparisons of individual welfare do not pose significant practical problems because nearly everyone agrees upon the goals of public health measures. If some individuals derive particular pleasure from raising water of questionable purity to their lips and drinking deeply, they are few in number and not outspoken.[165]

Calculating the maximization of social welfare also is not problematic. Regardless of the formula applied, principles of respect for individuals are unlikely to be offended given the shared goals and the nonintrusiveness of the means employed in public health measures. Furthermore, regardless of the formula applied, public health measures naturally yield egalitarian benefits. All members of the community are potentially vulnerable to contagious diseases. All potentially benefit from public health measures.

In the context of public health, welfarism properly defines the demands of justice. Policy makers fail to vindicate the demands of justice if they fail to calculate the most expedient means to achieve important shared goals.

### D. *Health Care Delivery Systems*

Health care delivery issues require policy makers to determine the requirements of justice with respect to the finance and delivery of individual health care services to defined communities.[166] In the health care delivery context, there is no consensus with respect to the goals of health care delivery; preferences are diverse.[167] In addition, the goals of health care delivery policy measures vary in their importance. The goal of obtaining access to expensive life-extending medical care evokes intense emotions and may implicate ethical principles. The goals of eliminating free riders and limiting overall spending on health care, although of concern to many, do not evoke the same responses. Thus, preferences regarding the goals of health care delivery are diverse, and some are highly valued, some are not.

With respect to the means for achieving these goals, there also is no consensus.[168] This is so for three reasons. First, the

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165. Interpersonal comparisons are more problematic with respect to policy measures such as mandatory helmet laws for motorcycle riders. Some individuals do derive pleasure from riding motorcycles without helmets.

166. The community may be defined by citizenship or residency status, or according to qualifications that include age, income, wealth, and health status. *See, e.g.*, Medicare, Title XVIII, and Medicaid, Title XIX, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395-1396u (1988 & Supp. IV 1992)).

167. *See supra* part II.

168. *See supra* part II.

intrusiveness of proposed policy measures varies. For example, if a communal system restricts choices of health care providers or the services that may be obtained, this directly affects matters of personal privacy and bodily integrity that arouse intense emotions and that may implicate ethical principles. On the other hand, there is broad indifference to the systemic means for regulating and financing health care delivery. For example, most do not care about the particulars of the mechanism for financing[169] health care services, provided that the mechanism does not negatively affect the delivery of individual health care services.[170] Second, the efficacy of various proposed policy measures in achieving important goals, such as improved health status, is limited.[171] Third, there are no economic problems that require reliance upon a particular means for delivering health care services. Health care providers are fully capable of charging for benefits rendered; health care services are abundantly produced. Thus, preferences regarding the means of health care delivery are diverse, and some are matters of indifference, some are not.

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169. Modern health care delivery systems, both communal and noncommunal, pool and redistribute the financial risks of obtaining health care services. A communal system pools the financial risks of a defined community and redistributes these risks through its compulsory funding mechanism. A noncommunal system pools financial risks in a wide variety of risk pools, from private insurance risk pools, to self-insured employer risk pools, to state high-risk pools for the uninsurable, to national risk pools for the disabled and elderly. The noncommunal system then redistributes the financial risks through private insurance payments, withheld wages, and tax assessments. For those individuals who are not members of pools, financial risks are either borne by the individuals, or shifted to others through the provision of uncompensated or undercompensated health care services.

170. Most Americans generally indicate indifference to particular systemic means; they care instead about matters of individual health care delivery. Grover G. Norquist, *The Great Patriotic War,* 26 AM. SPECTATOR 70 (1993) (citing October 1993 poll showing that only 19% of Americans believe that the Clinton Plan will improve health care delivery, while 34% believe quality will suffer). However, some political theorists and policy makers do care about the financing mechanism. *See generally* ROBERT NOZICK, ANARCH, STATE, AND UTOPIA (1974); *see also* Norquist, *supra.*

> [T]he "health care debate is the decisive battle about whether we become a free society or become a socialist state." The Clinton plan . . . "will transfer so much money and power to the government that it would change the nation." . . . [T]he Clinton plan relies on price controls, government bureaucracies, and the elimination of consumer choice. "Clinton's plan is based on the premise that a government monopoly can do things more effectively and more economically than the market and competition."

*Id.* (quoting Rep. Newt Gingrich and Sen. Phil Gramm).

171. *See supra* part II.

Thus the policy maker in the context of national health care policy faces a complex problem. In the absence of consensus upon goals or means, and given that goals vary from the mundane to the important, and means vary from the nonintrusive to the intrusive, the application of welfarist principles raises complex practical problems and problems with conflicting principles. In this context, welfarist analysis should play only a limited role. Other principles of justice suitable for this context have yet to be developed.[172]

First, determining the content of individual welfare in this context is highly problematic. Different characterizations of individual welfare yield entirely different conclusions. If, for example, individuals prefer secure access to health care because they mistakenly believe secure access will improve their health more than competing policy measures that improve job opportunities or education or wealth, then perhaps their preferences should be excluded because they are irrational. Nevertheless, individuals may feel great pleasure as a result of an assurance of secure access even if they are mistaken about its efficacy in improving health. Welfarism does not in itself offer a basis for choosing between rational preferences and irrational pleasures.[173]

Furthermore, if individual welfare is characterized as the satisfaction of rational preferences, additional problems arise with the process for determining these preferences. For example, the "Oregon Plan" imposes a rationing of health care benefits for Medicaid recipients to permit the extension of Medicaid benefits to an expanded group of poor individuals.[174] The Oregon Plan employs a methodology for determining the value of various medical services and for ranking them.[175] The methodology considers, among other things, the cost-effectiveness of the services as well as valuations of the services by Oregon citizens who expressed their opinions in telephone polling and in a series of town meetings.[176] The Oregon Plan thus establishes the con-

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172. *See infra* part III.E (discussing principles that should contribute to a suitable framework of justice).

173. *See* ENGELHARDT, *supra* note 117, at 107-09.

174. *See generally* RATIONING AMERICA'S MEDICAL CARE, *supra* note 25 (offering descriptions and analyses of the Oregon Plan from a variety of perspectives). The Oregon Plan went into effect on February 1, 1994. *See* Marilyn Chase, *Oregon's New Health Rationing Means More Care for Some but Less for Others,* WALL ST. J., Jan. 28, 1994, at B1.

175. The complex methodology is summarized in Michael J. Garland, *Rationing in Public: Oregon's Priority-Setting Methodology, in* RATIONING AMERICA'S MEDICAL CARE, *supra* note 25, at 44-50; *see also* Kaplan, *supra* note 32, at 60-75 (explaining the quality-of-life approach that he favors and generally applauding the Oregon Plan, although criticizing certain aspects of its implementation).

176. Garland, *supra* note 175, at 42-50.

tent of individual welfare characterized as rational preferences by reliance on the opinions of experts and of other Oregonians regarding what Medicaid recipients should prefer.

This process gives rise to practical objections as well as objections based upon conflicting principles. As a practical matter, individuals generally know their particular goals regarding medical interventions best and hence are in the best position to rationally pursue them. Although access to the medical advice of experts or the value-based advice of fellow community members may be valuable to individuals in this pursuit, decision-making by these experts and fellow community members is likely to be mistaken. Furthermore, because preferences regarding the goals and means of delivering individual health care services are diverse and highly valued, mistaken decisions will be both commonplace and offensive to principles of respect for individuals.[177]

Additional practical problems and problems with conflicting principles arise in attempting to compare and rank welfare experiences resulting from alternative health care delivery measures. For example, the Oregon Plan provoked enormous controversy, which threatened the political viability of the Plan, by its process of comparing and ranking the welfare experiences as a result of the delivery of various health care services.[178] In matters of individual health care services, involving diverse and highly valued preferences, such comparisons and rankings are both a practical impossibility and violative of principles of respect for individuals.[179]

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177. In rejecting the original request for a federal waiver necessary for implementation of the Oregon Plan, the Secretary of the United States Department of Health and Human Services objected to the Oregon Plan, in part, because of its inconsistency with the individual rights of disabled persons under the Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. §§ 12111-12213 and 47 U.S.C. § 225 (Supp. IV. 1992)). *See* Tom Mason, *Sullivan Made the Right Choice in Rejecting the Oregon Plan,* 2 HEALTH MATRIX 85 (1992); *see also supra* part III.B (discussing ethical principles embodying respect for individuals in the context of bioethics).

178. *See generally* CALABRESI & BOBBITT, *supra* note 79; RATIONING AMERICA'S MEDICAL CARE, *supra* note 25. Because the welfarist analysis ultimately requires comparisons that provoke controversy, policy makers applying welfarist analysis to health care delivery issues typically evade this requirement rather than squarely confronting it, as in Oregon. *See* Baker, *supra* note 25, at 221-24; *see also* CALABRESI & BOBBITT, *supra* note 79.

179. *See supra* note 5. An example of a governmentally funded program that reflects an anti-welfarist approach to the provision of health care to a particular group of individuals in light of their dire circumstances is the United States' End Stage Renal Disease (ESRD) Program. Under the ESRD Program, the U.S. Congress repeatedly has authorized large expenditures to save the lives of a relatively small number of individuals who suffer from end stage

Lastly, in calculating the maximization of social welfare, policy makers face stark choices in choosing between a strict aggregation or an alternative formula. If a utilitarian formula is applied, the sickest may lose the benefits of expensive treatments, the poorest may lose the benefits of more generous subsidies.[180] Alternative formulas that protect the interests of the worst-off comport with principles of respect for individuals and egalitarianism.[181] However, application of these alternative formulas may pose practical difficulties because of the potentially unlimited demand for health care services that could be of benefit to the sickest.[182]

Welfarism cannot succeed in guiding policy makers to just choices regarding national health care reform because welfarism cannot accommodate diverse and highly valued preferences regarding the delivery of individual health care services. Welfarist analysis can inform the debate regarding the expediency of various systemic means for regulating and financing health care delivery.[183] Ultimately, however, welfarism cannot resolve the question of what justice requires with respect to proposed reform of the national health care system.

### E. *Conclusion*

Policy makers apply different principles of justice in the contexts of bioethics and public health. There are good reasons for this. Welfarism is ill-suited to the context of bioethics because welfarism fails to accommodate diverse and highly

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renal disease. Two authors described the willingness to rescue at great expense an identifiable few and contrast the unwillingness, at far less expense, to save statistical lives. CALABRESI & BOBBITT, *supra* note 79, at 186-89. The ESRD Program, which assures renal dialysis to every American who could benefit from it, is often decried as an expensive program in relation to the relatively few who benefit from it. Nevertheless, for those who benefit, dialysis means the difference between life and death, hence the impetus to its adoption and the resistance to eliminating it. For a discussion comparing the approach in the United Kingdom, see HALPER, *supra* note 49, at 155-56; *see also* CALABRESI & BOBBITT, *supra* note 79, at 184-86.

180. See LEGRAND, *supra* note 32. The Oregon Plan has attracted significant opposition on the basis of its application of a utilitarian formula. *See* Sara Rosenbaum, *Poor Women, Poor Children, Poor Policy: The Oregon Medicaid Experiment, in* RATIONING AMERICA'S MEDICAL CARE, *supra* note 25, at 91-104; Robert M. Veatch, *The Oregon Experiment: Needless and Real Worries, in* RATIONING AMERICA'S MEDICAL CARE, *supra* note 25, at 82-87.

181. *See supra* part III.B (discussing conflicting principles in the context of bioethics); *see generally* CALABRESI & BOBBITT, *supra* note 79; RATIONING AMERICA'S MEDICAL CARE, *supra* note 25; Blumstein & Sloan, *supra* note 92, at 850.

182. *See* DANIELS, *supra* note 6, at 53-54.

183. *See supra* part II.

valued individual preferences. Welfarism is well-suited to the context of public health given the broad consensus that prevails regarding the goals of public health and the means for achieving those goals.

Welfarism tempts policy makers in the context of national health care delivery. Welfarism invokes the power of rationality, holding out the promise of clear and definite answers in determining what is ethically required of society in response to the suffering and deaths of its members. However, the power of rationality falls short and the promise of clear and definite answers is a false promise. It is futile to seek justice by imposing a welfarist calculus upon a context so rich in emotional and ethical content and diversity. The delivery of services to individuals who come to doctors seeking help in matters of deep concern that require intimate interactions is different than the delivery of purified water to the taps in a community.

Successful principles of justice for application in the context of national health care delivery must acknowledge this difference. These principles of justice must emerge from the context of health care delivery, a context in which doctors, patients, and the American legal system have developed ethical and legal principles that appropriately acknowledge the difference. These principles of respect for individuals should serve as the foundation of an appropriate framework of justice for application in this context; a framework yet to be developed.