REVIEWS

Moral Imperatives Versus Market Solutions: Is Health Care a Right?

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Mortal Peril: Our Inalienable Right to Health Care?. Richard A. Epstein. Addison Wesley, 1997. Pp vii, 503.

INTRODUCTION

Mortal Peril: Our Inalienable Right to Health Care? is an outstanding book about many of the most controversial issues in health care today. Arguing from a libertarian perspective that prizes individual property and contract rights, Richard Epstein, Professor of Law at the University of Chicago, is able to shed new light on a variety of controversies in medical care.

There is, however, something slightly anachronistic about Epstein's arguments. Perhaps this is best captured in his preface. He relates how he was asked to a taping of the television program "Nightline" on the Clinton health plan (p ix). Upon arrival, Epstein was relegated to the back of the auditorium, from where he was unable to obtain access to the microphone. Meanwhile, an inner circle of scholars, perhaps those more sympathetic to the Clinton health plan, were able to provide their impressions at will. For most academics, this would have been a

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very difficult position; for someone so full of trenchant arguments as Epstein, it must have been intolerable.

According to Epstein, the discussion presumed a universal right to health care. Moral imperatives and not market solutions—which Epstein was precluded from addressing—carried the day. Discussing the experience, Epstein notes, "I fall into a rival camp of beleaguered scholars who believe that the basic principles of human behavior and institutional organization do not magically cease to apply when health-related issues are on the table" (p xi). I would venture to propose that just the opposite is true: Epstein's anecdote aside, scholars of Epstein's stripe have won the day in health care. While twenty years ago, it was completely anathema to suggest that market principles should dominate health care, that is simply not the case today.[1]

For years, the major debate in health care policy centered on universal access through a single-payer system. Then Professor Joseph Newhouse at Harvard University, and the team he led at the RAND Institute, conclusively demonstrated what economic theorists had long predicted: universal first-dollar health insurance would lead to intolerable increases in demand for health care.[2] Alain Enthoven and Clark Havighurst, among others, provided the key insights, suggesting that managed care, which is nothing more than the application of the economic incentives of the marketplace to the doctor-patient relationship, would be and should be the critical basis for cost containment.[3] Over the past decade, as medical inflation has continued to increase, as regulatory methods have failed to decrease that inflation, and as business has made clear that it cannot tolerate perpetual double-digit increases in costs of health care, managed care methods have become far more widespread. Today in health care policy, there is only one subject: managed care. Almost any other health care initiative is viewed through this prism. Patients are the consumers in a managed care relationship, and physicians, hospitals, and other providers of health care must learn to succeed in a mar-

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[1] I will not provide extensive footnotes throughout this piece. A variety of summary law review articles published in the last year have done so. By far the most comprehensive and provocative of these is Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 Ind L J 1015 (1997). See also Einer Elhauge, *Allocating Health Care Morally*, 82 Cal L Rev 1449 (1994).

[2] See Joseph P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Harvard 1993).

[3] See, for example, Alain C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* 9 (Elsevier Science 1988); Clark C. Havighurst, *Deregulating the Health Care Industry: Planning for Competition* 14 (Ballinger 1982).

ketplace. Contracts dominate provider behavior. The beleaguered set of scholars from fifteen years ago has now triumphed.

But little of this is discussed in *Mortal Peril*. As a result, this fascinating book feels as though it is missing a dimension that could make it even more provocative. Instead, much of Epstein's attention is focused on somewhat peripheral issues that have not yet yielded completely to market approaches. Perhaps, however, this is the beginning of the worst kind of book review, one which criticizes the book for what does not appear, rather than investigating what does appear. And there is much to say about what does appear.

Mortal Peril is organized into three sections. In the first section, the Introduction, Epstein develops his theory of the state, profiling his libertarian political philosophy. Then, in Part One, which really grows out of the Introduction, Epstein discusses notions of access, and concludes that any form of a right to health care is intellectually bankrupt. This is the part I find most interesting, as it addresses certain critical issues in health care policy and financing. Finally, Part Two, the second half of the book, consists of three prolonged essays on specific subjects: the ethics of transplantation, euthanasia, and malpractice liability.

Each of the sections of the book's main body is a testament to Epstein's unique combination of intellectual insight and command of details. One cannot help but be astounded by Epstein's work ethic. His descriptions of issues as diverse as the history of Medicare, the operation of transplant waiting lists, and the use of Acute Physiology, Age, Chronic Health Evaluation scores in intensive care units are as deep and accurate as any found in the health policy literature. He never samples the literature selectively. All arguments, whether opposing or in sympathy with his position, are carefully dissected and addressed.[4]

Again, there is a slight rub. While Epstein's policy discussions are elegant and correct, there is some sense that he is missing the tiny details that give many policy issues their special urgency. Epstein appears to acknowledge as much in the concluding postscript to *Mortal Peril*. He notes that the job of academics is "to describe and prescribe, and to show how the descriptions we give support the prescriptions that we propose" (p 419). For managers in health care on the other hand, "[t]he constant theme is working the trade-offs that are implicit in all

[4] Teaching a course on Health Policy and Medical Ethics this summer to physicians training in health policy, I have concluded that *Mortal Peril* is the best available introduction for them on health policy. I doubt Epstein intended the book for this purpose, but his care in understanding and explicating policy issues is unrivaled.

decisions" (p 419). It is working these trade-offs that brings some of the issues that Epstein discusses to life, and that is apparent in several sections of the book.

The limits of this book review format will not allow me to review comprehensively all aspects of *Moral Peril*. Instead, I will pick and choose selectively, a perhaps unfair approach, but one that I think will best introduce Epstein's perspective. Because Epstein approaches his subject from a highly particular—and perhaps overly narrow—perspective, in Part I of the review, I discuss Epstein's political philosophy. Then, in Part II, I tackle how the application of Epstein's "negative rights" approach may play out in the distribution of health care in the United States. Finally, in Part III, I discuss the issue of medical malpractice, and conclude that today's ill-functioning malpractice system demonstrates that, in some cases, the negative rights approach cannot be relied on to produce desired social goals.

I. PHILOSOPHICAL PRINCIPLES

One cannot review the book without grappling with Epstein's political philosophy. He states that it is best first to discuss rights, before turning to health care (p 5). Epstein has a very straightforward view of the relationships between citizens. He uses Sir Isiah Berlin's notion of positive and negative rights to illustrate it. Negative rights, as Epstein understands (and embraces) them, are basically libertarian rights. One has a right to property and a right to participate in the marketplace. Neither of these rights can be infringed; any such infringement is immoral and, according to Epstein, should be illegal. As he notes, "[t]he first three rules of the system of negative rights set out what individuals can do. These rights of autonomy, property, and exchange have distinct correlative duties which coalesce in the fourth rule that prohibits the use of force or deceit (as with defamation) to interfere with the rights as stated" (pp 12-13). The attractiveness of this philosophy is its simplicity and endurance. However, Epstein's rendition differs from that provided by other libertarians, for Epstein is opposed to any forced redistribution of wealth. In a system of negative rights, one has a right to be free from interference by others. Absent a contractual relationship, however, one has no right to support from others, including health care support. Only a system of positive rights gives citizens a duty to support the less fortunate. Because a right to health care, or universal access, creates a duty to support

others and redistributes wealth, Epstein's opposition to such a right is simple and obdurate.[5]

In contrast to the latter parts of the book in which he considers many alternative viewpoints, the only opposing views Epstein considers in his discussion of negative and positive rights come from Judge Richard Posner and Professor Allen Buchanan. These scholars have little in common, but they do present what Epstein understands as the main intellectual opposition to his viewpoint. First, Epstein is forced to struggle with Posner's proposition that it is very difficult to make interpersonal comparisons of utility, and that the collapse of comparisons of utility into comparisons of wealth corrupts the libertarian position (pp 34-36). According to this argument in favor of a right to health care, a focus on wealth maximization alone cannot give rise to maximum social utility because desired—and desirable, from a utility maximization standpoint—transactions do not take place when the prospective buyer lacks the necessary funds. Epstein concludes that generally there is sufficient correspondence between wealth and utility that such concerns can be laid aside, and where such correspondence is lacking, voluntary charitable giving provides a better means of maximizing utility than a system of forced redistribution administered by the government (pp 35-37).

What is not discussed is the relationship between a utilitarian political theory and a libertarian political theory. Philosophers are quite able to develop hypotheticals in which utilitarian views come into conflict with libertarian views. Certainly there are ways to argue that a right to health care—or even of universal access to health care—would serve utilitarian ends by assuring adequate health care for the entire population. Careful cost-benefit analyses of such a large proposition are not really possible, but at least theoretically that argument can be made. Epstein would not be in favor of the redistribution entailed by such access to health care even if utility were maximized. Therefore, he should be more careful when utilitarian views grow out of his discussions of libertarianism.

Buchanan's argument that there is insufficient charity to provide care for all, and that universal access to health care is

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[5] Thus, Epstein would say he is out of step with the dominant regime. Yet the United States is hardly a leader in redistribution in health care, at least as far as industrialized countries go. In fact, we have almost no right to health care, and the patchwork of access to health care we do provide comes from a variety of common law rules, state regulations, and federal programs. We have inherited this patchwork because we have been unable or, more important, unwilling, to redistribute wealth in a way that would provide a right to health care. This makes us distinctive in the developed world. Libertarian views are more influential than Epstein gives them credit for (or, than Epstein believes).

simply an extension of charity, is more readily forced aside (pp 37-39). Epstein's libertarianism, faithful to the tradition, values free giving (charity) as an important part of a successful political structure. However, no one should be required to give: not only does forced redistribution violate the sanctity of the right to property, but such redistribution is not necessary to ensure the transfer of wealth from the monied members of society to those less well-off.

Epstein appears to have little interest, at least in this book, in taking on other twentieth century political philosophies. Many of these are just as philosophically elegant as the libertarian view. For example, Sandel's foundation of a communitarian political philosophy in Kantian epistemology[6] is every bit as interesting to those of us who do not bring strong political views to the dance.[7] In any case, *Mortal Peril* does not defend the libertarian view against opposing philosophies, but rather uses it to analyze health care issues. Therefore, we should understand that it offers a specific perspective.

Because many of us do not follow the libertarian philosophies, some readers might conclude that this is an appropriate time to put aside *Mortal Peril* for other reading. That would be a mistake. As Epstein argues, the libertarian is better acquainted with certain aspects of reality that are often overlooked by more classical liberals and especially social liberals. These are, as characterized by Epstein, the problems of scarcity, self-interest, and enforceability (pp 44-48). It is true that much of social liberalism overlooks issues of scarcity, and those issues are salient in health care. As the costs of health care continue to increase, pushed by new technology and demographic pressures, we will not be able to provide all that we have the capacity to provide. Indeed, it is cost constraints, not access or quality (the other major axes that are ground in discussions of health care policy), that have dominated and will continue to dominate policy discussion.

A corollary of scarcity is that all players in health care will continue to act according to their own self-interest. Like it or not, we are in a market-dominated liberal structure in which enlightened individuals maximize their own advantages. Thus, a system

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[6] Michael J. Sandel, *Liberalism and the Limits of Justice* (Cambridge 1982).

[7] Sandel, as I have noted, objects to the foundational role classical liberalism gives to rights and justice as the primary means of organizing social relations. Instead, Sandel favors ordering relations between citizens according to individual virtues and group solidarity, with notions of justice playing a secondary role. See Troyen A. Brennan, *Just Doctoring: Medical Ethics in the Liberal State* 84-85 (California 1991).

of universal access is plagued by difficulties not present in a negative rights system, such as extracting the wealth necessary to finance the health care system (pp 44-45). As Epstein notes, the social engineers behind the Clinton health plan tended to overlook issues of both scarcity and self-interest. They never realized and never addressed the fact that there was insufficient momentum to develop the kind of broad-based taxes necessary to fund a system of universal access. Their hubris in this regard is one of Epstein's major targets, but perhaps too easy of one.

Epstein's third problem, that of enforceability, is a much more debatable concept. A great student of the common law, Epstein has previously noted a host of problems that comes with turning moral principles into legal rights. He has insightfully argued that certain kinds of principles cannot be adhered to simply because they do not fit into our common law structure. For Epstein, a most significant problem is the "constant pounding" a system of universal access will take in a real world setting from the difficulties of government administration (p 46).

Unfortunately, *Mortal Peril* takes this argument too far. It appears at times that Epstein is positing that no system other than one based on negative rights can work because of the impossibility of translating positive rights into legal rules. Yet once he moves to the empirical analysis, he provides only anecdotes; he seems to overlook the need to go beyond the theoretical and into the assessment of evidence. It is certainly true that political corruption and incomplete knowledge will corrupt many programs intended to enforce positive rights. On the other hand, some redistribution systems do work, and do enhance utility, even if I doubt Epstein would be compelled to forsake libertarianism. Conversely, one need not embrace libertarianism simply because some or even many redistribution systems do not work, and fail to produce net utility.

We do have a certain amount of redistribution even in our relatively libertarian society, and this redistribution does "work" in certain aspects. If he were to travel from Hyde Park into neighborhoods in South Chicago, Epstein would find ample evidence that aspects of the welfare state are not producing their intended goals. On the other hand, he would find some that are operating appropriately, and producing outcomes that are completely in touch with the vision of those positive right advocates who created the original legislation.[8] Since there is such empiri-

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[8] The best example remains the expansion of Medicaid health care for pregnant women. See, for example, Paul A. Buescher, et al, *An Evaluation of the Impact of Mater-*

cal evidence, does this mean that the libertarian approach is fatally flawed? Definitely not. But it does mean that it should be seen simply as one perspective, not as the only approach possible to a successful political system. That Canada has a successfully functioning system of universal access, albeit with many warts, does not mean that we can dismiss Epstein. It does mean that Epstein's more absolutist libertarian tenets must be put aside.

Epstein himself seems to recognize this. For instance, in his discussion of euthanasia, he goes into great detail about the regulatory features of the Dutch euthanasia laws, and the efforts to emulate those in the Oregon propositions supporting euthanasia (pp 317-28). As a libertarian, he believes that individuals should have a right to euthanasia and physician-assisted suicide. Yet he appears to be willing to sanction some state oversight of this right in order to avoid potential abuses (pp 315-16). While later he states the right in more absolutist terms, one that is unfettered by state regulation, the reader nonetheless has the sense that there is a willingness to compromise.

II. ACCESS TO HEALTH CARE

Fresh from this philosophical background, Epstein launches into an analysis of universal access. He does not follow the usual path of discussing broad taxation and insurance-based access. Instead, he opts for analysis of the common law right to emergency medical care. This is an inspired move. Epstein recognizes that the right to health care in this country is nothing more than a common law right to emergency medical treatment. From an empirical point of view, there is no other right to health care, and this particular right is a very thin one. Epstein details the disparate set of cases that create a right to emergency room care and then focuses on the federal Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA") (p 91). He realizes that if he can provide the intellectual basis for rolling back EMTALA, it will go a long way toward stunting the already very scanty redistributional impulse in American health policy.

The structure of this argument is clever. Epstein knows that the relationship between doctors and patients has always been

nity Care Coordination on Medicaid Birth Outcomes in North Carolina, 81 Am J Public Health 1625 (1991); Joyce M. Piper, Edward F. Mitchel, Jr., and Wayne A. Ray, *Presumptive Eligibility for Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome*, 84 Am J Public Health 1626 (1994); Denise M. Oliansky, Susan Schooley, and Tommye Arnold, *Perinatal Outcomes and Patient Satisfaction in the Evaluation of Two Medicaid Demonstration Projects*, 13 AHSR and FHSR Annual Meeting Abstract Book 174 (1996).

one of free contract; doctors are able to decide whom to treat and when to treat them—within the constraints of the arcane restrictions of abandonment law.[9] Common law courts, on the other hand, have treated hospitals, in particular their emergency departments, as creating situations in which individuals come to rely on gratuitous undertaking. While Epstein may argue that this is somewhere the common law should never have gone, it is nonetheless a reality. The set of emergency care rights has since been fortified by courts that have woven in state regulations, accreditation issues, and antidiscrimination law to find a relatively vigorous right to emergency medical care. Once the doors of the emergency department are open to patients, then the usual parameters of tort law apply, and patients cannot be cared for except according to the standard expected of the reasonable medical practitioner.

To avoid being forced into providing emergency room treatment and to maintain their right to contract freely—as well as to avoid caring for impoverished patients with little or no chance of reimbursement—private hospitals in the 1970s and 1980s learned to transfer unwanted patients to public hospitals. Epstein notes that in Chicago, at Cook County Hospital, Dr. Gordon Robert L. Schiff and his colleagues documented an extraordinary growth in transfers of impoverished patients, including many transfers that endangered patient well-being (p 93). While Americans lack the political will to provide universal access for these patients, the abuses of so-called "dumping" spurred Congress into action, resulting in the EMTALA.

Prior to sending an unwanted patient to another medical facility, EMTALA requires hospitals to document that another hospital has accepted the patient, and that the patient is well enough to be transferred. Litigation around EMTALA, and a linkage of EMTALA claims to other forms of malpractice claims, has changed significantly the behavior of physicians working in emergency departments. In my opinion, the American College of Emergency Medicine has integrated fully the prohibitions against transfer from one emergency department to another into

[9] Abandonment law has traditionally held that a medical provider may not withdraw his services from a patient who needs further medical attention without giving the patient sufficient notice to find another provider. Epstein does not discuss the more modern notions of abandonment that are developing in cases brought by HIV-infected individuals who are refused treatment. See Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 Yale J Reg 1 (1996). It would be very interesting to see Epstein's perspective on these cases.

its training of residents and attending physicians. EMTALA reasonably has solved a problem that was significant and severe.

Epstein understands what an affront EMTALA is to freedom of contract for hospitals. As a result, he would like to characterize it as a rupture with common law. I think it is much more appropriate to see it as an evolution of the common law. Americans are not committed to a universal right to health care. But we do think that individuals who need care should be able to go to emergency departments, and if necessary be hospitalized. This is the extent of redistribution that we expect, and it would perhaps be better to view EMTALA as a reasonable compromise in a society that generally foregoes redistribution.

Moving from the theoretical to the factual, Epstein argues that EMTALA has hurt medical care by endangering emergency medical treatment. He argues that many emergency departments are closing because they do not wish to care for the patients who would now be admitted. Citing problems with certain urban emergency medical technician ("EMT") triage systems that have developed as a result of closure of emergency departments, Epstein points specifically to the experience of the University of Chicago hospitals (pp 95-99). As Epstein explains, the University hospital system at one time participated, along with other Chicago hospitals, in an ambulance network that carried patients to the participating hospital with the greatest number of beds available in its emergency room, regardless of whether the chosen hospital was closest to the point of pickup. The University hospitals withdrew from this network, however, after the city government rejected the diversion system in favor of a requirement that all patients go to the nearest hospital in the network—a requirement that, because of its location on the South Side of Chicago, proved especially burdensome to the University system.

I think that Epstein is somewhat off the mark in linking EMTALA with decreases in the availability and quality of emergency room treatment. The problem with EMT systems in certain cities, especially Los Angeles but to some extent in Chicago, is that they have been overwhelmed by the amount of trauma that results from urban violence. This has not been the case in most other large cities.[10] Moreover, for most urban hospitals, it does

[10] Epstein's hypothesis that EMTALA is inducing hospitals to close emergency departments may not hold up under empirical scrutiny. I contacted the American Hospital Association and American College of Emergency Physicians to compile the following table. The table indicates that the hospitals that are closing are those that do *not* have emergency departments, just the opposite of what Epstein would predict.

not make any economic sense to close the emergency department. First, in operating a reasonable health care system, you must be able to provide emergency treatment for the patients of the primary care doctors on your staff. Second, in most cities, under most insurance plans, trauma patients are well-insured, especially for the hospital willing to undertake reasonable coordination of benefits. Third, the University of Chicago experience is inapposite. While the University of Chicago did drop out of the triage system for EMTs in Chicago, it did not close its emergency department. Anyone who walks into the University of Chicago emergency department is subject to EMTALA. They cannot be "dumped" to Cook County or any other hospital. I believe, moreover, that a prohibition on dumping is clearly aligned with the moral and political sensibilities of most Americans, and would be considered rational in any rendition of liberalism. In both contexts, the inefficiencies associated with a ban on dumping would be tolerated, as would the infringement on negative rights. That Epstein finds this a critical issue in health care is indicative of the rather radical position he advocates.

Emergency Departments and Hospitals (1981-94)*

Year	Number of Emergency Department Visits	Number of Emergency Departments/ Percentage Change Since 1991	Number of Hospitals/ Percentage Change Since 1991	Percentage of Hospitals with Emergency Departments
1981	83,024,984	5,340	6,276	85.1
1982	81,147,512	5,318 (-0.4)	6,277 (0.0)	84.7
1983	77,522,254	5,406 (1.2)	6,353 (1.2)	85.1
1984	78,492,455	5,397 (1.1)	6,302 (0.4)	85.6
1985	80,079,345	5,382 (0.8)	6,304 (0.4)	85.3
1986	82,177,221	5,340 (0.0)	6,290 (0.2)	84.9
1987	83,478,208	5,272 (-1.3)	6,281 (0.0)	83.9
1988	86,641,305	5,197 (-2.7)	6,291 (0.2)	82.6
1989	89,730,589	5,133 (-3.9)	6,174 (-1.6)	83.1
1990	92,080,647	5,070 (-5.1)	6,105 (-2.7)	83.0
1991	93,469,930	4,973 (-6.9)	6,044 (-3.7)	82.3
1992	95,817,758	4,881 (-8.6)	5,916 (-5.7)	82.5
1993	97,379,119	4,988 (-6.6)	5,789 (-7.8)	86.2
1994	96,014,347	4,856 (-9.1)	5,387 (-14.2)	90.1

*Source: American Hospital Association, American College of Emergency Medicine.

The above data could be analyzed and perhaps some support for Epstein's theory would emerge, but the raw data suggest that as the climate grows more competitive, hospitals with emergency departments are more financially viable, and thus a higher proportion of hospitals have emergency departments. It is not clear why Epstein would not take a few hours to check the empirical evidence available on this critical point.

It is here, and only in this part of the book, where one gets the impression of mean spiritedness that makes Epstein's position a somewhat unattractive political philosophy. Epstein wonders why hospitals like the University of Chicago should be made to care for individuals who through their own responsibility have brought ill health upon themselves. He notes that:

> Unfortunately the current law makes it impossible for a hospital to treat drug addicts or alcoholics just once, or even twice, with this stern warning: there is no treatment next time, period—no matter what their personal consequences, including death. To the question, "you cannot let them die, can you?" we have to avoid the reflective answer, no. To restore long-term stability to the system of emergency care, the answer has to be "yes, we can sometimes." That threat becomes credible only if it is acted on at least once (p 103).

In support, Epstein notes a *Wall Street Journal* article in which a patient was noted to have infected her heart valve through use of heroin, received a new heart valve, and then reinfected the artificial valve, again using heroin (p 102).[11] Epstein would not treat this patient again.

Epstein's example comes from the real world and presents a dilemma faced by many physicians. Indeed, I have several patients, among a patient panel that includes numerous intravenous drug abusers and individuals infected with HIV through use of dirty needles, who have required valve replacement as a result of endocarditis from injecting. Should any of them reinfect an artificial valve, I will advocate (I suspect successfully) that the artificial valve be replaced. Hospitalization and professional costs for this episode will likely run over $75,000. Very little of this will be reimbursed by welfare programs, especially if the patient is a nondisabled male who does not qualify for Medicaid.

The overall majority of physicians would do exactly the same thing. They would do so because they are committed to the individual patient, and respect the principles of compassion that are central to medical ethics. Perhaps more importantly, I know each of these intravenous drug users as individual human beings. Most are clean for long periods of time, many slip back into episodes of a couple of weeks of drug abuse, and a reinfection could be seen as just a matter of poor luck. Almost none fit the metaphor of ghoulish irresponsibility that Epstein rails against.

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[11] Sally L. Satel, *Examining Entitlements for the Mentally Ill*, Wall Street J A14 (Jan 28, 1993).

I do not cite these differences for moralistic or bombastic purposes. Rather, the differences show the conflict between Epstein's analytical approach and more traditional views. The relationship of trust, the altruistic commitment to the patient, and the role of compassion in dealing with sick individuals only tangentially make the scene. *Mortal Peril* is a book about moral and political issues in medical care, but it is not a book about medical ethics. Epstein devotes no space to the discussion or analysis of ethical propositions in medical care, for, in Epstein's view, ethical considerations are trumped by the individual's right to be free from interference.

For example, in his discussion of euthanasia, Epstein takes issue with Dr. Leon Kass's assertion that the deep trust that characterizes the doctor-patient relationship and the medical ethics structure that grows out of it should prohibit any turn toward legalizing euthanasia or physician-assisted suicide (pp 306-08). In Kass's view, no doctor—even one who favors physician-assisted suicide—should be allowed to practice euthanasia, because doctors are bound to ethical standards that call for them to preserve life and prohibit them from killing patients, ever (p 306). Epstein quickly lays Kass's proposition aside as peripheral to the problem. While Epstein acknowledges the importance of trust between doctor and patient, he argues that a self-assumed ethical code should not interfere with the individual patient's rights. As Epstein notes, his goal is to make medical care into a competitive industry: "As with all competitive industries, market pressures bleed out cross-subsidies between customers." (p 122). Epstein's approach tends, perhaps overly, to bleed out notions of compassion that are critical to understanding medical care.

I do not wish to carry this point too far. In his discussion of the negative rights framework, Epstein emphasizes the importance of charity in any political state. Many libertarians have a charitable impulse that is much stronger than that of some liberals who would prefer to have the state undertake redistribution. The mean spiritedness is not that of libertarians, but of elements of libertarian philosophy.

The next target for Epstein, in his effort to restrict the redistribution that is central to universal access to health care, is community rating. Designed to increase the availability of insurance to high-risk persons, a community rating system forbids insurers from considering certain factors—such as age, sex, or prior medical history—when determining the insured's premium, notwithstanding their predictive value. Building on the distinc-

tion between casualty and social insurance, Epstein demonstrates that regulating health insurance by requiring insurers to "community rate" essentially eliminates the efficiency of any insurance market. Casualty insurance is a system of discrimination. If insurers are not allowed to discriminate, powerful economic incentives suggest that "good risks" will drop out of the market or engage in riskier activities, increasing the overall cost of insurance and frustrating the access intentions of the proponents of community rating. Epstein focuses on real world examples of community rating, including the New York state system. He allows that a series of qualifications on the New York law reduces the effect of community rating, qualifications that are based on the same economic insights that Epstein provides (pp 123-27). However, again the empirical story is not quite what one would predict theoretically.[12]

Epstein's economic analysis is even more compelling for the problems raised by genetic discrimination in insurance (pp 133-36). Genetic analysis of risk changes the whole framework for casualty insurance in health care. Epstein provides a very apt analysis, comparing health care to the shipping industry (p 129). In the shipping industry, there is a predictable yet random rate of breakage. Casualty insurance works very well in this regard, as the shipper can purchase relatively cheap insurance that closely approximates the risk of breakage multiplied by the value of the product. Once we begin to uncover significant information about the risk of the disease by analyzing the genetic structure of individuals, however, we lose the homogenous and random risk factor that makes casualty insurance attractive. Some individuals become simply uninsurable. At the point at which casualty insurance breaks down all together, what would Epstein do? If, for example, only 30 percent of the population have any interest in casualty health insurance—35 percent being too genetically burdened to purchase, 35 percent being genetically gifted enough to do without—then would it not be more attractive to move to systematic social insurance? This is an issue that deserves greater reflection than Epstein offers.

Epstein's discussion of Medicare raises similar concerns about the effect of redistribution on the social good. He provides an insightful exposition of the way Medicare works, with regards to paying both hospitals and doctors. He argues that Medicare

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[12] The story is indeed very complicated, with a large number of unanticipated effects when insurance regulations change. See Katherine Swartz and Deborah Garnick, *Regulating Individual Health Insurance Markets: Be Wary of Unintended Consequences*, Draft Report, Robert Wood Johnson Foundation (Oct 7, 1997).

currently operates as a "defined benefit" system, in that "the government first sets out entitlements and then scrambles to fund them" (p 176). The better economic approach, Epstein maintains, is a "defined contribution" system akin to a voucher system, under which "the government assumes a fixed financial obligation to Medicare recipients . . . that allows each recipient to purchase the Medicare set of benefits" that he or she so chooses from the available pool of private providers (p 176). He argues that if individuals are provided vouchers, they can make market decisions about how to spend them, fostering competition and enhancing efficiency among the providers.

As might be expected, Epstein is much more honest about the difficulties of a voucher system than are other economists on the right. Epstein explains that "a nominal defined contribution plan is really an estimated prepayment of anticipated expenses for future years" (p 179). Such a plan raises significant obstacles: under a voucher system, the government will be required to calculate each individual participant's future health care needs and provide vouchers in an appropriate amount to cover those needs. Otherwise, some voucher recipients will be able to obtain first-class insurance, while others—those more elderly or in frail health—will be out of pocket (pp 178-81). As Epstein points out, "it is not likely that any government agency can make these calculations for each person on a yearly basis without overwhelming the system." (p 179). Furthermore, Epstein allows, in a way that most voucher advocates will not, that:

> The only way to obviate this impasse is to set premiums that refuse to individuate to this degree and that force some individuals to bear privately the losses that were covered under the old, defined benefit program. . . . Only if the government—meaning public opinion—is prepared to "just say no" to persons with heavy disabilities and little means to cope with them, can this problem be attacked (p 181).

I agree with Epstein that the forms of Medicare that use vouchers to emulate the market will work only if Americans are prepared to have a market without redistribution. If the redistributive ethic remains, then vouchers are not a long-term solution to financing health care for the elderly. I might suggest that public opinion and political will are opposed to letting elderly people die because they do not have means to pay for medical care. However, a decade ago, I could not see that Havighurst- and Enthoven-style positions would come to dominate medical care as they

have. Perhaps Epstein is just slightly ahead of his time in these views.

I believe, however, we are headed in a different direction. Rather than explicitly rationing medical care under a libertarian market theory, or providing the broad revenues from taxes that would be necessary to undertake redistribution, I hypothesize that we will instead rely on physicians to undertake implicit rationing to constrain health care costs. I find some support for this even in *Mortal Peril*. In his discussion of the extent to which medical technology should be used to prolong life in terminal cases, Epstein overviews the Acute Physiology, Age, Chronic Health Evaluation ("APACHE") system for rating the likelihood of survival for patients admitted to intensive care units ("ICUs"). He suggests that APACHE scores could be used to ration ICU services (pp 72-76). However, he later relents and suggests that perhaps it would be better to give physicians global budgets and leave it to them to ration care appropriately (pp 77-79).

This is not what I expected from Epstein. As he acknowledges, leaving the rationing of ICU care to physicians is a rejection of "individual choice in favor of systematic coercion" (p 77), and thus an affront to the negative rights framework. As noted earlier, Epstein does not believe medical ethics should in any way trump patient liberties. Therefore, it is perhaps anti-libertarian to put physicians in control of doling out ICU resources.

Yet it is exactly this impulse that I argue is growing in health care. Managed care, as I noted at the outset, is nothing more than bringing economic incentives to the doctor-patient relationship. More importantly, true managed care, in which the physician receives prepayments for health care on a per capita basis, forces the doctor to decide how to spend resources on behalf of patients. In a hidden, implicit way, physicians then ration health care. As the per capita payment rates decrease, physicians increasingly face trade-offs between individual patients and make decisions on their behalf. This is not a libertarian approach. Nor is it necessarily a liberal approach. But it does lead to reductions in costs of health care, as it creates a trade-off between physician income and use of resources on behalf of patients—a blunt economic incentive.

Managed care, then, is a matter of market incentives. But it does not increase individual patient choice. In fact, as Enthoven has repeatedly noted, the main customer in health care is the

benefits manager at the place of employment.[13] Managed care eliminates the moral hazard faced by the physician in the indemnity insurance world, where physicians are encouraged to provide unnecessary services for patients so as to increase their income. However, managed care replaces this temptation with a situation in which it is in the physician's economic interest to reduce patient choice.

The market has produced managed care. But managed care is criticized for lack of patient choice. Epstein proposes libertarianism and the market as the basis for thinking through medical care. However, in this situation, the market and patient choice, and indeed individual patient liberties, are in conflict with one another. Perhaps this is why some of the thorny problems associated with managed care are avoided in *Mortal Peril*.

III. MALPRACTICE LIABILITY

Just as Epstein's approach to the thorny questions surrounding access to health care eschews traditional approaches in favor of a refreshing new perspective, so, too, does his approach to medical malpractice liability. Epstein invokes the common law of charitable immunity to argue in favor of contractual rather than tort solutions to medical injuries. He reviews the concept of charitable immunity, which historically held that charitable organizations, including hospitals, were immune from suit, and notes that hospitals would in certain cases waive their immunity in order to retain some residual protection in other cases. He appropriately sees any waiver of charitable immunity as akin to contracting and makes an almost communitarian appeal for contract:

> The alternative approach, therefore, rejects the view that medical malpractice is an extension of negligence law and stranger cases. Instead it places assumption of risk and freedom of contract at the fore in shaping legal rules. No longer is the primary job of the law to keep people apart. It seeks to develop optimal rules for risk-sharing between parties to a joint venture (p 366, footnote omitted).

Epstein then reviews the difficulties with the present system of medical malpractice. These arguments are perhaps less creative than those found elsewhere in *Mortal Peril*, but Epstein reaches the same point as do other commentators.[14] Tort law, at least in

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[13] See, for example, Enthoven, *Theory and Practice* at 82 (cited in note 3).
[14] See, for example, Paul C. Weiler, et al, *A Measure of Malpractice: Medical Injury,*

the area of medical malpractice, is ineffective at providing its intended social goals of injury prevention and compensation of injured plaintiffs. Epstein argues that the major alternatives to medical malpractice, tort reform, regulatory reform, and a no-fault system, are ineluctably weak.[15] The conclusion is that the present system does not "work," and a contract regime is the best alternative.

However, any reform is unlikely in medical malpractice, largely because the system does work for the key players. The market in medical malpractice benefits plaintiffs' attorneys, as well as malpractice underwriters and their defense attorneys, even if it is inefficient at reaching the social goals of deterrence and compensation. In this regard, Epstein's version of the history of medical malpractice misses some key points. Changes in the underpinnings of tort law from the 1930s through the 1950s reduced barriers to suits for plaintiffs. Plaintiffs' attorneys did not harvest these reductions until the 1960s and, especially, the 1970s, ensuring correlative increases in malpractice litigation. The tort crisis in the mid-1970s, which was especially severe for medical malpractice, forced many insurers out of the market and led to the creation of so-called "bed-pan" mutuals. These bed-pan mutuals took advantage of the relatively small amounts of tort reform and enjoyed slightly decreased rates of claims in the late 1970s. However, these amateur insurers settled small claims all too quickly, leading to an increase in the interest of plaintiffs' attorneys in medical malpractice claims.

The plaintiffs' attorneys rushed to file claims, creating the maelstrom of the mid-1980s and a tremendous increase in claims. This "second crisis" led to unprecedented tort reform in nearly every state, stabilizing the medical malpractice market. Since that time, claim rates have only very slowly increased, albeit while average settlements have increased at rates that are slightly greater than the rate of medical inflation. Today, the medical malpractice system is very stable, with relatively expert insurers and their defense firms lined up against a relatively small group of expert plaintiffs in most metropolitan areas. Thus, although it fails to accomplish its intended goals, medical malpractice is a stable market and, as such, its key players—the small cadre of successful plaintiffs' attorneys plus the medical malpractice underwriters and their defense attorneys—are unin-

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Malpractice Litigation, and Patient Compensation 76 (Harvard 1993).

[15] On these small points as well as many others, I would take exception with Epstein's conclusions. As usual, however, he does identify the most significant weaknesses of any opposing position.

terested in reform. They will exert their power in the legislature to maintain the status quo. It is likely that they will succeed in this endeavor.

The stable malpractice market scenario raises one more question for Epstein. Medical malpractice is not a heavily regulated market. There are a variety of common law rules and some statutory provisions that create the architecture for litigation, but the malpractice system is not, in traditional terms, "regulated." It is a market into which new providers of medical malpractice insurance, new providers of plaintiffs' attorneys' expertise, and new providers of defense expertise are able to move, once they overcome the usual barriers of self-education and capitalization. These are the characteristics of a relatively well-functioning market.

Yet the malpractice system does not accomplish the goals we expect. Many markets will not. That is why we have regulation. Of course, I would not expect Epstein to endorse this, but, as a society, we should recognize that some social goals require social engineering. Stable markets that create large profits for well-placed interests do not necessarily, through the invisible hand of the market, give rise to desired social goals.

CONCLUSION

Mortal Peril is both a fascinating and provocative book. From a perspective that is steadfastly libertarian and market-oriented, Richard Epstein offers a variety of valuable insights into our health care system. This reviewer's only complaint is that there is not more. While one might expect fairly patent libertarian answers to questions about euthanasia (strongly supportive of an individual's rights regarding euthanasia) and organ transplantation (open to a full market in organs, including living donor sale of kidneys), many other issues are less straightforward. Epstein's view on health care financing is brutally honest, especially insofar as it traces the ultimate outcome of any full-blooded voucher system. His view of malpractice litigation—that it should give way to contractual relationships—is intellectually vibrant.

Given this sample of Epstein's views, I would encourage him to address the most challenging issue rising in health care today, namely, managed care. It is here that notions of consumer choice in the market have come furthest in medical care. However, it is not clear that individual patients, as consumers, retain the libertarian negative rights that Epstein might expect. Managed care is a hard case for both the left and the right. Perhaps in the fu-

ture, Epstein will bring his unshakable libertarian beliefs and keen intellectual skills to the questions of our evolving organization of medical care.