To the Graduate Council:

I am submitting herewith a dissertation written by Margaret I. Lovell entitled "John Rawls, Social Justice, and Health-Care Delivery Systems." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of The Graduate School

JOHN RAWLS, SOCIAL JUSTICE, AND HEALTH-CARE DELIVERY SYSTEMS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Margaret I. Lovell

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To my Husband and Best Friend,

Ralph J. Lovell

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ABSTRACT

John Rawls' theory of justice holds special appeal for those who wish to apply a deontological moral theory to issues in medical ethics. This study is undertaken to examine Rawls' theory (and two notable modifications of it) to see if it is, in fact, a worthwhile evaluative tool in judging the justice of social issues in medicine.

In the first three chapters, issues are clarified and Rawls' theory is analyzed. The conclusion is that an unmodified Rawlsian theory is not applicable to distributive issues in medicine like access to the health-care delivery system without significant modification. Two notable modifications of Rawls' theory are analyzed and found to be conceptually and methodologically inconsistent. The author's own modification is undertaken, arguing for health as a social primary good with health care as a right subsumed into the second principle of justice. As a result, criteria for evaluating the justice of social issues in medicine are developed and applied to the issue of access in four health-care delivery systems. The criteria are found to be workable evaluative tools. Thus, Rawls' theory, although a "minimalist" theory with reference to second principle social primary goods, is applicable for evaluating social issues in medicine.

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INTRODUCTION

In A Theory of Justice (1971), John Rawls develops a concept of social justice in his perception of its proper element, i.e., the "basic structure of society or more exactly, the way in which the major social institutions distribute fundamental rights and duties and determine the division of advantages from social cooperation" (Rawls, 1971:17). Although many philosophers working in the field of medical ethics have attempted to do a Rawlsian analysis of health-care delivery, they have either used his theory directly on issues in the health-care professional/patient relationship, or applied his theory directly to issues relating to the health-care delivery system without modifying Rawls' theory. Careful study of Rawls' theory of justice will show, however, that one should not argue about social problems present in health care delivery or health care delivery systems--the institutions of health care--with Rawls' principles of justice as the starting point without significant modification of the theory as he constructs it. That is the focus of this essay.

This essay will be comprised of three areas of study. In the first area, Rawls' theory of justice will be briefly reviewed and some notable applications of his theory will be discussed. Furthermore, a strict application of Rawls' full theory to the institutions of health

care will be developed. It will be shown that Rawls' full theory, embedded in the principle of the common interest, is the only area in which such a strict application can be made. Area two will focus on modifications of Rawls' theory that are necessary in order to apply his concept of justice to the institutions of the health-care delivery system. In area three, a plausible structure of a Rawlsian society which includes provisions for a just health-care delivery system will be developed. Evaluative criteria developed during the modification process will be applied not only to Rawlsian, but also to existing and proposed health-care delivery systems for social systems similar to that of the United States. If Rawls' modified theory is applicable for evaluation of social issues in medicine, using these criteria (thus, Rawls' theory in general) will thus present a valid overall test of it.

Because of the scope of this study, the methodology will be somewhat different from typical Rawlsian analyses. First of all, I do not intend to include a complete Rawlsian approach in that his comparative analyses of other ethical theories will not be included in the scope of this project. Rather, my approach will include only his constructive method and his conclusions. Secondly, I do not intend to include the various critiques of Rawls' theory of justice. Rather, my intention is to test it in

a different way--through modification and application to social issues in medicine. Thus meta-ethical issues, although important in other studies, are not my concern in this study. As a result, the only "critiques" of Rawls' theory which will be used in this project are those which are relevant to the modification and application of Rawls' theory to social issues in medicine.

CHAPTER I

INSTITUTIONAL ISSUES IN HEALTH-CARE DELIVERY

Before analyzing Rawls' theory of justice, a preliminary step is necessary. Institutional issues in health care must be defined. After this delineation, a number of cases in this area will be presented as a focal point to be used in the discussion of justice in health-care delivery systems. The question of justice as it is related to social issues in medicine will be discussed as well.

I. DEFINITION OF ISSUES

A convenient distinction between types of issues in health care is one that distinguishes between the health-care professional/patient relationship and social issues in medicine. Generally, it seems obvious that issues such as truth-telling, patient autonomy, confidentiality in the doctor/patient relationship, etc., are issues included in the category of the health-care professional/patient relationship. Other issues such as access to the health-care delivery system and allocation of scarce resources in health care are just as obviously categorized under the heading of social issues in medicine. This distinction, however, can have overlaps in such issues as euthanasia and abortion. For example, in a society where voluntary

euthanasia is tolerated (a social policy), it is still a decision between the doctor and the patient whether such a practice will be followed.

The primary focus of this essay shall be on social issues in medicine and specifically limited to the single issue of access to the health-care delivery system. My reasons for this limitation are fairly simple. First of all, if the people in a contemporary, technologically advanced society were to consciously plan a health-care delivery system, one of their major social concerns would be the question: who will be served by such a system? Many other social issues in medicine (e.g., allocation of scarce medical resources, types of payment for medical services, etc.) would follow from the answer to that question. The second reason is that John Rawls, in his book, A Theory of Justice, focuses the range of his study to those areas concerned with the principles of justice, i.e., the justice of a society's institutions. Since the primary focus of this essay is Rawls' theory of justice and its applicability to a health-care delivery system, if Rawls' theory is feasible at all, it must then be feasible with regard to this particular issue. Other social issues in medicine may or may not fit into a Rawlsian structure. On the other hand, these issues may fit into Rawls' non-moral theory which is controlled by the principle of the

common interest. If there are such issues, they will be discussed briefly. The last reason for using access to the health-care delivery system as the main issue for study is that, due to the length of this project, treatment of every possible social issue in medicine would not only be redundant but would be best considered as issues for future studies. Furthermore, if Rawls' theory helps evaluate the justice of access to the health-care delivery system, there is strong indication that it would likewise be feasible for evaluating other social issues in medicine as well. Thus the primary focus of this project is the issue of access to the health-care delivery system.

II. CASE STUDIES RELATING TO ACCESS TO THE HEALTH-CARE DELIVERY SYSTEM

In this section, case studies relating to the issue of access to the health-care delivery system will be presented. The case studies will be presented in a format which will not only allow the issues to be more fully defined, but also delineate some of the types of solutions to this issue that have been used. With such a format, it will be possible to refer to these cases in future chapters without continually having to develop new cases once the methodological task of this essay has been completed. These case studies will be hypothetical in that no

particular real case is being used. On the other hand, since there probably are many existing real cases that closely parallel these hypothetical cases, they are, in a sense, conglomerates of real cases.

A. Case Number One: Indigent Care

A shabbily dressed elderly man in respiratory distress is brought to the emergency room of a private hospital. Although emergency care is given, he is refused entry to the hospital itself since he has no insurance and no visible means of support. He is taken by ambulance to a public hospital where he is admitted for further care. The cost of his treatment is paid by funds set aside by the city (as well as state and federal funding programs) for treatment of the indigent.

B. Case Number Two: Third-Party Payment

A middle-aged suburban housewife is taken by ambulance to a local hospital after she falls on a city sidewalk. After a few questions regarding identity and ability and method of payment at the desk of the emergency room, she receives emergency care for abrasions and is taken to X-Ray to determine whether there are broken bones in her hand. The staff radiologist determines that two fingers are broken. The fingers are set by an orthopedic surgeon. At this point the patient is released by the

hospital. However, she must have further out-patient treatment by the orthopedic surgeon. Since her husband has insurance through his place of work, most of her medical bills are paid by the insurance company with only a 20% co-payment required from the family.

C. Case Number Three: Health Maintenance Organization

A middle-class family is enrolled in a nearby Health Maintenance Organization (HMO), which is a pre-paid medical program. According to the law in their state, businesses must offer HMO coverage as an alternative to their normal health insurance program. As a result, the family's actual health-care costs are a little over $100.00 per year. When their six-year old child develops appendicitis, the physician at the HMO has the child admitted to the cooperating hospital for surgery. There is no additional cost either to the family or to the company for the child's care.

D. Case Number Four: Medicare

Prior to their retirement, an elderly couple review their post-retirement financial situation. They find that, with careful money management and elimination of some of their expenses, they will be able to live comfortably in their retirement. One of the expenses they choose to eliminate is their health insurance policy since

they are both in good health and are eligible for Medicare. Two years after their retirement, the husband finds that he has cancer of the prostate gland. Their part of his medical bills places an enormous financial burden on this couple since Medicare only pays a portion of their expenses.

Some of the statistics on Medicare will elucidate this point. First of all, the required Medicare deductible of $304.00 for hospitalization "as of Jan. 1, 1983, according to the Health Care Financing Administration, U.S. Dept. of Health and Human Services, Washington" (President's Commission, 1983a:107) is only the first step in one's personal financial burden for medical costs. There are also copayments for hospital and physician care as well as limits to the amount of services which are covered by Medicare (President's Commission, 1983a:146-147). In fact, the President's Commission (1983a:148) reports that, according to the Office of Research and Demonstrations, Health Care Financing Administration, in The Medicare and Medicaid Data Book, 1982, in 1980 personal reimbursements by type of service covers inpatient hospital most extensively at a rate of 66.3% reimbursement, with physician costs reimbursed at an average rate of 24.9%.

Since this couple has purchased the coverage for

physician care in their Medicare plan, their copayments are actually only 20%. Yet cancer is a costly disease to treat, and they have no supplementary insurance to cover the additional outpatient hospital costs which have a low reimbursement rate. As a result, the costs of his treatments financially devastate them. Eventually, they are forced to sell their home and move into an apartment in a subsidized low-rent housing project.

E. Case Number Five: Medicaid

A young, middle-class family happily awaits the birth of their second child. The child, however, is born with Spina Bifida, and will require considerable medical treatment if it is to survive. To their dismay, they find that their health insurance policy is woefully inadequate in covering those medical expenses. Although they attempt to pay for those expenses themselves, they soon find that they are facing bankruptcy. Even taking the course of bankruptcy is inadequate in that future medical bills soon will put them into a devastating financial situation again. Although they oppose using state-aided financial assistance, they finally apply for state Medicaid benefits since it is the only way in which they will be able to financially provide for the medical care needed for their child.

F. Case Number Six: Financial Disaster

A young couple has no health insurance. They both work at part-time jobs and go to the state university. Their parents are blue-collar workers who try to help them occasionally with their college expenses. Since they are both healthy but have limited money, they choose not to enroll in the college health insurance program believing that whatever health problems they would encounter could be handled by the student health clinic. After enduring blinding headaches for two weeks, the wife goes to the student health clinic for relief. Upon examination, the physician finds that she needs further tests in the hospital. After being admitted to the University Hospital, she undergoes numerous tests, including a CAT-scan. The doctors finally determine that there is no tumor and that she is suffering from migraine headaches. The hospital bill for her stay is enormous. Since they have no insurance and have declared themselves financially responsible, the young couple is under an enormous financial burden. They make arrangements for payment, and attempt to make timely payments on their bill. Because of her headaches, however, the wife loses her part-time job. She is unable to find another job and the payments of her medical bills fall behind. When they go to register for the next semester of college, they find that the University

Hospital has used its connections with the university to hold up their registration for classes until their bill is either currently paid or paid in full. Since they do not have the money, and since their parents are also unable to come up with the money, the two of them are forced to leave school. Whether or not they will return in the near future is in doubt.

G. Case Number Seven: Socialized Medicine

An American family is taking a vacation in Canada where the health-care delivery system is a form of universal health care, i.e., socialized medicine. During their visit, one of the children falls. Besides her obvious abrasions, it looks like she may have a broken wrist. Her parents take her to the local hospital for examination and treatment. Her abrasions are treated; she is taken to X-ray where it is determined that she has indeed broken her wrist. After the cast work is completed, the parents ask where they can pay the bill or present their insurance card for third-party payment. They are told that the total cost for their child's care is $5.00 Canadian. They are flabbergasted.

H. Case Number Eight: Federally Subsidized HMO for Low-Income Persons

A group of young health-care professionals and citizens in a low-income section of a large city apply for a federal grant to subsidize an alternative health-care program for its residents. What they propose to do is set up a federally subsidized HMO available to all of the residents of the area based on a sliding scale payment program based upon each person's or family's ability to pay. Since these people are aware that few area residents have large amounts of cash available for a one-time prepayment, they provide for monthly payments for entry into the program. They receive the grant, but it has stipulations that the program must be financially independent in five years. The HMO starts up rather fitfully, but within a year, many residents of the area have enrolled in the program. Many of the costs of the HMO are eliminated with creative and progressive use of health-care professionals. Nurse practitioners have first contact with patients. If patient complaints are minor, no doctor is seen. Serious complaints requiring a physician's care are referred to one of the staff physicians. Minor surgery is provided as an out-patient service thus avoiding costly hospital stays for minor problems. The emphasis at the HMO is on preventive health care, so many health problems

are either treated early or even avoided. Part of the grant requires that public health research is done surveying the general health conditions of the population before, during and after the grant period. The results indicate that the project is a success since the general health of the local population is considerably better as a result of the HMO's presence in the area. Grant funds expire. Even with a modest increase in the pre-payments required of the local patients, the HMO finds that it can not exist without a major subsidy provided by the government. The HMO closes. The residents of the area return to the meager health-care they received prior to the establishment of their HMO. Access to the health-care delivery system is again either minimal or unavailable.

III. ACCESS TO THE HEALTH CARE DELIVERY SYSTEM: A PRELIMINARY DISCUSSION

All of these cases are examples of issues related to access to the health-care delivery system. Some of the cases seem rather uneventful, even ordinary. For most of the people in a modern, high-technology, somewhat affluent society, access to the health-care delivery system is just that. It is uneventful and ordinary. The burden of payment is light. Health care is taken for granted. HMO's and third-party payments relieve the financial

burden. Medicare and Medicaid certainly provide some of the financial needs of their targeted groups. In many areas, there are local provisions for the indigent. Some nations--like Canada in Case Seven--even provide socialized medicine so that all citizens and even visitors are able to receive needed health care.

Yet many people find their medical costs insurmountable because they are unable to afford insurance or their third-party payments pay only a small fraction of their medical costs. Other people with chronic and degenerative diseases find that they are uninsurable, that their premiums are so costly that they are financially out of reach, or that their disease and conditions resulting from that disease are excluded from their insurance umbrella. For these people, access to the health care delivery system can be an enormous financial burden or even cause financial disaster.

The form of the health-care delivery system provides the key to access to health care. The health-care delivery system is one of the institutions of a society. If there is injustice in that system, then justice demands that just solutions be provided.

Up to this point, I have been assuming that access to the health-care delivery system is an ethical question. Is this, in fact, an ethical question? Certainly there is

no clear-cut answer in the sense that different people would phrase their answers differently. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (henceforth, the President's Commission), in their three volume report, Securing Access to Health Care, begin their study with this very question. Their method in searching for an answer to this problem involves examining the special nature of health-care problems. They focus on four key areas affecting health care: well-being, opportunity, information, and the interpersonal significance of illness, birth, and death (President's Commission, 1983a:16-17).

Regarding well-being, the President's Commission states that the ethical nature of issues in access to health care "derives from the special importance of health care in promoting personal well-being by preventing or relieving pain, suffering, and disability and by avoiding loss of life" (President's Commission, 1983a:16). They even refer to health as a primary good, "that is, there is no need to know what a particular person's other ends, preferences, and values are in order to know that health is good for that individual" (President's Commission, 1983a:16). For the President's Commission (1983a:16), good health is important to people.

The President's Commision cites Norman Daniels (1981:146-179), (whose work on Rawls--including this citation, in fact--will be the subject of later analyses), when referring to the issue of opportunity as it affects health care. Access to health care will affect our opportunities by broadening the range of available opportunities that one is able to pursue. "In this view, health care is that which people need to maintain or restore normal functioning or to compensate for inability to function normally" (President's Commission, 1983a:17).

Information is important in health care through the role it provides in relieving worry and enabling "patients to adjust to their situation by supplying reliable information about their health" (President's Commission, 1983a:17). The Commission acknowledges that information may sometimes cause concern when the health problem is serious, but even in these cases "accurate information can help patients plan how to cope with their situation" (President's Commission, 1983a:17).

With regard to the interpersonal significance of illness, birth, and death, the President's Commission refers to the religious role and to society's basic attitudes in these areas of health concerns.

> Moreover, health care takes on special meaning because its role in the beginning of a human being's life as well as the end. In spite of all the advances in the scientific understanding

> of birth, disease, and death, these profound and universal experiences remain shared mysteries that touch the spiritual side of human nature. For these reasons a society's commitment to health care reflects some of its most basic attitudes about what it is to be a member of the human community. (President's Commission, 1983a:17)

The President's Commission concludes that the "special nature of health care helps to explain why it ought to be accessible, in a fair fashion to all" (President's Commission, 1983a:18). Although the President's Commission's discussion does not prove that access to health-care is an ethical issue, it does reflect the views of many that access to the health-care delivery system is a matter of social justice.

It would seem then that Rawls' theory of justice would be an appropriate vehicle to determine the justice of a health-care delivery system. Just what, if any, type of health-care delivery system would be provided in a Rawlsian society? An attempt to answer this question will be provided in the following chapters.

CHAPTER II

RAWLS' THEORY OF JUSTICE: AN OVERVIEW

I. INTRODUCTION

Rawl's A Theory of Justice has generated an enormous amount of critical literature since its publication in 1971. In the field of medical ethics there have been numerous attempts to apply his theory to issues in medicine. For example, some philosophers have attempted to apply his theory directly to the doctor/patient relationship or to social issues in medicine. On the other hand, some philosophers have claimed that Rawls' theory is not applicable to problems in medicine. In this essay, a somewhat different approach will be used. An internal analysis of Rawls' theory of justice shall be made showing where (if at all) it is applicable to issues in medicine. Then, if modifications are necessary, they will be made as consistent as possible with Rawls' concepts and methodology. The issue of access to the health care delivery system will then be used to see if Rawls' theory of justice is indeed applicable to social issues in medicine.

In this chapter, the analysis of Rawls' theory of justice will begin. Since the planned in-depth analysis of his theory will focus primarily on the first section of Rawls' study, a brief over-view of The Theory of Justice

with an explanation of some of the technical terminology Rawls uses will be the project for this chapter.

II. RAWLS' PRINCIPLES OF JUSTICE

A. Early Theoretical Considerations

Rawls sets out to derive "a conception of justice which generalizes and carries to a higher level of abstraction the familiar theory of social contract as found, say in Locke, Rousseau, and Kant" (Rawls, 1971:11). Rawls wants to set up a concept of an ideal, well-ordered society. It is hypothetical, and it forms the basis for his distinction of strict compliance versus partial compliance. These two terms are a fundamental part of Rawls' ideal theory which relates to a hypothetical, just society. When Rawls works in his ideal theory, strict compliance is assumed.

> Everyone is presumed to act justly and to do his part in upholding just institutions. Though justice may be. . . the cautious, jealous virtue, we can still ask what a perfectly just society would be like. (Rawls, 1971:8)

> The parties are presumed to be capable of a sense of justice and this fact is public knowledge among them. This condition is to insure the integrity of the agreement made in the original position. . . . Once principles are acknowledged the parties can depend on one another to conform to them. (Rawls, 1971:145)

In strict compliance, then, one is dealing with issues

directly relating to the principles of justice. Partial compliance, on the other hand, is concerned with issues of injustice. Rawls delineates the issues in partial compliance theory:

> The latter studies the principles that govern how we are to deal with injustice. It comprises such topics as the theory of punishment, the doctrine of just war, and the justification of the various ways of opposing unjust regimes, ranging from civil disobedience and militant resistance to revolution and rebellion. Also included here are questions of compensatory justice and of weighing one form of institutional injustice against another. (Rawls, 1971:8)

A comment is necessary here. The distinction between strict and partial compliance will lead to certain methodological steps in this project. The problems of justice and injustice in the cases set out in Chapter I are issues of partial compliance. In fact the issues regarding the ultimate structure of a health-care delivery system in a well-ordered society are issues of compensatory justice, hence, partial compliance. On the other hand, providing for the institutions responsible for the health care of the well-ordered society are issues that will directly relate to the principles of justice, hence will be issues relating to strict compliance. As a result, those case discussions--which raise particular issues regarding a particular institution (the health-care delivery system)--will be inappropriate when working in strict compliance if methodological consistency is to be maintained.

B. Original Position Reasoning

Rawls defines his theory as a deontological ethical theory in that it "does not interpret the right as maximizing the good" (Rawls, 1971:30). In the original position, the parties first choose the principles of justice, then conform their conception of the good to the requirements of those principles. For Rawls, the "concept of right is prior to that of the good" (Rawls, 1971:31). Individual values and interests do not take priority over the principles of justice.

> A just social system defines the scope within which individuals must develop their aims, and it provides a framework of rights and opportunities and the means of satisfaction within and by the use of which these ends may be equitably pursued. The priority of justice is accounted for, in part, by holding that the interests requiring the violation of justice have no value. Having no merit in the first place, they cannot override its claims. (Rawls, 1971:31)

Rawls' theory is based on classical contract theory. In a manner consistent with contract theory, he sets up an original contract. For Rawls, the

> guiding idea is that the principles of justice for the basic structure of society are the object of the original agreement. They are the principles that free and rational persons concerned to further their own interests would accept in an initial position of equality as defining the fundamental terms of their association. These principles are to regulate all further agreements; they specify the kinds of social cooperation that can be entered into and the forms of government that can be established. This way of regarding the principles of justice

> I shall call justice as fairness. (Rawls, 1971:11)

The original agreement as delineated by Rawls is one in which the persons entering into the contract are stripped of all facets of their individuality. Rawls' "veil of ignorance" is the primary feature of original position reasoning that is used to do this. The constraints of the veil of ignorance, allow only very general types of knowledge. These types include social, economic and political theory as well as

> the basis of social organization and the laws of human psychology. Indeed, the parties are presumed to know whatever general facts affect the choice of the principles of justice. (Rawls, 1971:137)

What is excluded is all <u>particular</u> knowledge, which leads Rawls (1971:139) to make the following claim:

> To begin with, it is clear that since the differences among the parties are unknown to them, and everyone is equally rational and similarly situated, each is convinced by the same arguments. Therefore, we can view the choice in the original position from the standpoint of one person selected at random. If anyone after due reflection prefers a conception of justice to another, then they all do, and a unanimous agreement can be reached.

The parties, under the constraints of this veil of ignorance, base their choice on certain rational desires. Here Rawls introduces the concept of primary goods of which there are two kinds: social and natural. Social

primary goods are not the objects of individual, particular desires. For Rawls, social primary goods

> are things which it is supposed a rational man wants whatever else he wants. Regardless of what an individual's rational plans are in detail, it is assumed that there are various things which he would prefer more of rather than less. . . . The primary social goods, to give them in broad categories, are rights and liberties, opportunities and powers, income and wealth. (A very important primary good is a sense of one's own worth [i.e., self-respect] . . . . .) (Rawls, 1971:92; bracketted statement added.)

The obvious point being made by Rawls is that these social primary goods are not merely the objects of particular desires; they are desires common to all human beings--fundamental desires. Furthermore, they provide a dimension within the context of the original position that allows for the justification of a person who is considered to be a free and rational being as well as a moral being.

Rawls distinguishes between social primary goods and natural primary goods. They do, however, have one important characteristic in common. Natural primary goods, like the social primary goods, are not the objects of individualistic and particular desires. They include "health and vigor, intelligence and imagination" (Rawls, 1971:62). Rawls distinguishes between social and natural primary goods by claiming that the social primary goods are directly under the control of the basic structure of society, while the natural primary goods are only

influenced by it (Rawls, 1971:62). Thus in the original position, Rawls only takes the social primary goods into consideration.

Rawls' places a number of constraints on original position reasoning in addition to the veil of ignorance and the role of the social primary goods. These constraints include the circumstances of justice, the formal constraints of the concept of right, as well as the importance of the rationality of the parties who participate in original position reasoning. The circumstances of justice (in which Rawls follows Hume's account) are "described as the normal conditions under which human cooperation is both possible and necessary" (Rawls, 1971:126). Rawls distinguishes between the objective circumstances of justice (i.e., considerations of geographic territory, similar capacities of individuals, moderate scarcity of resources) and the subjective circumstances of justice (which include the following conditions for cooperation: similar needs and interests, individual plans of life which make conflicting claims on natural and social resources, limited knowledge and understanding as well as a limited sense of altruism). For Rawls, the circumstances of justice also include a concern for future generations and the postulate of mutual disinterest "which

is made to insure that the principles of justice do not depend upon strong assumptions" (Rawls, 1971:129).

Rawls' formal constraints on the concept of right define the moral point of view. These constraints are summarized by Rawls (1971:135):

> a conception of right is a set of principles, general in form and universal in application, that is to be publicly recognized as a final court of appeal for ordering the conflicting claims of moral persons. Principles of justice are identified by their special role and the subject to which they apply.

Finally, Rawls provides an account of rationality under special conditions. These conditions include not only the circumstances of justice (wherein the parties try to advance their own interests) and the moral point of view, but also the constraints of the veil of ignorance which keeps them from knowing their specific plan of life. As a result, they accept as their interests (for purposes of original position reasoning) the social primary goods:

> they assume that they would prefer more social primary goods rather than less. . . . The special assumption I make is that a rational individual does not suffer from envy. He is not ready to accept a loss for himself if only others have less as well" (Rawls, 1971:142,143).

Rawls adds one further assumption to his account of rationality which guarantees strict compliance:

> The parties are presumed to be capable of a sense of justice and this fact is public knowledge among them. This condition is to insure the integrity of the agreement made in the original position. . . . (I)t means that the

> parties can rely on each other to understand and to act in accordance with whatever principles are finally agreed to. Once principles are acknowledged the parties can depend on one another to conform to them. (Rawls, 1971:145)

Thus, Rawls' strictures on the original position, plus the social primary goods as a rational basis of choice, allow for the adoption of moral principles--the principles of justice. These principles, as stated in Rawls' most complete delineation which include priority rules not stated here, are the following:

> First Principle
> Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
> Second Principle
> Social and economic inequalities are to be arranged so that they are both:
> (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and
> (b) attached to offices and positions open to all under conditions of fair equality of opportunity. (Rawls, 1971:302)

These two principles of justice--which are in lexical order (i.e., a hierarchical ordering in which the constraints of the first principle are always prior to the constraints of the second principle) according to Rawls--form the first stage of his four-stage sequence of deliberations which set up the structure of a well-ordered society. Before discussing the four-stage sequence, however, a more complete discussion of the lexical ordering of the two principles of justice is in order.

C. The Lexical Ordering of the Two Principles of Justice

Rawls begins his arguments for the lexical ordering of the two principles of justice during his original position reasoning, specifically in his discussion of the general conception of justice which embodies both principles of justice. Rawls (1971:152) treats serial ordering as a special original position assumption in that "the parties know that the conditions of their society, whatever they are, admit the effective realization of the equal liberties." For Rawls, this special assumption leads to the serial ordering of the two principles of justice "if the general conception is consistently followed" (Rawls, 1971:152). He uses the maximin rule both as an analogy to use this special assumption systematically and as a heuristic device to elucidate the need for the lexical ordering of the two principles of justice. The maximin rule depicts the "qualitative anatomy" of "the structure of the choice problem in the original position" (Rawls, 1971:157).

The maximin rule, according to Rawls (1971:152-153), "tells us to rank alternatives by their worst possible outcomes: we are to adopt the alternative the worst outcome of which is superior to the worst outcome of the others." Ultimately the use of this rule is to derive the principles of justice based on the fact "that the two

principles are those a person would choose for the design of a society in which his enemy is to assign him his place" (Rawls, 1971:152). He defends using this rule in original position reasoning on the basis of three reasons.

> First, since the rule takes no account of the likelihoods of the possible circumstances, there must be some reason for sharply discounting estimates of these probabilities. . . . In this case it is unreasonable not to be skeptical of probabilistic calculations unless there is no other way out, particularly if the decision is a fundamental one that needs to be justified to others.
>
> The second feature that suggests the maximin rule is the following: the person choosing has a conception of the good such that he cares very little, if anything, for what he might gain above the minimum stipend that he can, in fact, be sure of by following the maximin rule. . . . This last provision brings in the third feature, namely, that the rejected alternatives have outcomes that one can hardly accept. The situation involves grave risks. (Rawls, 1971:154)

Now Rawls argues that the maximin rule is consistent with original position reasoning and constraints. The veil of ignorance is the important feature here in that knowledge that would allow probabilistic calculations is not allowed. The parties in the original position know nothing about the particulars of their society, nor do they even know their own conception of the good. Since the first feature of the maximin rule closely parallels the constraints of the veil of ignorance, according to Rawls, the first feature arguing for the maximin rule is justified.

The second feature of the maximin rule (which leads to the arguments for the difference principle) takes effect in a situation where taking chances for further advantages is not worthwhile, "especially when it may turn out that" one may lose "much that is important to" oneself (Rawls, 1971:154). The constraints of the original position are in effect here as well--especially the veil of ignorance, which means that particular conceptions of a person's good are unknown.

The second reason on behalf of the applicability of the maximin rule is relevant to both the choice and the lexical ordering of the two principles of justice. First of all, Rawls claims that if the two principles chosen on this basis "provide a workable theory of social justice" and "are compatible with reasonable demands of efficiency, then this conception guarantees a satisfactory minimum" (Rawls, 1971:156). He admits that further arguments are needed and promises to provide them in a later section. Rawls, however, makes a more fundamental claim here as well. He states that

> this line of thought is practically decisive if we can establish the priority of liberty, the lexical ordering of the two principles. For this priority implies that the persons in the original position have no desire to try for greater gains at the expense of the equal liberties. The minimum assured by the two principles in lexical order is not one that the parties wish to jeopardize for the sake of greater economic and social advantages. (Rawls, 1971:156)

In the case of the third reason showing the consistency of the maximin rule with original position reasoning, Rawls claims that the conceptions of justice derived allow for the choice of an acceptable minimum and do not lead to the choice of unacceptable alternatives.

> And having the ready alternative of the two principles of justice which secure a satisfactory minimum, it seems unwise, if not irrational, for them to take a chance that these outcomes are not realized. (Rawls, 1971:156)

As a result of these considerations, Rawls concludes that, in original position reasoning, "the arguments for the two principles can be subsumed under" the maximin rule since the use of this rule allows them to be chosen (Rawls, 1971:156-157).

> The original position clearly exhibits these special features to a very high degree in view of the fundamental character of the choice of a conception of justice. These remarks about the maximin rule are intended only to clarify the structure of the choice problem in the original position. They depict its qualitative anatomy. (Rawls, 1971:157)

Thus, the use of the maximin rule plays an initial and important role in Rawls' original position reasoning, and is the beginning point for the arguments leading to the lexical ordering of his two principles of justice.

The maximin rule also ties in with Rawl's use of the difference principle, an important aspect of Rawls' constructive theory and part of the second principle of

justice. When he claims that the deliberations leading to the adoption of the principles of justice can be made from the standpoint of a single person--the representative equal person--he actually adopts the standpoint of the least-advantaged representative equal person. This standpoint is based not on equal citizenship--that is the same for all persons--but on the issue of the distribution of social and economic inequalities. Rawls' difference principle, which "removes the indeterminateness of the principle of efficiency by singling out a particular position from which the social and economic inequalities of the basic structure are to be judged" (Rawls, 1971:75), is the basis for determining the least advantaged representative person rather than just a representative equal citizen. Rawls (1971:75) states:

> Assuming the framework of institutions required by equal liberty and fair equality of opportunity, the higher expectations of those better situated are just if and only if they work as part of a scheme which improves the expectations of the least advantaged members of society. The intuitive idea is that the social order is not to establish and secure the more attractive prospects of those better off unless doing so is to the advantage of those less fortunate.

For Rawls, the framwork of institutions in a just society is constrained, however, by liberty--i.e., the first principle of justice. Thus, the issue of lexical ordering of the two principles of justice must be analyzed and defended. He uses a number of examples to argue for

the priority of liberty over second principle claims on the social order. He claims that his arguments not only fit our considered judgments but also support and "provide the strongest arguments for freedom" (Rawls, 1971:243). He defines the priority of liberty as

> the precedence of the principle of equal liberty over the second principle of justice. The two principles are in lexical order, and therefore the claims of liberty are to be satisfied first. Until this is achieved no other principle comes into play. The priority of the right over the good, or fair opportunity over the difference principle are not presently our concern.
>
> . . . There are two sorts of cases. The basic liberties may either be less extensive though still equal, or they may be unequal. If liberty is less extensive, the representative citizen must find this a gain for his freedom on balance; and if liberty is unequal, the freedom of those with lesser liberty must be better secured. (Rawls, 1971:244)

Rawls then distinguishes between ideal theory where strict compliance to the principles of justice is maintained and non-ideal theory where there is partial compliance--or even no compliance in real cases existing in the world.

Lexical ordering of the two principles of justice is pertinent to ideal theory--a just society. With the assumption of strict compliance, ideal theory for Rawls (1971:245)

> works out the principles that characterize a well-ordered society under favorable circumstances. It develops the conception of a perfectly just basic structure and the corresponding duties and obligations of persons under the fixed constraints of human life.

Rawls maintains that such a just society is a hypothetical ideal--but one which "we are to achieve if we can" (Rawls, 1971:246). He furthermore conceives of the notion of an ideal society as an ethical model which can be used to determine injustices in existing societies' institutions.

> Existing institutions are to be judged in the light of this conception and held to be unjust to the extent that they depart from it without sufficient reason. The lexical ranking of the principle specifies which elements of the ideal are relatively more urgent, and the priority rules this ordering suggests are to be applied to nonideal cases as well. Thus as far as circumstances permit, we have a natural duty to remove any injustices, beginning with the most grievous as identified by the extent of the deviation from perfect justice. (Rawls, 1971:246)

After a discussion of the possible limitations of liberty, Rawls concludes that lexical ordering has an advantage in that it ultimately achieves equilibrium in a just society (Rawls, 1971:250).

Further discussion of the cases of less extensive liberty or unequal liberty move Rawls to limit paternalism as being a "protection against our own irrationality, and must not be interpreted to license assaults on one's convictions and character by any means so long as these offer the prospect of securing consent later on" (Rawls, 1971:250). The delineation of these issues leads Rawls to the final formulation of the first principle of justice and the priority rule that upholds lexical ordering.

Although Rawls does not defend lexical ordering until later sections, the final and complete basis for it can be seen in the following statement:

> Some writers have distinguished between equality as it is invoked in connection with the distribution of certain goods, some of which will almost certainly give higher status or prestige to those who are more favored, and equality as it applies to the respect which is owed to persons irrespective of their social position. Equality of the first kind is defined by the second principle of justice which regulates the structure of organizations and distributive shares so that social cooperation is both efficient and fair. But equality of the second kind is fundamental. It is defined by the first principle of justice and by such natural duties as that of mutual respect; it is owed to human beings as moral persons. The natural basis of equality explains its deeper significance. The priority of the first principle over the second enables us to avoid balancing these conceptions of equality in an ad hoc manner, while the argument from the original position shows how this precedence comes about. (Rawls, 1971:511)

Second principle concerns are less fundamental for Rawls. The notion of equality in this principle connects with fair distribution of goods. In fact, inequalities are ultimately allowed in this principle in terms of social standing and distribution of the other social primary goods. However, when equality concerns the respect we must have for one another as moral individuals, it is more fundamental. Here the basis of equality is natural rather than artificially imposed by society. In fact, it would be difficult to have any just arrangement of second

principle opportunities and distributions of goods without having a prior, more fundamental notion of equality that entails mutual respect. Rawls points to the argument from the original position to prove his position regarding the lexical ordering of the two principles of justice.

For Rawls, liberty can only be constrained for the sake of a more extensive liberty. There is only one condition in which the priority of liberty is challenged. "The denial of equal liberty can be accepted only if it is necessary to enhance the quality of civilization so that in due course the equal freedoms can be enjoyed by all" (Rawls, 1971:542). Lexical ordering is a long-run tendency. Rawls argues that as our most urgent needs and wants as defined by the social primary goods are satisfied, our needs for liberty of conscience and freedom of thought are increased. Rawls (1971:543) states it this way: "the fundamental interest in determining our plan of life eventually assumes a prior place." Part of this is based on the social primary good of self-respect having a central place in his theory. For Rawls, this primary good has two aspects--(1) the sense of one's own worth which enables one to conceive of a rational plan of life; and (2) the self-confidence necessary so that one will be able to carry out that rational plan of life (Rawls, 1971:440).

> Thus the desire for liberty is the chief regulative interest that the parties must suppose they all will have in common in due course. The veil of ignorance forces them to abstract from the particulars of their plans of life, thereby leading to this conclusion. The serial ordering of the two principles then follows. (Rawls, 1971:543)

Rawls maintains that another reason for the precedence of liberty is that material needs are less important due to the lack of envy and jealousy--particular features of human nature eliminated in the original position. This is especially true, according to Rawls, in a hypothetical, ideal, well-ordered society.

The social primary good of self-respect is central in this reasoning for lexical ordering. First of all it has an effect on how others value us. In this sense, it affects the concern for mutual respect. As a result of this, Rawls makes the following point.

> But in a well-ordered society the need for status is met by the public recognition of just institutions, together with the full and diverse internal life of the many free communities of interests that equal liberty allows. The basis for self-esteem in a just society is not then one's income share but the publicly affirmed distribution of fundamental rights and liberties. And this distribution being equal, everyone has a similar and secure status when they meet to conduct the common affairs of the wider society. . . . [M]en [are not] disposed to acknowledge a less than equal liberty. For one thing, doing this would put them at a disadvantage and weaken their political position from a strategic point of view. It would also have the effect of publicly establishing their inferiority as defined by the basic structure of society. (Rawls, 1971:544)

Thus, for Rawls, according priority to the equality of opportunity and the distribution of goods (i.e., the second principle of justice rather than to liberty, the first principle of justice) leads not only to a lack of political equality, it also affirms one's lesser social status in a public way. Self-respect cannot then be secured.

Another problem with the social primary good of self-respect results if liberty is not given lexical priority to the second principle of justice. Status becomes ever more important and puts citizens at odds with one another in pursuing it. According to Rawls, this could not result in achieving a true well-ordered society--what he later calls a social union where lexical ordering of the two principles is established. He further claims that equal distribution of the social primary goods (a condition in which there is no lexical ordering of the principles of justice since they are derived from the social primary goods) is an irrational desire

> in view of the possibility of bettering everyone's circumstances by accepting certain inequalities. Thus the best solution is to support the primary good of self-respect as far as possible by the assignment of the basic liberties that can indeed be made equal, defining the same status for all. At the same time, distributive justice as frequently understood, justice in the shares of material means, is relegated to a subordinate place. Thus . . . the precedence of liberty entails equality in the social bases of esteem. (Rawls, 1971:546)

All of this is relevant in the context of the original position. The constraints of the original position, according to Rawls, assume that the parties have a sense of justice from the beginning and include the veil of ignorance. Furthermore rationality is assumed. Yet the knowledge of the general facts known by the parties in the original position allows for the knowledge of the changes undergone in societies over time.

> For our problem is how society should be arranged if it is to conform to principles that rational persons with true general beliefs would acknowledge in the original position. The publicity condition requires the parties to assume that as members of society they will also know the general facts. The reasoning leading up to the initial agreement is to be accessible to public understanding. . . . We have to concede that as established beliefs change, it is possible that the principles of justice which it seems rational to choose may likewise change. Thus when the belief in a fixed natural order sanctioning a hierarchical society is abandoned, . . . a tendency is set up that points in the direction of the two principles of justice in serial order. The effective protection of the equal liberties becomes increasingly of first importance. (Rawls, 1971:547-548)

In this way, Rawls finally argues for his position for the lexical ordering of the two principles of justice. The importance of the social primary good of self-respect leads to the priority of liberty over second principle concerns. The problem of social change is accomodated as a general fact--knowledge allowed under the veil of ignorance--in Rawls' theory; hence the priority of

material needs as defined by some of the social primary goods recedes in favor of the priority of liberty as the ultimate choice for the parties in the original position. Thus the priority of liberty as the first principle of justice is confirmed.

III. THE FOUR-STAGE SEQUENCE: THE STRUCTURE OF A WELL-ORDERED SOCIETY

Rawls' development of the principles of justice is just a starting point in developing the structure of a well-ordered society. Simply applying the principles of justice to a society is too cumbersome. Hence, Rawls develops the simplifying device of the four-stage sequence. Once this framework of a society is developed, the institutions included in a well-ordered society can be delineated. For Rawls, these are the background institutions needed in a well-ordered society.

This section will consist of two parts. First, the four-stage sequence itself will be discussed. A discussion of Rawls' background institutions is then in order.

A. The Four-Stage Sequence

In setting the framework for a just society, Rawls uses the simplifying device of the four-stage sequence as an elaboration of his original position. He notes that, for the contracting parties, determining the principles of

justice and then applying them to their society becomes a complex process if there are only two principles upon which they must judge their claims.

> But if several intermediate stages are imagined to take place in a definite sequence, this sequence may give us a schema for sorting out the complications that must be faced. Each stage is to represent an appropriate point of view from which certain kinds of questions are considered. (Rawls, 1971:196)

Rawls notes that his "four stage sequence is suggested by the U. S. Constitution and its history" (Rawls, 1971:196n). Another point is appropriate here. In fact, it is a caveat. Determinations made in the four-stage sequence are a part of Rawls' moral theory and are thus a part of ideal theory until the fourth and final stage is implemented.

> The idea of the four-stage sequence is part of a moral theory, and does not belong to an account of the working of actual constitutions, except insofar as political agents are influenced by the conception of justice in question. In the contract doctrine, the principles of justice have already been agreed to, and our problem is to formulate a schema that will assist us in applying them. The aim is to characterize a just constitution and not to ascertain which sort of constitution would be adopted, or acquiesced in, under more or less realistic (though simplified) assumptions about political life, much less on individualistic assumptions of the kind characteristic of economic theory. (Rawls,1971:197n)

As a consequence of Rawls' point here, it is also apparent that he is still working from the point of view of the

representative person, not from a point of view of individuals with their particular wants and needs. Furthermore, the standpoint is not that of any representative person; the parties must look at the

> system from the standpoint of the least advantaged representative man. Inequalities are permissible when they maximize, or at least all contribute to, the long-term expectations of the least fortunate group in society. (Rawls, 1971:151)

Deriving the two principles of justice is the first stage of the four-stage sequence. All of the conditions of the original position are, of course, in effect at this stage. The one condition of the original position that will be affected by each succeeding stage of the four-stage sequence, however, is the veil of ignorance. It is partially lifted at each succeeding stage. At the point of the determination of the two principles of justice, the veil is at its thickest. It would probably be helpful at this point to quote in full Rawls' two principles of justice including the priority rules and the general conception of justice.

> First Principle
> Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
> Second Principle
> Social and economic inequalities are to be arranged so that they are both:
> (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and

(b) attached to offices and positions open to all under conditions of fair equality of opportunity.

First Priority Rule (The Priority of Liberty)

The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty. There are two cases:

(a) a less extensive liberty must strengthen the total system of liberty shared by all;

(b) a less than equal liberty must be acceptable to those with the lesser liberty.

Second Priority Rule (The Priority of Justice over Efficiency and Welfare)

The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle. There are two cases:

(a) an inequality of opportunity must enhance the opportunities of those with the lesser opportunity;

(b) an excessive rate of saving must on balance mitigate the burden of those bearing this hardship.

General Conception

All social primary goods--liberty and opportunity, income and wealth, and the bases of self-respect--are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored. (Rawls, 1971:302-303)

The full delineation of the two principles of justice is the result of original position reasoning. It is the standpoint from which all further stages of the four-stage sequence are to be determined. In other words, each stage must be consistent with the prior stage and satisfy the principles of justice determined in the first stage (Rawls, 1971:197).

The second stage of the four-stage sequence is the

constitutional stage. Rawls considers this in the context of a constitutional convention.

> Here they are to decide upon the justice of political forms and choose a constitution: they are delegates, so to speak, to such a convention. Subject to the constraints of the principles of justice already chosen, they are to design a system for the constitutional powers of government and the basic rights of citizens. It is at this stage that they weigh the justice of procedures for coping with diverse political views. (Rawls, 1971:197)

It is important to point out that this is the stage of deliberations which deals with the first principle of justice. Since the first principle of justice is devoted to liberty, second principle concerns are not justifiably covered in this stage.

> In pursuit of this ideal of perfect procedural justice . . . , the first problem is to design a just procedure. To do this the liberties of equal citizenship must be incorporated into and protected by the constitution. These liberties include those of liberty of conscience and freedom of thought, liberty of the person, and equal political rights. (Rawls, 1971:197)

Rawls notes that perfect procedural justice may not be attainable--that unjust laws may be enacted. In order that the deliberations at the constitutional stage can be effectively made, the veil of ignorance must be partially lifted.

This lifting of the veil includes the addition of certain kinds of allowable knowledge for the parties selecting a constitution. First of all, the parties now

"know the relevant general facts about their society, that is, its natural circumstances and resources, its level of economic advance and political culture, and so on" (Rawls, 1971:197). Secondly, they must know, regarding the problem of the possible enactment of unjust laws, the

> beliefs and interests that men in the system are liable to have and of the political tactics that they will find it rational to use given their circumstances. The delegates are assumed, then, to know these things. (Rawls, 1971:198)

They still do not know any particular facts about themselves, their particular place in society, and so on. This lifting of the veil of ignorance is necessary because the parties now need more information for effective deliberations.

> Given their theoretical knowledge and the appropriate general facts about their society, they are to choose the most effective just constitution, the constitution that satisfies the principles of justice and is best calculated to lead to just and effective legislation. (Rawls, 1971:197, emphasis added.)

Rawls ultimately defines the notion of needed knowledge in the following manner:

> The flow of information is determined at each stage by what is required in order to apply these principles intelligently to the kind of question of justice is at hand, while at the same time any knowledge that is likely to give rise to bias and distortion and to set men against one another is ruled out. The notion of the rational and impartial application of principles defines the kind of knowledge that is admissible. (Rawls, 1971:200)

The knowledge Rawls allows here is knowledge which

elucidates social theory and one's own culture and time. This the only additional knowledge needed at this stage of the four-stage sequence. Any further additional knowledge would lead into particular kinds of facts, awareness of which may adversely affect the justice of the society.

Rawls specifically considers the problem of the possible enactment of unjust laws. He identifies the best solution as one in which the parties are to "select from among the procedural arrangements that are both just and feasible those which are most likely to lead to a just and effective legal order" (Rawls, 1971:198). With the additional knowledge allowed (and the principles of justice), "the rules (just procedure) are to be framed to give legislation (just outcome) likely to accord with the principles of justice" (Rawls, 1971:198). The limitations of the veil of ignorance which are still in effect rule out particular information so that "the idea of the original position is not affected" (Rawls, 1971:198). Furthermore, the two principles of justice "define an independent standard of the desired outcome" (Rawls, 1971:198).

Just as the first principle of justice defines the scope of the constitutional stage of the four-stage sequence, the second principle of justice defines the scope of the legislative stage. Rawls perceives this distinction as a division of labor dealing with the

different questions implied in the basic structure of society determined by the two principles of justice.

> The first principle of equal liberty is the primary standard for the constitutional convention. Its main requirements are that the fundamental liberties of the person and liberty of conscience and freedom of thought be protected and that the political process as a whole be a just procedure. Thus the constitution establishes a secure common status of equal citizenship and realizes political justice. The second principle comes into play at the stage of the legislature. It dictates that social and economic policies be aimed at maximizing the long-term expectations of the least advantaged under conditions of fair equality of opportunity, subject to the equal liberties being maintained. . . . The second part of the basic structure contains the distinctions and hierarchies of political, economic, and social forms which are necessary for efficient and mutually beneficial social cooperation. (Rawls, 1971:199)

Two points are necessary to elucidate Rawls' reasoning.

First of all, the placement of each stage of the sequence is consistent with Rawls' position that the principles are to be in lexical order with liberty prior to opportunities and the distribution of goods. Thus the first three stages of the four stage sequence are parallel to the original position, the first principle and then the second principle of justice while the fourth stage deals with the application of those three stages to particular cases. Rawls (1971:199) states: "Thus the priority of the first principle of justice to the second is reflected in the priority of the constitutional convention to the

legislative stage." And if the four-stage sequence is seen as a simplifying device, it is used by Rawls in a systematically and methodologically sound manner.

Secondly, more knowledge is needed in this third stage than in the constitutional stage. Rawls (1971:199) sees that the full "range of general and economic and social facts" is applicable here. This is a considerably greater body of allowable knowledge when it is contrasted with the knowledge allowed at the constitutional stage. Furthermore, in order to establish the institutions which are responsible for the social and economic forms in a just society, more particular knowledge of this type is needed. Thus, on a purely procedural basis, the legislative stage must follow the constitutional stage if the methodology is to be consistent.

The type of additional knowledge allowed is consistent with legislative stage reasoning. Rawls allows for the full range of <u>general</u> economic and social facts to be known about a society, but he still does not allow for particular facts to be known either about a society or about persons who exist in such a society. For example, it would be known that a society is capitalistic, socialistic, and so on. It would also be known whether or not such a society is technologically advanced. The basic social structure would also be known. Particular economic

and social facts would not, however, be known at this stage. For example, whether or not the economy is in a recession, depression, or a period of growth would not be known, but whether or not a society suffers from these types of economic cycles could be known since those would be general facts embedded in theories of capitalism, socialism, and so forth. Other information that would not be known is a person's own social status, level of income or power or similar particular facts. Thus the legislators would still deliberate from the standpoint of the representative equal citizen--actually, the least advantaged representative citizen--in the legislative stage of the four-stage sequence. Thus, even at this stage, Rawls is maintaining an abstract and ideal theory. In other words, Rawls is developing his framework for a just society from the thin, rather than the full theory of the good--i.e., from the standpoint of the social primary goods, not from the standpoint of a particular individual's full theory of the good (his/her rational plan of life). In this sense, Rawls' theory of the right is prior to the theory of the good.

The legislative stage is also bound by the decisions made in the constitutional stage as well as by the principles of justice. This is apparent by the fact that if the first principle considerations are lexically prior to

the second principle considerations, the decisions made in the constitutional stage (first principle concerns) will decide the framework under which the legislative stage will operate. If, for example, the constitutional convention deliberators choose a constitutional monarchy, the institutions and policies made in the legislative stage will have to conform to that form of government. Rawls' admitted use of the U. S. Constitution and its history suggests that a society similar to that of a Western Constitutional Democracy is most compatible with his theory, but he does not exclude the possibility of the choice of a constitution which allows for a society based upon socialistic economic principles (choices made at the legislative stage of deliberations) or a society which is structurally a mixture of both capitalism and socialism. Since any form of government is bound by the principles of justice in Rawls' theory, the major problems of social justice embedded in existing societies (whatever their form of government) are less able to plague an ideal, well-ordered society which is formulated by the four-stage sequence. The principles of justice--as independently derived but internally the heart of the framework of Rawls' theory of justice--define "an independent criterion for both procedure and outcome" (Rawls, 1971:197).

In summation, the first three stages of the four-

stage sequence are delineated within the constraints of ideal theory and, in general, within the limits of the original position. Strict compliance is assumed. All decisions are derived from the standpoint of the least advantaged representative citizen. The veil of ignorance is progressively lifted in each succeeding stage, but only insofar as necessary for making appropriate decisions in each stage of deliberation. Finally each succeeding stage is bound by the decisions made in the previous stages of decision-making. As a result, a coherent and just framework for a well-ordered society can be developed.

The final stage of Rawls' four-stage sequence differs from the previous stages in a number of ways. Rawls' reasoning here is based upon the problem that this stage is meant to handle as well as the scope of the fourth stage.

> The last stage is that of the application of rules to particular cases by judges and administrators, and the following of rules by citizens generally. . . . However, it is not from this standpoint that we are to decide the grounds and limits of political duty and obligation. This third type of problem belongs to partial compliance theory, and its principles are discussed from the point of view of the original position after those of ideal theory have been chosen . . . . Once these are on hand, we can view our particular situation from the perspective of the last stage, as for example in the cases of civil disobedience and conscientious refusal . . . . (Rawls, 1971:199-200)

Thus even though the fourth stage does not initially deal

with Rawls' grounds and limits of political duty and obligation (Rawls, 1971:200), in the fourth stage, one is necessarily in partial compliance theory since this stage deals with the applications of those grounds and limits.

In the last stage, the veil of ignorance is also completely lifted. First of all, as Rawls (1971:200) states, "there are no reasons for the veil of ignorance in any form" since the veil is used to prevent the use of knowledge "that is likely to give rise to bias and distortion and to set men against one another" (Rawls, 1971:200). Furthermore, it is really impossible to conceive of the application of the fourth stage with any limits of the veil in force since this stage is devoted to the application of rules to particular cases. Complete access to the facts is necessary if judges and administrators are to be able to carry out their roles effectively. "No limits on knowledge remain since the full system of rules has now been adopted and applies to persons in virtue of their characteristics and circumstances" (Rawls, 1971:199). As a result of the particular facts now being allowable, decisions are no longer made from the standpoint of the least advantaged representative citizen. The citizen, with her/his own particular plan of life, is no longer an abstraction in this stage. Rawls delineates

once and for all the availability of knowledge in the four-stage sequence:

> Let us distinguish between three kinds of facts: the first principles of social theory (and other theories when relevant) and their consequences; general facts about society, such as its size and level of economic advance, its institutional structure and natural environment, and so on; and finally particular facts about individuals such as their social position, natural attributes, and particular interests. In the original position, the only particular facts known to the parties are those that can be inferred from the circumstances of justice. . . . In the next stages, however, the general facts about their society are made available to them but not the particularities of their own condition. . . . The notion of the rational and impartial application of the principles defines the kind of knowledge that is admissible. At the last stage, clearly, there are no reasons for the veil of ignorance in any form and all restrictions are lifted. (Rawls, 1971:200)

This, then, is Rawls' four-stage sequence. It is a simplifying device for developing the framework of a hypothetical, ideal, just, well-ordered society. Rawls leaves this discussion, however, with a warning.

> It is essential to keep in mind that the four-stage sequence is a device for applying the principles of justice. This scheme is part of the theory of justice as fairness and not an account of how constitutional conventions and legislatures actually proceed. It sets out a series of points of view from which the different problems of justice are to be settled, each point of view inheriting the constraints adopted at the preceding stages. (Rawls, 1971:200)

He also warns that justice is indeterminate at times (Rawls, 1971:201) and as a result, many forms of governments can be devised which are compatible with his

theory of justice. The indeterminacy leads to the use of "quasi-pure procedural justice":

> [L]aws and policies are just provided that they lie within the allowed range, and the legislature, in ways authorized by a just constitution, has in fact enacted them. This indeterminacy is not a defect. It is what we should expect. Justice as fairness will prove a worthwhile theory if it defines the range of justice more in accordance with our considered judgments than do existing theories, and if it singles out with greater sharpness the graver wrongs a society should avoid. (Rawls, 1971:201)

The four-stage sequence is thus an important part of Rawls' theory of justice. It is a simplifying device in applying the principles of justice, but it also hones our considered judgments in working with Rawls' theory.

B. Rawls' Background Institutions

Rawls sets up a scheme of background institutions to determine the outcome of distributive shares in a just manner at the legislative stage of the four-stage sequence.

> In establishing these background institutions the government may be thought of as divided into four branches. Each branch consists of various agencies or activities thereof, charged with preserving certain social and economic conditions. These divisions do not overlap with the usual organization of government but are able to be understood as different functions. (Rawls, 1971:275-276)

Rawls' four branches of the background institutions and a brief description follow:

1. the allocation branch, which is set up "to keep

the price system workably competitive and to prevent the formation of unreasonable market power" (Rawls, 1971:276);

2. the stabilization branch, which is responsible for full and free employment that "strives to bring about reasonably full employment in the sense that those who want work can find it and the free choice of occupation and the deployment of finance are supported by strong effective demand" (Rawls, 1971:276);
3. the transfer branch, which provides the social minimum by making provisions for the citizens' basic needs; and
4. the distribution branch, which has the task of preserving "an approximate justice in distributive shares and the necessary adjustments in the rights of property" (Rawls, 1971:277).

According to Rawls, the first two branches, allocation and stabilization, "together are to maintain the efficiency of the market economy generally" (Rawls, 1971:276). The transfer branch has a radically different purpose:

> Since the market is not suited to answer the claims of need, these should be met by a separate arrangement. Whether the principles of justice are satisfied, then, turns on whether the total income of the least advantaged (wages

> plus transfers) is such as to maximize their long-run expectations (consistent with the constraints of equal liberty and fair equality of opportunity). (Rawls, 1971:277)

The distribution branch is set up to satisfy--through taxation--both principles of justice. It has two parts and each part satisfies one of the principles:

> The taxation of inheritance and income at progressive rates (when necessary), and the legal definition of property rights, are to secure the institutions of equal liberty in a property-owning democracy and the fair value of the rights they establish. Proportional expenditure (or income) taxes are to provide revenue for public goods, the transfer branch and the establishment of fair equality of opportunity in education, and the like, so as to carry out the second principle. (Rawls, 1971:279)

These, then, are the four background institutions that Rawls uses to determine the outcome of distributive shares in his theory of justice.

The transfer branch will be of special importance in later chapters when my modifications of Rawls' theory of justice are being made to include health care as a second principle right. As a result, a deeper analysis of that branch of a Rawlsian government will be made at the appropriate time.

The four-stage sequence and the institutions that Rawls develops within its constraints are important to anyone who attempts to work within Rawls' theory of justice. They provide the methodological basis for any modifications of his theory.

IV. SOME CONCLUDING NOTES

One of Rawls' early distinctions in A Theory of Justice is between societies in general and a well-ordered society. Rawls defines society in general as follows:

> [A] society is a more or less self-sufficient association of persons who in their relations to one another recognize certain rules of conduct as binding and who for the most part act in accordance with them. Suppose further that these rules specify a system of cooperation designed to advance the good of those taking part in it. Then, although a society is a cooperative venture for mutual advantage, it is typically marked by a conflict as well as by an identity of interests. There is an identity of interests since social cooperation makes possible a better life for all than any would have if each were to live solely by his own efforts. There is a conflict of interests since persons are not indifferent as to how the greater benefits produced by their collaboration are distributed, for in order to pursue their ends they each prefer a larger to a lesser share. (Rawls, 1971:4)

A well-ordered society, on the other hand, is different. Although it has the basic characteristics of societies in general, it also possesses a shared conception of justice and is regulated by it.

> That is, it is a society in which (1) everyone accepts and knows that the others accept the same principles of justice, and (2) the basic social institutions generally satisfy and are generally known to satisfy these principles. In this case while men may put forth excessive demands on one another, they nevertheless acknowledge a common point of view from which their claims may be adjudicated. (Rawls, 1971:5)

Rawls acknowledges that existing societies are rarely

if ever well-ordered societies. In fact one of the basic disagreements within existing societies is about the very nature of justice itself. He also notes that there are other problems in any society beyond justice itself. These problems include "those of coordination, efficiency, and stability" (Rawls, 1971:6). Thus Rawls also sees an overriding need for a shared conception of justice, for without that, these three social problems may be unmanageable.

> In the absence of a certain measure of agreement on what is just and unjust, it is clearly more difficult for individuals to coordinate their plans efficiently in order to insure that mutually beneficial arrangements are maintained. Distrust and resentment corrode the ties of civility, and suspicion and hostility tempt men to act in ways they would otherwise avoid. So while the distinctive role of conceptions of justice is to specify basic rights and duties and to determine the appropriate distributive shares, the way in which a conception does this is bound to affect the problems of efficiency, coordination, and stability. (Rawls, 1971:6)

Assessment of the conception of justice is not only made on the basis of distributive issues, but also on how one conception of justice as opposed to another affects the social issues of efficiency, coordination, and stability (Rawls, 1971:6). A choice of a conception of justice that deals best with all of these issues is one that is ultimately preferable.

Rawls' unique approach to contract theory is

embedding his conception of justice into the heart of the structure of a society. The principles of justice are the central and overriding basis for the structure of society since they are derived in the original position rather than being developed separately and independently from the social order. In other words, in a well-ordered society, a conception of justice is intrinsic rather than extrinsic to its structure. The four-stage sequence which Rawls sets out as the framework for a well-ordered society depicts this point. The first stage is embodied in the original position where the principles of justice are developed. The rest of the stages are constrained by those principles.

Rawls' theory of justice is not just limited to the areas discussed in this chapter. Much has been left out here. Yet this discussion is sufficient for the purposes of this essay. It provides the reader with an overview of Rawls' arguments which form the basis for this project. Other areas of Rawls' theory of justice will be analyzed in their appropriate context.

Rawls' theory of justice is not appropriate as it stands for dealing with issues of health-care delivery. In fact, health-care issues are not even appropriate topics for Rawls' conception of justice. That is the subject of analysis in the next chapter.

CHAPTER III

HEALTH CARE IN RAWLS' WELL-ORDERED SOCIETY

I. INTRODUCTION

In the last chapter, the structure of Rawls' theory of justice was developed. No real mention of a health-care delivery system was made. The reason for this ommission lies in Rawls' distinction between the social and natural primary goods. Rawls (1971:62) considers health a natural primary good, rather than a social primary good. Since natural primary goods are not directly under the influence of the institutions ruled by the principles of justice, health concerns in Rawls' theory are allocative rather than distributive goods. Distributive goods are those which are ruled by the principles of justice through the use of the difference principle (Rawls, 1971:302-303). Allocative goods are those ruled by the principle of the common interest (Rawls, 1971:97). For Rawls, this principle is complex and has a specific role apart from distributive concerns. Rawls argues his case here from the standpoint of equal citizenship. Furthermore, in Rawls' scheme, the principle of common interest is governing in matters of health care--at least in terms of public health. Rawls (1971:97) states that this principle regulates concerns of public health and order. The

reasoning for Rawls leads back to his placement of health as a natural primary good.

Yet there are issues of health care from which the allocative stance--that of equal citizenship--is important. For example, public health, nutrition, immunology, control of contagious diseases are all health-care issues which affect all citizens. In other words, these issues are more than purely distributional issues--like access to the health-care delivery system, distribution of research funds, the scope of a just health-care delivery in terms of quality, quantity, and the ability of the citizen to contribute financially to his or her own health care. These allocative issues are beyond the scope of justice as used by Rawls.

This chapter will focus on allocative issues in a Rawlsian system of health care. Before analyzing the institutions needed to handle these issues, however, an analysis of the role of the principle of the common interest in Rawls' theory is needed. That is the first task of this chapter. This analysis will be followed by a development of Rawls' ideas in terms of appropriate health-care issues for the principle of common interest.

The final sections of this chapter will focus on the alternatives for a health-care delivery system in a pure, unmodified Rawlsian society. If health care is an

allocative issue in a Rawlsian society, then the type of health-care delivery system that will be developed in such a society will be based on Rawls' non-moral theory. Here allocative goods governed by the exchange branch of his background institutions are the focus rather than distributive goods which are governed by the four branches of background institutions concerned with issues of distributive justice. As part of this discussion, alternative health-care delivery systems for this pure Rawlsian system will be presented and analyzed. This will include the type of health-care delivery system that seems most consistent with unmodified Rawlsian theory--a health-care delivery system based on socialized medicine.

II. RAWLS' USE OF THE PRINCIPLE OF THE COMMON INTEREST: AN ANALYSIS

The principle of the common interest is only rarely mentioned in Rawls' A Theory of Justice, yet it forms one of the most pervasive themes in the book. This principle relates significantly not only to the "thin" theory of the good--used as the basis of social primary goods (Rawls, 1971:396)--but also to the moral point of view. Without this principle of the common interest, the congruence of Rawls' theories of right and good would fall apart. Yet Rawls generally only refers to the principle of the common

interest indirectly rather than directly. On the other hand, his primary concern is the structure of a just society--one governed by the two principles of justice; as a result the principle of the common interest is one which is a corollary but not directly related to the theory of justice. It is, as will be shown, an important corollary.

A. An Examination of the Principle of the Common Interest

Just what is the principle of the common interest? This question must be answered fully before analyzing its relationship to the theory of justice itself. Rawls defines it in the following manner:

> According to this principle institutions are ranked by how effectively they guarantee the conditions necessary for all equally to further their aims, or by how efficiently they advance shared ends that will similarly benefit everyone. (Rawls, 1971:97)

At this point, the principle seems relatively innocuous. In fact it seems to be simply a criterion by which one can judge or rank the institutions which function within the social order. However the context in which this principle operates is somewhat different. This principle is operant when "there are matters which concern the interests of everyone and in regard to which distributive effects are immaterial or irrelevant" (Rawls, 1971:97).

Two points are significant regarding the applicable

context of the principle of the common interest. First, these "matters which concern everyone" must be assessed from the standpoint of the representative equal citizen (Rawls, 1971:97, 246). Rawls (1971:319) eventually uses, however, the standpoint of the least advantaged representative citizen for the principle of the common interest. There is no need to do so at this point for the representative equal citizen is an abstraction--a tool--which is used so that the special and specific interests of everyday human beings can be disregarded. Rawls (1971:97), in discussing the position of equal citizenship, claims that

> this position is defined by the rights and liberties required by the principle of equal liberty and the principle of fair equality of opportunity. When the two principles are satisfied, all are equal citizens and so everyone holds this position.

Since the representative equal citizen is an abstraction--an abstraction used in original position deliberations--only the "thin" rather than the "full" theory of the good can be used to delineate these interests. As Rawls notes, the full theory of the good is relative to the particular interests and abilities of individual human beings (1971:447). The thin theory, however, fits nicely into the role of the representative equal citizen.

> Nevertheless, the thin theory of the good which the parties are assumed to accept shows that they should try to secure their liberty and self-respect, and that in order to advance their

> aims, whatever these are they normally require more rather than less of the other primary goods. . . . Summing up these points, we need . . . the thin theory of the good to explain the rational preference for primary goods and to explicate the notion of rationality underlying choice of principles in the original position. (Rawls, 1971:397)

Since the principle of the common interest is inextricably intertwined with these primary goods--goods that everyone would want in any case (1971:214)--and since it is used by the abstract representative equal citizen, the connection of this principle to the thin theory of the good is obvious. Furthermore (as will be discussed later), the thin theory of the good--as used by Rawls to show the congruence between the sense of justice (and the moral point of view) and the full theory of the good--is a continuous indirect utilization of the principle of the common interest.

The second significant point about the context in which the principle of the common interest is used is that it is only applied when "distributive effects are immaterial or irrelevant" (Rawls, 1971:97). The immediate question that comes to mind is this: when or how can these effects be immaterial or irrelevant? Part of the answer is supplied by Rawls when he (1971:97) states that "reasonable regulations to maintain public order and security, or efficient measures for public health and safety promote the common interest . . . ." Although

people may benefit unequally from these regulations and policies in some ways, Rawls' important point here is that "if social and economic inequalities are just, these effects may be left aside and the principle of the common interest applied" (Rawls, 1971:97). This point can be shown and understood more effectively with an examination of Rawls' explicit usage of the principle of the common interest.

First of all, Rawls limits liberty of conscience by the "common interest in public order and security" (Rawls, 1971:212). He claims that this can be derived "from the contract point of view" (Rawls, 1971:212). These public interests are not

> superior to moral or religious interests. . . . Rather given the principles of justice, the state must be understood as the association consisting of equal citizens. It . . . regulates individuals' pursuit of their moral and spiritual interests in accordance with the principles to which they themselves would agree in an initial situation of equality. (Rawls, 1971:212)

Another point follows from this contract view. The common interest is relevant when those principles chosen in the original position are in danger of being disrupted or abrogated.

> The government's right to maintain public order and security is an enabling right, a right which the government must have if it is to carry out its duty of impartially supporting the conditions necessary for everyone's pursuit of his

> interests and living up to his obligations as he understands them. (Rawls, 1971:213)

Obviously there is a strong connection to the original position functioning when this principle of the common interest is invoked. Rawls states this connection rather obliquely when he talks about the limits which can be set on the principles chosen in the original position. For example, liberty can only be limited when the reference to the common interest points out that a greater liberty is a disruption which endangers liberty for all. The principle of the common interest is thus a restraining principle in terms of its connection to the original position.

It would seem that there is a danger that the principle of the common interest could be invoked too soon resulting in a situation where liberty may be unjustly restrained. Rawls guards against this. The principle of the common interest must reflect the moral point of view. His publicity criterion as part of the moral point of view is especially relevant in answering this objection. Referring to the publicity criterion, Rawls states:

> For this criterion appeals to what everyone can accept. It represents an agreement to limit liberty only by reference to a common knowledge and understanding of the world. . . . [The] parties consent to publicly recognized criteria to determine what counts as evidence that their equal liberty is pursued in ways injurious to the common interest in public order and to the liberty of others. (Rawls, 1971:213-214)

If the publicity criterion provides no absolute guarantee

that liberty will be too severely limited by the government through the application of the principle of the common interest, it does perform a watchdog role which makes any abrogation of liberties more difficult.

A final point can be made about Rawls' use of the principle of the common interest. Although the standpoint of the representative equal citizen is a useful abstract tool, this can be unwieldy--and, at times, confusing--since it seems more consistent with efficiency than with justice. Rawls (1971:319) states that

> it is a political convention of a democratic society to appeal to the common interest. . . . But how is the convention to be understood? . . . Surely it is something more than the principle of efficiency, and we cannot assume that government affects everyone's interest equally. Since it is impossible to maximize with respect to more than one point of view, it is natural, given the ethos of a democratic society, to single out that of the least advantaged and to further their long-term prospects in the best manner consistent with the equal liberties and fair opportunity.

Rawls chooses the standpoint of the least advantaged for the following reason.

> It seems that the policies . . . do at least tend in this direction in the sense that this sector of society would be worse off should they be curtailed. These policies are just throughout even if they are not perfectly just. (Rawls, 1971:319)

However, using the standpoint of the least advantaged representative citizen as part of the principle of the

common interest seems inconsistent at first glance with Rawls' statement that the principle of common interest is important (to the two principles of justice and ruled by the difference principle) when distributive effects are "immaterial or irrelevant" (Rawls, 1971:97). How can two different governing principles--the difference principle and the principle of the common interest--be used from the same starting standpoint--that of the least advantaged representative citizen? This relates back to the point that, even when the principle of the common interest is invoked, the results may be of unequal benefit to the citizens. Even if this representative person in this instance benefits the most by the application of the principle of the common interest, the difference principle is already satisfied. Rawls implies this when he (1971:97) states that as long as social or economic policies are just, this condition (the principle of the common interest) can be applied. By singling out the least advantaged and furthering their aims and prospects distributive justice does seem to be assumed.

Furthermore, this is not inconsistent with the connection to the thin theory of the good. One of Rawls' uses for the thin theory is "to define the least favored members of society. The difference principle assumes that this can be done" (Rawls, 1971:396). By linking the least

advantaged representative citizen into both the thin theory of the good and the difference principle, the principle of the common interest assumes a significant role in Rawls' theory of justice. This is especially significant in that the difference principle maintains a direct link to the common interest through the use of the standpoint of the least advantaged representative citizen. In speaking of the common interest as a political convention of a democratic society--and by the link between the difference principle and the principle of the common interest through the least advantaged representative citizen--Rawls ends by stating:

> The difference principle can therefore be interpreted as a reasonable extension of the political convention of a democracy once we face up to the necessity of adopting a reasonably complete conception of justice. (1971:319)

Thus the principle of the common interest is used from the standpoint of the least advantaged representative person in a manner which is consistent with the thin theory of the good as well as not being inconsistent with the notion that distributive effects are immaterial or irrelevant in this application.

There does, however, seem to be one more problem in applying the principle of the common interest from the standpoint of the least advantaged representative person. The problem is this: Can using this standpoint be

consistent with the definition of the principle which states that the "institutions are ranked . . . by how efficiently they advance shared ends that will similarly benefit everyone" (Rawls, 1971:97)? Although Rawls does not discuss this, I believe that the connection with the difference principle allows for such a consistency. A major point concerning this principle is made by Rawls (1971:76-77) as follows:

> No matter how much either person's situation is improved, there is no gain from the standpoint of the difference principle unless the other gains also.
> . . . . . .
> . . . It is no longer a matter of shuffling about a fixed stock of goods. Also, nothing is lost if an accurate interpersonal comparison of benefits is impossible. It suffices that the least favored person can be identified and his rational preference determined.

In other words, the difference principle assumes that everyone will gain, and that because of this, the standpoint of the least advantaged citizen can be taken. The cut-off at the point of no gain or loss within the parameters of the difference principle--and the use of the standpoint of the least advantaged here--allows the principle of the common interest (again from the standpoint of the least advantaged) to advance those shared ends. Hence the use of the standpoint of the least advantaged enhances the consistency of Rawls' definition of the principle of the common interest.

An example from an issue concerning public health may more clearly show how the standpoint of the least advantaged is consistent with both the difference principle and the principle of the common interest. Immunization against contagious diseases is important if epidemics are to be avoided. A good case in point is polio. New cases of polio were almost non-existent after the development of the vaccine. Health officials note that if enough people are immunized, there is an "umbrella" effect which spreads over those who, for one reason or another, have not been vaccinated. Part of the success in nearly eliminating polio was the dispensing of the vaccination in the schools. After a number of years, however, parents were expected to provide this health care for their children before their children entered the school system. Many parents did not do so. As a result, new cases of polio recently started showing up among children in Arkansas, among other places. (This was reported on CNN Network's Health Watch in July, 1982.)

Now if this were a Rawlsian society, there would probably be a public health program which is concerned with immunizations against contagious diseases. Vaccinations would be available to everyone at no cost since the aim is to have all members of society innoculated. (Payments would possibly be a factor which contributes to

non-participation in the program by those who are least able to pay, i.e., the least advantaged members of society. Hence, the government would provide the vaccinations free to all members of society.) Obviously, this would benefit the least advantaged members of society the most. Even if they were responsible for getting their children vaccinated prior to entering the school system, they would be able to do so without bearing the cost for those vaccinations. A major stumbling block in achieving the "umbrella effect" in immunization would be thus eliminated. The difference principle would be satisfied. The poor people would not bear the additional burden of being at risk for epidemics of communicable diseases. The principle of the common interest rules in cases of public health, according to Rawls (1971:97). Such a public health policy would be under its dominion. Yet it shares the standpoint of the least advantaged representative person with the difference principle--i.e., it is compatible with the difference principle. The shared ends of the society (in this case, achieving the "umbrella effect" in controlling communicable diseases) are advanced. In cases like this, then, the use of the standpoint of the least advantaged person enhances the consistency of Rawls' definition of the principle of the common interest.

In concluding this section, a brief review of Rawls'

concept of the principle of the common interest is worthwhile. This section has dealt only with Rawls' explicit references to this principle. Even in this quick analysis, however, this principle has been shown to be harmonious with the difference principle. In fact, the two principles interact upon one another directly. Furthermore, the definition as well as the context of the principle of the common interest has been shown to operate within the publicity criterion of the moral point of view. Further investigation would probably show that all criteria are applicable, I believe, but the important criterion to be fulfilled is the publicity criterion because of the very nature of this principle. Another aspect which this principle displays is its inherent compatibility with Rawls' use of contract theory. In fact, no contract theory could function effectively without a principle of this type. Finally, the principle of the common interest shares many of the features of the thin theory of the good by definition. In fact, both the principle of the common interest and the thin theory of the good seem to be incomplete if taken alone, since they share so many mutual characteristics. Because of these major pervasive aspects, the principle of the common interest would seem to be a very important factor in the congruence between

the right and the good. This is, in fact, the subject of the next part of this discussion.

B. The Role of the Principle of the Common Interest and the Congruence of the Right and the Good in Rawls' Theory

In this section two particular aspects of congruence will be discussed. First of all, since the principle of the common interest is an institutional principle--i.e., it is one according to which institutions are ranked or judged--the congruence between the right and good in terms of the social union will be investigated. Then, since the thin theory of the good plays a role through the representative equal citizen who makes the judgment, the congruence of the right and the good will also be investigated from this point of view. In neither case does Rawls refer to the principle of the common interest. However, given its already pervasive role in his theory of justice, I believe that a case can be made that the principle of the common interest plays a central part in the congruence between the right and the good.

1. Congruence Between the Right And The Good.

In the last chapter of his book, Rawls devotes a complete section to the congruence of the right and the good concerning the well-ordered society and its institutions. He claims that the principles of justice and the contract doctrine form a society that can claim unity within

diversity. The original position is the vehicle by which persons behind the veil of ignorance choose the society that provides for autonomy and objectivity.

> The veil of ignorance prevents us from shaping our moral view to accord with our own particular attachments and interests. We do not look at the social order from our situation but take up a point of view that everyone can adopt on an equal footing. In this sense . . . we share a common standpoint along with others and do not make our judgment from a personal slant. . . . The acceptance of the principles of right and justice forges the bonds of civic friendship and establishes the basis of comity amidst the disparities that persist. (Rawls, 1971:517)

This background view of a well-ordered society provides a point of comparison with the concept of a private society in which "each person assesses social arrangements solely as a means to his private aims" (Rawls, 1971:521). Although Rawls admits that such a society can be just, he maintains that this type of society would not be one which is congruent with the theory of justice delineated through the original position. Certainly such a society would not be consistent with the principle of the common interest which is inherent in Rawls' use of the contract doctrine. The standpoint of the representative equal citizen denies those particular aims which are the focus of a private society; on the other hand, this standpoint enhances those aims which are common to all. Rawls (1971:522-523) states this in another way.

> Thus human beings have in fact shared final ends, and they value their common institutions and activities as goods in themselves. We need one another as partners in ways of life that are engaged in for their own sake, and the successes and enjoyments of others are necessary for and complimentary to our own good.

Furthermore, since this representative person values those institutions, it is in the common interest to rank and judge them to assure their continued effectiveness (as well as justice) in their particular role. The social union can operate only through this shared conception of ends which the principle of the common interest guarantees in the institutional setting.

Rawls (1971:527) maintains "that a well ordered society (corresponding to justice as fairness) is itself a form of social union. Indeed it is a social union of social unions." He maintains that this society has both characteristic features of a social union--the shared final end and the fact that the institutions are valued as good in themselves (Rawls, 1971:527). The common interest as a regulative function plays an important role here since everyone would have an effective sense of justice.

> Each citizen wants everyone (including himself) to act from principles to which all would agree in an initial situation of equality. This desire is regulative, as the condition of finality on moral principles requires; and when everyone acts justly, all find satisfaction in the very same thing. (Rawls, 1971:527)

Two points are relevant here. Both tie Rawls' statement

to the principle of the common interest. First of all, there is a strong implication that the principle of the common interest is being applied to the phrase, "the desire is regulative," since the principle is a regulative one for institutions as well as being regulative concerning its operations on the principles of justice themselves (e.g., liberty, as discussed earlier). Secondly, another criterion of the moral point of view--finality--is explicitly referred to in this connection. In other words, the regulative function of the principle of the common interest is an expression of the finality criterion.

Before turning to the congruence of the right and the good, one point should be made regarding the shared final ends of Rawls' conception of a social union. Shared final ends are not dominant ends--a dominant end being considered one that is a controlling end. Rawls states this explicitly at least twice.

> But this larger plan does not establish a dominant end, such as that of religious unity . . . much less national power and prestige, to which the aims of all individuals are subordinate. The regulative public intention is rather that the constitutional order should realize the principles of justice. And this collective activity . . . must be experienced as a good. (Rawls, 1971:528)
>
> . . . . . .
>
> It may be thought that once the principles of justice are given precedence, then there is a dominant end that organizes our life after all. . . . But it is the principles of individual

> duty and obligation that define the claim of this ideal upon persons and these do not make it all controlling. . . . The principles of justice . . . represent more or less definite social aims and restrictions. . . . Once we realize a certain structure of institutions, we are at liberty to determine and to pursue our good within the limits which its arrangements allow. (Rawls, 1971:565-566)

Again, the principle of the common interest seems to play a role in keeping justice as fairness from assuming a dominant end theory. The regulative function of this principle helps to realize the principles of justice. Furthermore, its function as a limit on these principles allows one the liberty to pursue one's own aims within the society.

This last point leads to the congruence between the right and the good in a well-ordered society. According to Rawls (1971:396), the right is prior to the good. Certainly the thin theory of the good which delineates the social primary goods provides a rational basis for determining the structure of society. The thin theory will also play a prominent role in the final, individual determination of congruence. Yet Rawls, by separating the thin theory from the full theory of the good, allows for the priority of right over good--and the development of the full theory in light of the principles of right. This is reflected in a Rawlsian well-ordered society. The principles of justice lead to the richness and diversity

which form the good of the well-ordered society. To repeat Rawls' (1971:566) point:

> Once we realize a certain structure of institutions, we are at liberty to determine and to pursue our good within the limits which its arrangements allow.

In the last section, the point was made that the regulative function of the principle of the common interest allows for the limitation of a too-extensive liberty for some so that the greater liberty of all can be realized. Once this liberty is realized the good of individuals can be pursued. This principle thus plays an important role in the realization not only of the principles of justice but also indirectly allows the members of society to pursue their own good within the limitations of justice.

> The essential thing is that there be a shared final end and accepted ways of advancing it which allows for the public recognition of the attainments of everyone. When this end is achieved, all find satisfaction in the very same thing; and this fact together with the complementary nature of the good of individuals affirms the tie of community. (Rawls, 1971:526, emphasis added.)

Thus the principle of the common interest plays a vital role in the congruence of the right and the good in a well-ordered society in Rawls' scheme.

2. Congruence between the Right and the Good and the Representative Equal Citizen. The link between the principle of the common interest and the thin theory of the good through the representative equal citizen provides the

connection for this principle to operate in the final test of congruence in Rawls' theory of justice. As Rawls (1971:567) points out:

> The concepts of justice and goodness are linked with distinct principles and the question of congruence is whether these two families of criteria fit together.

Again, Rawls only indirectly refers to the principle of the common interest in that he refers to its regulative function. He wants to test congruence by using the thin theory of the good--"with no restrictions on information"--to see if "the regulative desire to adopt the standpoint of justice belongs to a person's own good" (Rawls, 1971:567). Rawls wants to know if the desire is rational--"being rational for one it is rational for all and therefore no tendencies to instability exist" (1971:567). In order to examine this issue of congruence, Rawls must use his representative equal citizen. Along with the first ground for congruence--that "the principles of justice are public" (Rawls, 1971:570) as provided for in the contract doctrine and that "there is a connection between acting justly and natural attitudes" (Rawls, 1971:570)--Rawls shows that a representative equal citizen has natural ties to friends and associations through the content of justice and the laws of moral psychology. One must also remember that this individual is in a well-ordered society. Hence Rawls maintains that

> these bonds extend rather widely and include ties to institutional forms. . . . Thus in a well ordered society where effective bonds are extensive both to persons and to social forms, . . . there are strong grounds for preserving one's sense of justice. (Rawls, 1971:571)

To do otherwise than support the society would hurt those close to this individual as well as those s/he knows nothing about. It is in the interest of this person--in the common interest since this is also determined by this representative citizen--to preserve and support the principles of justice. Thus the common interest enhances the good of the representative equal citizen. The first ground of congruence is satisfied and the principle of the common interest plays a supportive role in doing this.

The second ground of congruence is stated by Rawls (1971:571) in the following manner:

> it follows from the Aristotelian Principle (and its companion effect) that participating in the life of a well-ordered society is a great good.

Rawls defines the Aristotelian Principle as follows:

> [O]ther things equal, human beings enjoy the exercise of their realized capacities (their innate or trained abilities), and this enjoyment increases the more the capacity is realized, or the greater its complexity. . . . [H]uman beings take more pleasure in doing something as they become more proficient at it, and of two activities they do equally well, they prefer the one calling on a larger repertoire of more intricate and subtle discriminations. (Rawls, 1971:426)

For Rawls, the Aristotelian Principle is inherent in the idea of a social union. Because of the features of a

social union--the enhancement of richness and diversity--possessed by a well-ordered society, Rawls points out that it is necessary to "acknowledge the principles of its regulative conception. . . . [W]e must affirm our sentiment of justice" (Rawls, 1971:571). Rawls (1971:571) further claims that "it is this general affirmation which extends the ties of identification over the whole community and permits the Aristotelian Principle to have its wider effect." Given the previous discussion of the social union itself and the regulative role of the principle of the common interest, the second ground of congruence--the enrichment of richness and diversity embodied in the Aristotelian Principle--is enhanced by the regulative role of the principle of the common interest. Its role is small but important in establishing the grounds for congruence between the right and the good.

The final ground for congruence is involved in Rawls' Kantian interpretation: "acting justly is something we want to do as free and equal beings" (Rawls, 1971:572). There is little room for the role of the principle of the common interest here except in the very protection of the moral autonomy of the representative equal citizen from the institutions of society. The principle of the common interest sets limits on liberty so that all can pursue their nature as free and autonomous beings. It is a

rational goal that all would desire in a well-ordered society. But the principle of the common interest functions in a manner that assures others that their aim of autonomy is not thwarted by those who would demand more. Rawls (1971:574) states this indirectly:

> But the desire to express our nature as a free and equal rational being can be fulfilled only by acting on the principles of right and justice as having first priority. This is a consequence of the condition of finality: since these principles are regulative, the desire to act upon them is satisfied only to the extent that it is likewise regulative to other desires.

Because of this Rawls maintains that the sense of justice cannot be balanced with other desires. The good follows from the right; it is not separate from nor is it equal with the right. Rational aims determine this to be so. The principle of the common interest guarantees the pursuit of these aims through the relevant institutions. This is its primary role and provides assurances to the other members of society that their own rational aims will not be thwarted.

Rawls admits that adherance to this sense of justice cannot always be guaranteed by the congruence of the right and the good. There are some persons, because of their aims and particular natures, who would not agree that the grounds for congruence provided sufficient reason to adhere to the principles of right and justice. He also

admits that the persons in the original position would want assurance that the activities of these persons would not destabilize a well-ordered society. Rawls claims that egoism would be rejected and that constraints would be put on those persons who did not wish to adhere to the principles chosen. Again, Rawls indirectly refers to the principle of the common interest. Rawls states that

> the principles of right and justice are collectively rational; and it is in the interest of each that everyone else should comply with just arrangements. . . . Thus in agreeing to penalties that stabilize a scheme of cooperation the parties accept the same kind of constraint on self-interest that they acknowledge in choosing the principles of justice in the first place. (Rawls, 1971:576)

Rawls is certainly appealing to the principle of the common interest here. He is, in fact, appealing to all of the important aspects and functions of this principle.

The principle of the common interest has an important role in supplying stability to the social order when congruence fails to influence certain individuals. In fact, the principle of the common interest supplies the stabilizing back-up of the congruence of the right and the good. It functions within each ground of congruence so that a sense of justice can be maintained consistently with the thin theory of the good. More importantly, it provides the necessary assurance to the representative equal citizen of a well-ordered society that it is to the

person's own good to develop and adhere to one's sense of justice and to the principles of right and justice.

The principle of the common interest has been shown to have an important function in Rawls' conception of the congruence of the right and the good. Rawls, however, does not explicitly make these connections. In the next section, we will see that Rawls does explicitly connect the principle of the common interest to the notion of public goods.

C. The Principle of the Common Interest and Public Goods

Rawls, in his discussion of the principle of the common interest, designates it as being appropriate when "distributive effects are immaterial, or irrelevant" (Rawls, 1971:97). In fact this principle is defined in its institutional role whereby public goods are allocated. The principle is defined by Rawls as follows:

> [I]nstitutions are ranked by how effectively they guarantee the conditions necessary for all equally to further their aims, or by how effectively they advance shared ends that will similarly benefit everyone. Thus reasonable regulations to maintain public order and security, or efficient measures for public health and safety, promote the common interest in this sense. (Rawls, 1971:97)

Public goods as defined by Rawls must then be ruled by the principle of the common interest. Rawls (1971:266) defines public goods as having

> two characteristic features, indivisibility and

> publicness. That is, there are many individuals, a public so to speak, who want more or less of this good, but if they are to enjoy it at all must each enjoy the same amount. The quantity produced cannot be divided up as private goods can and purchased by individuals according to their preferences for more or less.

The two characteristics, indivisibility and publicness, of public goods tie this concept to the principle of the common interest in that the shared ends of all are similarly benefitted--one of the institutional roles of the principle of the common interest. This is also verified in Rawls' statement regarding public goods (specificially, here, the polar case: defense against foreign attack):

> All citizens must be provided with this good in the same amount; they cannot be given varying protection depending on their wishes. The consequence of indivisibility and publicness in these cases is that the provision of public goods must be arranged for through the political process and not through the market. Both the amount to be produced and its financing need to be worked out by legislation. Since there is no problem of distribution in the sense that all citizens receive the same quantity, distribution costs are zero. (Rawls, 1971:266-267)

Although Rawls does not specifically name the principle of the common interest here, he does appeal to the characteristics defining its role--i.e., the notion of equally shared ends being advanced equally, the fact that there is not a distribution problem, and the fact that it is an institutional problem, not a marketplace problem. Thus, the issue of public goods in Rawls' theory is ruled by the principle of the common interest.

The two characteristics of public goods have inherent problems according to Rawls--isolation and assurance.

> The first sort of problem arises whenever the outcome of the many individuals' decisions made in isolation is worse for everyone than some other course of action, even though, taking the conduct of the others as given, each person's decision is perfectly rational. . . . The isolation problem is to identify these situations and to ascertain the binding collective undertaking that would be best from the standpoint of all. The assurance problem is different. Here the aim is to assure the cooperating parties that the common agreement is being carried out. . . . Therefore to maintain public confidence in the scheme that is superior from everyone's point of view, or better anyway than the situation that would obtain in its absence, some device for administering fines and penalties must be established. (Rawls, 1971:269-270)

A good example of both problems here is again that of immunization against contagious diseases. It is a well-known fact that, when a majority of persons are immunized from a contagious disease like polio, there is a resulting "umbrella effect" protecting non-immunized people. In this case, the isolation problem would have an effect. It may be rational, in isolation, not to be immunized. The problem here is that when too many people make such a decision, the umbrella effect is destroyed and outbreaks of polio occur. Hence, assurance is needed here that a policy of enforced immunization be delineated. "Each person's willingness to contribute is contingent upon the contribution of others" (Rawls, 1971:270). It must be

shown to the general public that compliance is a public good--to eliminate the isolation problem. Furthermore the policy of immunization must be enforced. Fines and other penalties must be enforced for those who do not comply with the policy regarding total immunization of the public from this (and other) communicable disease(s).

This example also shows that there are public goods in the health-care arena. Public health, immunology, sanitation, environmental policies regarding clean air and water as well as toxic waste treatment on land are obvious health-care issues that would be considered public goods in Rawls' scheme. Certain types of research--like resarch on health problems affecting the general public (e.g., control of communicable diseases, nutrition, etc.) are also public goods rather than distributional goods. It could be argued that other types of health-care research areas like genetic research, artificial heart research, in vitro fertilization, or research into diseases like diabetes are distributional goods rather than public goods. These areas of research are targeted at specific groups of people--people whose health problems are not "universal" to the population. The basic point, however, is that public goods--at least in a well-ordered society--will be regulated by the institutions which are governed by the principle of the common interest.

D. Some Problems in Using the Principle of the Common Interest for Health-Care Issues

There is, as has just been shown, a legitimate use of the principle of the common interest interest in health care. When the health-care issue is a public good--one that concerns all persons equally--then the principle of the common interest is the legitimate one to use in applying Rawls' theory to health-care issues. The problem in Rawls is that he seems to relegate all health-care issues to the principle of the common interest--or worse, completely to the private citizen's area of responsibility. In directly appealing to the principle of the common interest, Rawls states that institutions must develop regulations "to maintain public order and security, or efficient measures for public health and safety," . . . (Rawls, 1971:97). In discussing public goods, he extends the range of health concerns beyond public health.

> There are public goods of many kinds, ranging from military equipment to health services. Having agreed politically to allocate and to finance these items, the government may purchase them from the private sector or from publicly owned firms. The particular list of public goods produced and the procedures taken to limit public harms depend upon the society in question. It is a question not of institutional logic but of political sociology, including under this heading the way in which institutions affect the balance of political advantages. (Rawls, 1971:270)

The ambiguity here is related to the fact that Rawls considers health a natural primary good as opposed to a social primary good. As such, health-care issues are not to be determined directly by the principles of justice. To reiterate Rawls' position on health as a good:

> Other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure, they are not so directly under its control. (Rawls, 1971:92)

On the other hand, in dealing with primary social goods, Rawls discusses the indexing problem with regard to their distribution. Serial ordering gives priority to liberty.

> The fundamental liberties are always equal, and there is fair equality of opportunity: one does not need to balance these liberties and rights against other values. The primary social goods that vary in their distribution are the powers and prerogatives of authority, and income and wealth. But the differences are not so great as they might seem at first because of the nature of the difference principle. The only index problem that concerns us is that for the least advantaged group. The primary goods enjoyed by other representative individuals are adjusted to raise this index, subject of course to the usual constraints. . . . The index problem largely reduces, then, to that of weighting primary goods for the least advantaged, for those with the least authority and the lowest income, since these also tend to be associated. (Rawls, 1971:93-94)

Health, since it is not a social primary good, would not be one of those goods thus considered distributionally.

This is a major problem for a pure Rawlsian theory of health-care delivery. It is obvious that the principle of

the common interest is appropriate for only a small number of health-care issues--those health-care issues that affect all persons equally. Issues like access to the health-care delivery system, research on health problems that affect only some persons, scarce resources in health-care delivery do not affect everyone equally. The rich and powerful can afford health care. The middle class, through some form of third-party payment or pre-paid plans can afford health care. These people have access to the health-care delivery system. The poor--the least advantaged persons--do not have access unless the government or some other institution intervenes. They simply cannot afford to bear the brunt of health-care costs; some cannot even afford the premiums which would enroll them into a third-party system of health care delivery. Issues like these are not allocational problems. They are distributional problems.

As it stands, Rawls' theory does not allow for these kinds of distinctions. Distributional health-care issues can only be handled in a limited number of ways.

1. The first way seems to be Rawls' way. Health care is a public good. It therefore is regulated by the institutions designed to fulfil the role of the principle of the common interest. The problem here has already been pointed out. There are

distributional issues in health care. The principle of the common interest does not, on the face of it, seem to cover these issues. My analysis of this principle can lead to no other conclusion. Hence Rawls' unmodified theory does not effectively handle distributional issues in health-care delivery, and is ineffective in designating all health-care issues as public goods.

2. The second way of solving the problem in a pure Rawlsian way is to be consistent in accepting that only certain health-care issues are allocational and fall under the umbrella of the principle of the common interest. However, since health is not a social primary good, distributional issues in health care must be converted to issues of lack of opportunity. Since opportunity is a social primary good, this may be a viable option. However, expanding opportunity beyond Rawls' purposes may do violence to the other social primary goods.
3. A third option would be to agree that health is not a social primary good, and that distributional issues in health-care delivery are not second principle concerns. Hence these health care issues are the responsibility of the individual citizens of society. Although I do not wish to

develop a complete argument here, it is my opinion that this option flies in the face of Rawls' intentions in developing his theory of justice. The least advantaged members of a society--a hypothetical well-ordered society as well as an existing society--are the focal point in Rawls' theory of justice. To deny them access to the health-care delivery system because of their lack of ablity to pay seems utterly inconsistent with Rawls' theory. It certainly devalues what Rawls calls the worth of liberty. At the very least it would destabilize a society if only the privileged few were allowed access to the health-care delivery system because only they were able to pay. If Rawls' idea of a minimum income were used--a minimum income which included provisions for health-care issues--it might account for some health care needs. However, it would be very cumbersome if the scheme were to account for chronic and degenerative conditions which ultimately are more expensive. This option, as it stands, seems to be too problematical to be viable for use in a Rawlsian theory of health-care delivery.

4. A fourth option would be a modification of Rawls'

theory which would include health as a social primary good and health care as a right under the second principle of justice. On the face of it, this option may be acceptable. It allows the distinction between allocational and distributional concerns in the health-care delivery system. As a result, issues like access to the health-care delivery system would be considered distributional issues which are ruled by the second principle of justice. This option also allows for the continued appropriate application of the principle of the common interest where health-care issues are allocational like public health--i.e., issues of public goods. Furthermore, this option, at first glance, seems ultimately more consistent with Rawls' theory than the other three options. It does not use the principle of the common intrest inconsistently, nor does it give priority to a single aspect of what should be a group of second principle considerations, i.e., the social primary goods (except liberty which belongs to the first principle of justice). Finally, it will be shown that this modification of Rawls' theory of justice allows for consistent use of the theory not only in setting up an analysis of health-care issues in

an ideal well-ordered society, but also for judging existing systems of health-care delivery in terms of their degrees of justice.

The first option is somewhat expanded upon in the next section of this chapter. Option two is the topic of Section II of the Chapter IV. Option three is not viable, thus will not be further discussed. Option four, on the other hand, is the main subject of this essay. It will be fully discussed starting with Section III of Chapter IV with Green's modifications. In Chapter V and continuing throughout the rest of this essay, my own modifications and applications of Rawls' theory will continue the discussion of option four.

III. HEALTH-CARE CONSIDERATIONS USING THE PRINCIPLE OF THE COMMON INTEREST: METHODS AND INSTITUTIONS

There are health-care considerations which are obviously governed by the principle of the common interest. The salient characteristics of this principle which governs public goods are indivisibility and publicness. Although the list of health-care considerations that are public goods is incomplete, it includes public health concerns, immunology programs, research aimed at containing or eliminating communicable diseases, sanitation and some environmental concerns. Each of these

health care issues can be shown to be public goods. They are the concern of everyone, and policies and procedures governing these issues affect everyone.

An example of this point is the environmental issue. Everyone would like to have clean air, water or have toxic wastes already in the environment cleaned up (or at least they would not like to be negatively affected by living in a polluted area). Air pollution is not a local issue. Pollution is carried by winds and the jet stream. Extreme examples include the wide-spread effects of volcanic eruptions. Water pollution is carried down streams and rivers and affects locales which do not in themselves contribute to water pollution. Acid rain affects locales far-removed from the source of pollution. In these respects, environmental problems affect everyone--they are public goods. Furthermore, they are indivisible. One cannot completely escape polluted air, water or land affected by toxic wastes if the society in general does not have environmental regulations. On the other hand, each person benefits by the delineation and enforcement of such regulations.

Immunology has already been discussed in terms of isolation and assurance. That discussion leads to the conclusion that immunology programs are also public goods in that the programs are public--no one wants to be

involved in an epidemic, and everyone (even non-compliers if there are few enough of them) benefits equally by the immunology programs and their enforcement (i.e., indivisibility).

Another public health example concerns public health regulations covering those who handle food for public consumption. Unless one is so isolated from the community that s/he is entirely self-sufficient in gathering, growing, storing, and consuming food, all members of the community benefit from these regulations. Given the diseases that can be transmitted by food handlers, everyone wants good regulations and enforcement covering those who do handle food.

Similar examples can be given for all of the health-care concerns listed above. There may be other health-care issues that qualify as public goods. The task here is not to identify all of them. If a health-care issue qualifies as a public good, then the following discussion shall apply to it.

Allocative issues in health care are ruled by the principle of the common interest with its criteria of publicness and indivisibility. The next consideration is the appropriate stage for determining the institutions and regulations to be set up in a well-ordered society. Although Rawls' four stage sequence is primarily

established to determine the appropriate place for determining the principles of justice, it is also his device for the appropriate determination of the institutions of that society. The discussion in Chapter II determined that the legislative stage was appropriate for the determination of distributive goods and the institutions that administer those distributions. It is this stage that is used for developing the background institutions that are a part of the well-ordered society. Although Rawls does not confront this issue regarding the principle of the common interest directly, he does state the following in terms of public goods which are regulated by that principle.

> The consequence of indivisibility and publicness in these cases is that the provision of public goods must be arranged for through the political process and not through the market. Both the amount to be produced and its financing need to be worked out by legislation. (Rawls, 1971:267)

If Rawls is not using the term "legislation" in an equivocal manner, then the legislative stage appears to be the appropriate place for the determination of the issues regulated by the principle of the common interest.

However, Rawls also considers a possible fifth branch in his scheme of background institutions--the exchange branch which is concerned with public goods. Rawls seems to make this a legislative stage concern in his discussion.

It is authorized by the constitution to consider

> only such bills as provide for government activities independent from what justice requires, and these are to be enacted only when they satisfy Wicksell's unanimity criterion [Wicksell, Finanztheoretische (Jena, 1896)]. This means that no public expenditures are voted upon unless at the same time the means of covering their costs are agreed upon, if not unanimously, then approximately so. A motion proposing a new public activity is required to contain one or more alternative arrangements for sharing the costs. (Rawls, 1971:282, bracketed reference added.)

This branch, however, is not, strictly speaking, part of the legislative stage because of the restrictions of the veil of ignorance at that stage. Rawls' definition of public goods leads into this problem:

> If a sufficiently large number of them find the marginal benefits of public goods greater than that of goods available through the market, it is appropriate that ways should be found for government to provide them. (Rawls, 1971:282)

The problem here is that particular interests are involved--interests that violate the veil of ignorance needed at the legislative stage.

> Since the conception of background institutions is to help us organize our considered judgments of justice, the veil of ignorance applies to the legislative stage. The exchange branch is only a trading arangement. There are no restrictions upon information (except those required to make the scheme more efficient), since it depends upon citizens' knowing their relative valuations of public and private goods. We should also observe that in the exchange branch representatives (and citizens through their representatives) are quite properly guided by their interests. . . . Ideal legislators do not vote their interests. (Rawls, 1971:283-284)

In other words, Rawls maintains that public goods are

benefits, not issues of justice. Thus it appears that there are two kinds of governmental activities--activities that deal with issues of justice and activities that deal with benefits. To be sure, Rawls only invokes the principle of the common interest when distributional effects are not involved, and common benefits or goods are involved. Yet Rawls admits that the distinction here can be somewhat muddy.

> To be sure, it is often hard to distinguish between the two kinds of government activities, and some public goods may appear to fall into both categories. (Rawls, 1971:284)

Even with this admission, strictly speaking, the use of the legislative branch for allocational health-care issues seems, on the face of it, to be ultimately inappropriate for the application of the principle of the common interest.

The following methodology, on the other hand, seems to be appropriate for application of the principle of the common interest. If the issue being faced is one of liberty, then application of the principle of the common interest is a constitutional stage concern. Rawls seems to be clear on this point when he states:

> One type of situation is that involving a less extensive liberty. Since there are no inequalities, but all are to have a narrower rather than a wider freedom, the question can be assessed from the perspective of the representative equal citizen. To appeal to the

> interests of this representative man in applying the principles of justice is to invoke the principle of the common interest. (Rawls, 1971:246)

Perhaps some public health issues are appropriate here. When regulations are necessary to protect public health--like mass immunization programs, one's liberty to be non-compliant can be limited. In fact, Rawls even justifies coercion regarding public goods.

> Assuming that the public good is to everyone's advantage, and one that all would agree to arrange for, the use of coercion is perfectly rational from each man's point of view. Many of the traditional activities of government, insofar as they can be justified, can be accounted for in this way. The need for the enforcement of rules by the state will still exist even when everyone is moved by the same sense of justice. The characteristic features of essential public goods necessitate collective agreements, and firm assurance must be given to all that they will be honored. (Rawls, 1971:267-268)

If coercion is justified regarding public goods, then the use of the principle of the common interest--and the concomitant coercion that may be needed regarding less extensive liberty--can certainly be justified as well.

In considering the appropriate stage for determination of the institutions and regulations of public goods, it seems apparent that only the fourth stage--the judicial and administrative stage--of the four-stage sequence can be used. Here there no constraints on the veil of ignorance, and nothing (other than the limitations set by the three previous stages) limits pursuing one's

interests. The standpoint of the representative equal citizen can be used here without inconsistency. Certain public goods may be considered more important than others, and as such, they will receive priority because of the public's more urgent concerns. Thus while distribution of goods is a legislative stage consideration, public goods generally are judicial/administrative stage concerns. As a result, most, if not all, health-care issues that are considered public goods would be considered in the fourth stage of the four-stage sequence.

These deliberations do lead to an interesting consequence, however. Suppose that the distributional issues like just access were accounted for in a society without socialized medicine. However, people came to the conclusion that universal health care would be a public good. Then, rather than just access to the health-care delivery system, arrangements were made through the exchange branch to institute such a system. As a result, socialized medicine could be instituted as a policy. A society could still institute such a system even if, in fact, socialized medicine is not the only just system of health-care delivery. However, it would be one which goes beyond the principles of justice to an institution which equally benefits all members of a society. In fact, strict adherence to Rawls' theory of justice as he delineates it

might demand such a move. The discussion of the problems of Rawls' theory as it stands seems to demand this since denial of access to the health-care delivery system--because of the inabilty to pay for health services--seems inconsistent with Rawls' theory as it stands. To avoid problems of instability which would arise without a just health-care delivery system, the provision of universal care would tend to be the stabilizing solution.

Leaving these considerations aside, the application of the exchange branch must be further developed. Rawls bases much of his deliberations here on Wicksell's unanimity criterion (which has been delineated on p. 100). This criterion is one of efficiency "and institutes, in effect, a special trading body that arranges for public goods and services where the market mechanism breaks down" (Rawls, 1971:283). Furthermore, the unanimity criterion has a special use. Only when justice is provided for can this criterion be used. Since public goods are considered benefits, the unanimity criterion demands that expenditures be accounted for by the agreement--the approximately unanimous agreement--that taxes can be raised and agreed upon to cover the additional expenditures.

> The size of the exchange budget, as distinct from the national budget, is then determined by the expenditures that are eventually accepted. In theory members of the community can get together to purchase public goods up to the

> point where their marginal value equals that of private goods. (Rawls, 1971:283)

Hence it would seem that the government would have two budgets--the national budget and the exchange budget (which must be balanced by appropriated taxes for each public good).

Issues of health care which are considered as public goods must then be agreed upon by the citizens of the community. They must then determine the taxes (with appropriate alternatives specified) which pay for each program they desire and they must agree to them unanimously (or nearly so). If the unanimity criterion is satisfied, the budget for instituting the program must be a balanced one. As a result, the institutions and regulations as well as the enforcement of the regulations for public goods in health care may be only minimally financed and limited in scope. The more the public sees an issue of health care as an urgently needed public good, the more it must be willing to tax itself to pay for that good. Hence some programs or even parts of programs may be perceived as more urgent than others. In the face of a yearly polio epidemic, for example, the public may wish to give polio research priority. Regulations may be put into effect regarding the community's mobility and the meeting of citizens in public places during outbreaks of the disease. Once an effective immunization program has been

delineated, mass, enforced immunization programs may be put into effect with penalties enforced for non-compliance. Yet once there is an immunization program, research funds (those dealing with cure and care of victims, for example, or for even better vaccines) may be cut back and regulations regarding mobility and meeting in public places may be rescinded. Only continued immunization provisions and policies may be continued to be funded and enforced. Since the exchange branch is not a distributional branch (i.e., a matter of justice), such fluidity in the existence of institutions and regulations is not of special concern. The particular interests of a community may change, and the taxation in the exchange branch is only justified when it is unanimously agreed upon. As concern wanes in a particular area, it is only efficient to dismantle those programs that are of less benefit or urgency to the community.

Health-care issues that affect the society as a whole are usually considered as important in the society. In more affluent societies where technology is developed and where there is a relatively high standard of living, it would be likely that public health concerns, immunization programs, research on the containment or elimination of contagious diseases, sanitation policies and environmental policies would be deemed important enough to be funded by

taxation and regulations concerning them enforced. Yet in economically troubled times, since these issues are Rawlsian public goods, citizens' priorities may change and the programs they choose may be restricted. In a Rawlsian society, since health-care issues are public goods and not matters of justice, the deliberations of the community through the exchange branch are the only appropriate mode for determining such issues. As a result, the fourth stage of Rawls' four-stage sequence rather than the third stage--the legislative stage--is the governing stage. There is a difference, then, between allocative goods and distributive goods in Rawls' theory. Distributive goods in a possible health-care delivery system are a matter of justice to be determined at the legislative stage; allocative or public goods in health-care delivery systems are fourth stage concerns and are treated as benefits rather than rights due citizens in a well-ordered society.

In conclusion, the principle of the common interest has a pervasive role in Rawls' theory of justice. It is appropriately applied only when distributive concerns are no longer relevant. It plays a role in enhancing public health and safety. The regulations delineated affect first principle concerns when a more extensive liberty threatens the liberty of all. This principle is also important in the congruence of the right and the good in

Rawls' theory. Concerning public goods, the principle of the common interest is also applicable. Its application provides for assurance that all will comply with the regulations set up regarding public goods. Yet in terms of health-care issues, it only concerns allocative health-care issues--like public health, immunology, etc. The application here is provided for by Rawls' conception of an exchange branch governed by a unanimity criterion and supported by a system of taxation that demands a balanced budget and unanimous agreement on the method and amount of taxation. Furthermore, these issues, being benefits rather than issues of justice are not concerns of the legislative stage--they are the appropriate concerns of the judicial/administrative stage of Rawls' four-stage sequence. Finally allocative health-care considerations, since they are benefits, are given priority only by the consent of the citizens. (This priority is relative, however; there is no priority here to distributional issues--the issues of justice.) The unanimity criterion is consistent with the standpoint of the representative equal citizen which is the appropriate one for the principle of the common interest. In health care, then, the principle of the common interest is important but limited to public goods. In Rawls' theory as it stands without modification, health is a natural primary good; hence the

health care delivery system is relegated to the vagaries of the exchange branch and is ruled by the principle of the common interest. Various modifications to avoid this consequence are the subject of the following chapters.

CHAPTER IV

MODIFICATIONS OF RAWLS' THEORY FOR HEALTH-CARE DELIVERY: AN ANALYSIS

I. INTRODUCTION

In the last chapter, some possible modifications of Rawls' theory of justice were suggested to avoid the problems in treating health-care delivery systems as part of the exchange branch. Two of the modifications of Rawls' theory mentioned in the last chapter are discussed here. First of all, I discuss the option to agree that health is a natural primary good but to treat health care as a right through the social primary good, opportunity. The other modification is considering health (in this case, health care) as a social primary good. With either modification, the health-care delivery system in a well-ordered society would be considered as a concern of the principles of justice. As such, it would be, in part, a distributional issue rather than solely an allocational issue.

II. HEALTH AS A NATURAL PRIMARY GOOD

A. A Review of Rawls' Position

Rawls' two principles of justice are grounded in the just distribution of the social primary goods--"rights and

liberties, powers and opportunities, income and wealth . . . . [and] self-respect" (Rawls, 1971:62). Health is not a social primary good on Rawls' view, but rather a natural primary good. He states:

> Other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure, they are not so directly under its control. Imagine, then, a hypothetical arrangement in which all the social primary goods are equally distributed: everyone has similar rights and duties and income and wealth are evenly shared. This state of affairs provides a benchmark for judging improvements. (Rawls, 1971:62)

For Rawls, the difference between the social and natural primary goods seems to be that social primary goods can be acquired--they are social attributes--natural primary goods seem to be personal attributes (one cannot significantly raise one's intelligence or acquire it like one can acquire wealth).

The development of the two principles of justice, then, is a focus on the social primary goods--not on the natural primary goods. Indeed, when Rawls argues for the principles of justice, the content of those principles includes only the social primary goods. By weighing these goods from the standpoint of the least advantaged representative individual and interpreting them in light of lexical ordering through the use of the priority rules and in light of the difference principle, the two principles

of justice are derived by asking which combination it would be rational to prefer (Rawls, 1971:302-303). As Rawls' theory stands, health and health care are not issues which are properly considered when using the two principles of justice; they are governed, as has been shown in the last chapter, by the principle of the common interest.

B. Daniels' Modification of Rawls' Theory

Norman Daniels, in "Health-Care Needs and Distributive Justice" (1981:146-179) starts his argument with an analysis of needs by distinguishing between subjective and objective needs. He argues that subjective needs or preferences are not relevant to issues of distributive justice, but that a truncated notion of objective needs is important.

> Our task is to characterize the relevant categories of needs in a way that explains two central properites these special needs have. First, these needs are objectively ascribable: we can ascribe them to a person even if he does not realize he has them and even if he denies he has them because his preferences run contrary to the ascribed needs. Second, and of greater interest to us, these needs are objectively important: we attach a special weight to claims based on them in a variety of moral contexts, and we do so independently of the weight attached to these and competing claims by the relevant individuals. (Daniels, 1981:152)

Daniels then connects his concept of objective needs with a notion of species-typical normal functioning. He

argues that such basic life-needs are objectively describable--human beings need throughout their lives such things as "food, shelter, clothing, exercise, rest, companionship, a mate . . ." (Daniels, 1981:153). Furthermore, basic life-needs are objectively important since

> impairments of normal species functioning reduce the range of opportunity we have within which to construct life-plans and conceptions of the good we have a reasonable expectation of finding satisfying or happiness-producing. (Daniels, 1981:154)

These steps taken by Daniels in his analysis of needs are important. First of all, he uses them as the basis for his definition of health. Furthermore, the concept of opportunities, which he will apply to Rawls' theory of justice, is already embedded in his theory.

The concept of health (and its use) is highly debated. Although I do not want, at this time, to enter that debate, it would be useful to note some of the different definitions that have been presented. At the most limited end of the spectrum of definitions of health is one which is purely physical and refers to the absence of lesions which can be detected or of disease organisms which cause an illness. At the other end of the spectrum is the famous (or infamous) World Health Organizations's (WHO) definition of health. That definition follows:

> Health is a state of complete physical, mental and social well-being and not merely the absence

> of disease or infirmity. (WHO, 1946. Quoted from the Preamble to the Constitution of the World Health Organization.)

Note that the WHO definition includes both mental and social factors besides the physical ones. In a sense, this definition encompasses every factor of human existence except possibly the spiritual factor. There are, of course, mid-range definitions of health as well.

Daniels' concept of health has a non-normative biological basis that is combined with the concept of species-typical functioning. For Daniels (1981:155), "health is the absence of disease or diseases," and diseases "are deviations from the natural functional organization of a typical member of a species." Strictly speaking, Daniels adopts a non-normative, physicalist concept of health (the most limited definition of health) although he does

> not exclude normative judgments about diseases, for example, about which are undesirable or which excuse us from normally criticizable behavior and justify our entering a 'sick role.' (Daniels, 1981:156)

Ultimately, he distinguishes between health and health-care needs--the latter being fairly broad.

> Health-care needs will be those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning. They can be divided into:
> (1) adequate nutrition, shelter
> (2) sanitary, safe, unpolluted living and working conditions
> (3) exercise, rest, and other features of healthy life styles

> (4) preventive, curative, and rehabilitative personal medical services
> (5) non-medical personal (and social) support services. (Daniels, 1981:158)

Daniels' next step is to tie together the concepts of disease and opportunity allowing that the range of opportunity will vary between societies and that certain diseases will affect some members more severely. He further distinguishes between normal opportunity range and effective opportunity range. The latter is a subset of normal opportunity range and is tied to individual opportunities. Daniels is consistent with his distinction between objective and subjective needs when he appeals for the use of the concept of the normal range.

> By appealing to the normal range I abstract from these differences in effective range, just as I avoid appeals directly to a person's conception of the good when I seek a measure for the social importance (for claims of justice) of health care needs.
>
> What emerges here is the suggestion that we use impairment of the normal opportunity range as a fairly crude measure of the relative importance of health-care needs at the macro level. In general, it will be more important to prevent, cure, or compensate for those disease conditions which involve a greater curtailment of normal opportunity range. (Daniels, 1981:159)

According to Daniels, this position is consistent with an application of Rawls' principles of justice. He does not claim, however, that his theory of distribution of health-care as a concern of principles of justice is compatible only with Rawls' theory of justice.

> But my account does not presuppose the acceptability of Rawls' theory. If a rule or ideal code-utilitarianism, or some other theory, establishes a fair equality of opportunity principle, my account will probably be compatible with it (though some of the argument that follows may not be). (Daniels, 1981:161)

Daniels' next series of arguments are specifically arranged to show the compatibility he claims with Rawls' theory of justice.

Daniels argues against using his conception of health as a social primary good. He claims, first of all, that to view health as a primary social good would violate Rawls' notion of these goods as idealized

> to apply to individuals who are 'normal, active and fully cooperating members of society over the course of a complete life' [Rawls, "Responsibility for Ends"]. There is no distributive theory for health care because no one is sick" (Daniels, 1981:164).

Rather than argue against Rawls' claim, Daniels moves to a second objection against using health as a social primary good--i.e., if health or health care is included as a primary social good, the "useful" generality of Rawls' theory of primary social goods is abandoned and risks the generation of a long list of social primary goods (Daniels, 1981:164). As a result, he suggests that:

> The most promising strategy for extending Rawls' theory without tampering with the useful assumptions about the index of primary goods simply includes health-care institutions among the background institutions involved in providing fair equality of opportunity. Once we

> note the special connection of normal species functioning to the opportunity range open to an individual, this strategy seems the natural way to extend Rawls' view that the subject of theories of social justice are the basic institutions which provide a framework of liberties and opportunities within which individuals can use fair income-shares to pursue their own conceptions of the good. Insofar as meeting health-care needs has an important effect on the distribution of health, and more to the point, on the distribution of opportunity, the health-care institutions are plausibly included on the list of basic institutions a fair equality of opportunity principle should regulate. (Daniels, 1981:165)

There are a number of objections to Daniels' position concerning the position of health care in Rawls' theory of justice.

First of all, rather than accept Rawls' assumption in "Responsibility for Ends" (Daniels, 1981:164) that members of society are healthy, I would maintain that this point runs contrary even to the knowledge allowed behind the veil of ignorance which Rawls uses to derive his theory. Even on Daniels' limited conception of health and disease, one must admit that human beings are subject to disease and deformity. All of us get sick. Many of us have chronic and degenerative diseases. Whether or not we recover depends upon the state of medicine and the biological sciences and on our own natural abilities to recover. Furthermore, Daniels also admits that diseases are relative in terms of our normal and effective opportunity range. Thus one could have a disease like diabetes

in a highly-developed technological society and have minimal or even no impairment in functioning as an active and productive member of society. Certainly treatment is needed in such a case to maintain that state of functioning. But the important point is that one can have a disease and have such minor impairment that nearly normal functioning is possible. To allow for the knowledge that human beings are subject to diseases, then, would be a part of the general knowledge allowed by the veil of ignorance in Rawls' theory.

My second objection centers on Daniels' claim that adding to the list of primary social goods risks further tampering by adding to a growing list of social primary goods. First of all, any good first-year logic student would note that this is an informal fallacy--identified sometimes as the domino theory or the slippery slope fallacy. Any inclusion into Rawls' list of social primary goods must be justified. If it can be justified, it deserves inclusion. Secondly, part of the problem rests with Daniels' conception of health and/or health care. His conception is physicalistic including physical impairments and diseases. Health care, for Daniels, focuses on course-of-life needs like food, clothing, shelter, treatment, and so forth. Health is certainly affected by health care or the lack of it. Yet there needs to be a

distinction between these course-of-life needs and other objective needs. Daniels does this in his list for health-care needs. Yet it must be noted that health care can be provided and one can still suffer from disease (i.e., be unhealthy). On the other hand, one may go through a period when one or more aspects of health care is lacking and still be in good health.

For Daniels, health is a non-normative, physicalist concept. The social primary goods delineated by Rawls, however, are not so narrowly defined. In fact, the list of primary social goods is general in nature and, I would argue, normative in content. For Rawls, they are necessary means to the ends--the final ends of rational plans. In this sense they are teleological.

> Now the assumption is that though men's rational plans do have different final ends, they nevertheless all require for their execution certain primary goods, natural and social. Plans differ since individual abilities, circumstances, and wants differ; rational plans are adjusted to these contingencies. But whatever one's system of ends, primary goods are necessary means. Greater intelligence, wealth and opportunity, for example, allow a person to achieve ends he could not rationally contemplate otherwise. The expectations of representative men are, then to be defined by the index of primary social goods available to them. (Rawls, 1971:93)

A further example would involve the important social primary good of self-respect. Rawls definition entails a self-knowledge of a person's values as well as one's

ability to live up to those values and the teleological aspect as well.

> We may define self-respect (or self-esteem) as having two aspects. First of all, . . . it includes a person's sense of his own value, his secure conviction that his conception of his good, his plan of life, is worth carrying out. And second, self-respect implies a confidence in one's ability, so far as it is within one's power, to fulfil one's intentions. . . . [T]he parties in the original position would wish to avoid at almost any cost the social conditions that undermine self-respect. (Rawls, 1971:440)

The first part of Rawls' definition inherently implies that a person has and shares values with others in a society--especially in a Rawlsian well-ordered society where citizens share a sense of justice. The second part of Rawls' definition of self-respect involves knowing one's capacities and talents as well as one's limitations. These capacities and limitations are certainly relative to the individual.

Other primary social goods, if analyzed, could be shown to have similar normative and relative components. Thus, a criterion for a Rawlsian social primary good could be established that demands that all primary social goods be general in nature, be basic enough (in the sense that they are not derivable from another social primary good) that they are primary and social, and have a normative component similar to that which is contained in Rawls'

original list of primary social goods. This would prevent that list from becoming overwhelmingly large.

Now health as it is conceived by Daniels certainly is not a primary social good. Health care as he conceives it cannot be a primary social good either. His is simply too broad a list of health care needs. Furthermore, some distinctions in Daniels' conception of health care need to be made similar to Rawls' distinctions between distributive considerations (ruled by the principles of justice) and allocative considerations (ruled by the principle of the common interest). Given his definition of health and his list of health care needs, Daniels is correct in not including either in the list of Rawls' social primary goods. This does not mean, however, that Daniels' modification of Rawls' theory is correct. There are some fundamental problems in subsuming health care under the principle of opportunity in Daniels' manner.

First of all, Daniels justifies all of his considerations by his criterion of need. Rawls' conception of justice begins with social primary goods--goods based on common and objective desires. He avoids Daniels' problem of social hijacking--whereby one chooses the principles, etc., on the basis of one's personal desires so as to advance one's own position in society--by use of the veil of ignorance. No one knows where s/he will be placed in

society. Therefore it is to a person's advantage to choose from the standpoint of the least advantaged person. In this context, the primary social goods are those that anyone would want in any case. Daniels, in fact, notes that Rawls has compensated for the hijacking case.

> Rawls urges that we hold society responsible for guaranteeing the individual a fair share of basic liberties, opportunity, and all-purpose means, like income and wealth, needed for pursuing individual conceptions of the good. But the individual is responsible for choosing his ends in such a way that he has a reasonable chance of satisfying them under such just arrangements. Consequently, the special features of an individual's conception of the good--here his extravagant tastes and resulting dissatisfaction--do not give rise to any special claims of justice on social resources. (Daniels, 1981:162)

Before delineating the main objection to Daniels' position here, it should be noted that despite Rawls' conception of the primary goods being the objects of rational desires and means to ends, Daniels' builds his conceptions of needs into Rawls' notion of primary goods being means to ends. He does not justify this inclusion. Rawls, in discussing needs, does not use this concept in the same manner as Daniels. A claim by one person on others in a society

> does not entail that distributive shares are equal. Each is to receive what the principles of justice say he is entitled to, and these do not require equality. (Rawls, 1971:312)

Insofar as a person has a legitimate claim on others, that

claim is based upon the justice of distributive shares. Once that has been satisfied, no person can legitimately make claims on a society based on less good fortune than a similarly endowed person who has more power or wealth, for example (Rawls, 1971:312).

Daniels' claim is another way of stating Rawls' distinction between the thin and full theory of the good. The thin theory of the good is the theory of primary social goods. It is a part of the original position constraints which allow for a development of the principles of justice in a contract situation. The full theory of the good, on the other hand, comes into force after the principles of justice have been agreed upon and the four-stage sequence for the structure of the institutions of society has been accomplished. Here there is no veil of ignorance and society has decided on the minimum fair standard for distribution of social primary goods. Hijacking cannot effectively be an issue in the original position. The thin theory of the good prevents it since this theory only takes into account the social primary goods under a veil of ignorance which does not allow one knowledge of one's place in society after the society has been constructed. Nor is hijacking a true issue in an ideal society--except as a violation of the difference principle--once the principles of justice have

been determined. It must be remembered that members of a well-ordered society have a sense of justice.

Still, if this were the only problem, perhaps Daniels' modification of Rawls' theory would be acceptable. There is, however, a more fundamental problem. Daniels' modification of Rawls' theory involves a much thinner veil of ignorance.

> In Rawls' contract situation, a "thick" veil of ignorance is imposed on contractors choosing basic principles of justice: They do not know their abilities, talents, place in society, or historical period. In selecting principles to govern health-care resource-allocation decisions, we need a thinner veil, for we must know about some features of society, for example, its resource limitations. Still, using the normal opportunity range and not just the effective range as the baseline has the effect of imposing a plausibly thinned veil. It reflects basic facts about the society but keeps facts about individuals' particular ends from unduly influencing social decisions. Ultimately, defense of a veil depends on the theory of the person underlying the account. The intuition here is that persons are not defined by a particular set of interests but are free to revise their life plans. Consequently, they have an interest in maintaining conditions under which they can revise such plans, which makes the normal range a plausible reference point. (Daniels, 1981:167)

Daniels is ambiguous here. If he is referring to the original position reasoning, his notion of a thinner veil is incompatible with Rawls' thicker veil of ignorance. The additional knowledge he wants to include into Rawls' theory seriously damages Rawls' four-stage sequence and makes unintelligible the allowable knowledge for each

stage. Simply put, he wants to include knowledge appropriate at the legislative stage (stage three) into the first stage of the deliberations. If Daniels' wants a thinner veil at the original position stage of the four-stage sequence, he must take into account all of Rawls' methodology and show how his modifications do no serious damage to Rawls' theory.

The problems may be somewhat limited in that Daniels has four layers of institutions for health care. Yet a close examination of even the first layer of institutions shows that it is problematic. Daniels includes institutions "which provide for public health, environmental cleanliness, preventive medical services, occupational health and safety, food and drug protection, nutritional education, and educational and incentive measures to promote individual responsibility for healthy life styles" (Daniels, 1981:167-168). This layer blurs the distinctions Rawls makes between distributive concerns (the concerns of justice) and allocative concerns (concerns ruled by the principle of the common interest). In the previous chapter, these distinctions were analyzed. Allocative considerations are those which concern everyone equally. As such, they are considerations which operate outside the principles of justice and are ruled by the principle of the common interest. Public health is an allocative

concern. It affects all members of society equally. Hence the principle of the common interest is the ruling principle, not the principles of justice which allow for just inequalities. In fact, most of the institutions Daniels includes in his layers of health care concerns fall under the principle of the common interest. Issues of distributive justice which would ultimately be ruled by the principles of justice would include issues of access to the health-care delivery system. None of Daniels' layers of institutions specifically deals with the issue of just access.

To summarize, Daniels' ambiguity about the point of entry of his thinner veil causes methodological problems. His layers of institutions for health care are equally problematic in terms of the distinctions Rawls makes between distributional and allocative concerns in his theory of justice. As a result, it is difficult to use Daniels' modification of Rawls' theory of justice for issues in health-care delivery. In fact, it would be difficult to deal with the problem of just access to the health-care delivery system because all necessary distinctions would have to be made by using his four layers of institutions--all of which may be critically important to the issue of access since all serious health problems

ultimately involve access to the health-care delivery system if they are to be treated.

This discussion is not meant to imply that Daniels does not analyze distributional issues in health-care delivery. He does, in fact, attempt to deal with the issue of just access to the health-care delivery system. Daniels is internally consistent in that his position on just access to the health-care delivery system is a need-based one. He states:

> My account is compatible with (but does not imply) a multi-tiered health-care system. The basic tier would include health-care services that meet important health-care needs, defined by reference to their effects on opportunity. Other tiers would include services that meet less important health-care needs or other preferences. However the upper tiers are to be financed--through cost-sharing, at full-price, at "zero" price--there should be no obstacles, financial, racial, sexual, or geographical to initial access to the system as a whole. (Daniels, 1981:175)

The problem with this position is that the issues of access may ultimately have to depend on the effective range of opportunity rather than the normal range--especially at lower tiers of health-care in Daniels' system. In distinguishing between normal and effective range Daniels makes the following distinctions:

> From the perspective of an individual with a particular conception of the good (life plan or utility function), one who has developed certain skills and capacities needed to carry out chosen projects, effective opportunity range will be a sub-space of the normal range. A college

> teacher whose career and recreational skills rely little on certain kinds of manual dexterity might find his effective opportunity diminished little compared to what a skilled laborer might find if disease impaired that dexterity. By appealing to the normal range I abstract from these differences in effective range . . . . (Daniels, 1981:159)

Even abstracting from the differences in effective range among individuals to achieve normal range of functioning, the relativity of needs presents a difficulty in light of Daniels' claim that medical support services are a matter of justice. Daniels' use of support services for the blind may be such an abstraction:

> But where restoration of function is beyond the ability of medicine per se, we begin to enter another area of services, non-medical social support (we move from (4) to (5) on the list of health-care needs . . .). Such support services provide the blind person with the closest he can get to the functional equivalent of vision--for example, he is taught how to navigate, provided with a seeing-eye dog, taught braille, and so on. From the point of view of their impact on opportunity, medical services and social support services that meet health-care needs have the same rationale and are equally important. . . . These are matters of justice, not charity; we are not facing conditions of scarcity so severe that these steps to provide equality of opportunity must be forgone in favor of more pressing needs. (Daniels, 1981:177-178)

Given Daniels' example of a college professor versus a skilled laborer having impairment in dexterity, it seems difficult to make an abstraction from effective range to normal range. If one makes impairment a criterion for being eligible for non-medical support services, is

impairment to be defined only insofar it prevents a person from participating in society to his/her fullest extent? Or does Daniels intend to develop a list of impairments which are to become as important to matters of justice as the initial access to the health-care delivery system? If there is a list of impairments, would the college professor and the skilled worker sharing the same impairment in dexterity have an equal claim (with regard to justice) for the non-medical support services?

At the very least, an affirmative answer here would completely muddy his point that the first tiers of health-care are more important to issues of justice than the lower tiers. Daniels bases his position on needs. The college professor does not need the non-medical support services in the way that the skilled worker needs them. The college professor can continue career goals without these services; the skilled worker cannot do so. If there are no treatments available to restore functioning, the skilled worker needs support services for training in a new career and so on. Given these considerations, how can determinations of payments be made if both persons receive the support services? One would have hoped that somehow the issue of access would parallel the list of needs in terms of payment especially since Daniels suggests a tier system for making a proper share of payments.

Once the effective range of opportunity is inserted into the formula (and it seems to be relevant here), the system seems to collapse into judgments of the costliness of those services somehow judged by the resources available to society. As such, his originally careful distinctions between normal range and effective range of needs becomes unwieldy.

There is a final objection to Daniels' modifications of Rawls' theory of justice. The health-care delivery system is treated by Daniels as a background institution which is a part of Rawls' equality of opportunity. This is a fundamental methodological mistake. First of all, equality of opportunity as a second-principle concern deals with social primary goods. As Rawls states, the principles of justice "are a special case of a more general conception of justice" (Rawls, 1971:62). Now it is important to note that the general conception of justice includes only the social primary goods.

> All social primary goods--liberty and opportunity, income and wealth, and the bases of self-respect--are to be distributed equally unless an unequal distribution of any or all of these goods is the the advantage of the least favored. (Rawls, 1971:303)

Thus the two principles delineate the restrictions and inequalities which are permissible under the general conception of justice.

Rawls does maintain that the two principles with

their lexical ordering and priority rules are the proper guide for application to situations in non-ideal theory, since the general conception alone would lack structure for practical use. Thus, because the principles of justice are a special case of the general conception of justice, and are based on Rawls' specification of social primary goods, any argument about the right to health care from the standpoint of his two principles is illegitimate--unless the case is made for health as a social primary good. Now Daniels embeds health-care into opportunity--a social primary good or a secondary good which is a function of a social primary good. Yet it has already been shown that Daniels' theory is based upon needs, whereas social primary goods are not need-based in the way Daniels uses the concept. In order to properly claim that health-care needs are part of the structure of the social primary good of opportunity, Daniels must make his conception of needs more consistent with Rawls' conception of social primary goods.

There is a second fundamental objection to Daniels' treatment of health care under the second principle of justice. Even if a case can be made for health-care as appropriate in the context of background institutions, the result would be inflation of the principle of equal opportunity. (This could be an enormous mistake, as the

analysis of that principle in Chapter VI will show. I will return to Daniels at that point to specificially show the problems in this inflation of the principle of fair equality of opportunity.) The list of social primary goods itself can be safeguarded against unwarranted inflation by setting out criteria that any addition to that list must possess. Rawls sets out a major criterion to prevent inflation of the second principle itself by limiting its scope to the social primary goods in the general conception of justice. Daniels' treatment of the issues of health care thwarts that criterion when he attempts to treat health care as a background consideration to the principle of opportunity. Yet he gives no criteria for entry of issues as background issues other than comparing health care to education which is a legitimate background consideration. At the very least, he should introduce the criteria which make his analogy sound. He furthermore treats equality of opportunity as the second principle social primary good without examining the context in which it is used by Rawls. Thus, starting with his concept of opportunity range, he embeds a concept of opportunity into his definition of health, health care, etc., without really examining his concept of opportunity to see if it fits with the principle of fair equality of opportunity as Rawls uses it.

Any attempt to modify a theory for special uses should try to be methodologically sound and be as consistent with that theory as possible. Daniels' modifications of Rawls' theory of justice for use in issues of health-care delivery are highly problematic. They are ambiguous at the level of theoretical and methodological modifications as shown by his position regarding the veil of ignorance. They are internally inconsistent in the use of the normal as opposed to the effective range of opportunity. Finally, and most importantly he treats health care as a background institution of Rawls' principle of fair equality of opportunity without examining the conceptual and methodological differences between his use of the concept of opportunity and Rawls' principle of fair equality of opportunity. Although Daniels' modification of Rawls' theory is an interesting attempt to treat health-care issues as issues of justice, it is not truly Rawlsian. Furthermore, it has its own inconsistencies in terms of the ambiguity of the treatment of the normal range of opportunity as opposed to the effective range of opportunity. His treatment of the issue of access shows this.

III. HEALTH CARE AS A SOCIAL PRIMARY GOOD

Ronald Green, in "Health Care and Justice in Contract Theory Perspective" (1976:111-126), takes a completely different course than Daniels does. Daniels denies that health is a social primary good; Green disagrees. In the following statement, he claims that access to health care is one of the most important social primary goods:

> Access to health care is not only a social primary good, in Rawls' sense of the term, but possibly one of the most important such goods. . . . Even more apparently than governmental interference, disease and ill health interfere with our happiness and undermine our self-confidence and self-respect. Indeed, some who have disputed the priority that Rawls gives to the civil liberties have done so precisely because they believe that other values, especially physical well-being and security, are to be rationally preferred. (Green, 1976:117)

Green notes that critics have challenged Rawls' placement of intelligence as a natural primary good, and uses this as a basis to challenge Rawls' statement that health is also a natural primary good.

> Modern medical technology, with its enormous preventative and therapeutic powers, renders almost archaic the notion that health depends on natural contingencies. Social decisions concerning medical care thus have a vital impact on everyone's health, even where health is construed only in the narrowest sense as freedom from disease. Despite Rawls, then, health care ought to be considered a primary social good in his terms, and ought to be directly considered by a theory of justice. (Green, 1976:112)

There is a basic problem with this point by Green,

however. He cannot use the example of modern technology in medicine as an argument for health care as a social primary good. It is a violation of the veil of ignorance used by Rawls in his original position reasoning. Green's argument focuses on modern knowledge and perhaps is relevant for modern, technological societies in legislative stage reasoning. He must show, to be consistent with Rawls, that health care is an issue that is pervasive over time--that it is an issue important to people whatever their place in history and whatever their society.

Green also notes that the issue of health care cannot be limited to the

> function of a just distribution of income. Indeed, this view may underlie [Rawls'] definition of health as a natural primary good only indirectly mediated by the social structure (Rawls, 1971:62). (Green, 1976:112)

Green believes that embedding the issue of health care delivery indirectly into the issue of distribution of income runs contrary to Rawls' intentions in A Theory of Justice since this would entail private distributions of medical care based on the amount of income available to the citizens--possibly with provisions for those at the bottom of the social ladder.

> If this is Rawls' final view of the matter, however, it runs against the general tenor of his position. It is very doubtful that the rational agents whose choices define social principles in this theory would neglect to establish separate principles for medical care

> or would substantially leave its distribution to be determined by one's income share. (Green, 1976:112)

This argument of Green's is methodologically consistent with Rawls' theory. It is the kind of argument which is good over time and is relevant to all societies.

Green's major problem is, however, consistency with Rawls' methodology. He ignores the four-stage sequence as delineated by Rawls and packs all of his arguments into the original position reasoning. For example, when discussing the level of health care chosen by a society, he states:

> In contract terms, we can say that the members of the original position have very good reasons for not settling for a society whose members are free from physical disability but who otherwise live at a level of economic austerity. Thus it is rational for them here to qualify their maximin logic and sacrifice some health care to economic considerations. (Green, 1976:121)

Green uses the wrong stage of reasoning here. The original position reasoning is used to derive the principles of justice. It is the first stage of Rawls' four stage sequence of reasoning used to set the structure of the institutions of a well-ordered society. The stage of reasoning regarding the money spent on health care would be a legislative stage consideration since health care would presumably be a second principle consideration.

There are, however, some problems with Green's account of what it is that is to be considered as a social

primary good. Is it health? Is it health care? Or is it access to health care? Rawls maintains that health is a natural primary good. Green does not really address this point directly since he is not considering health itself as a social primary good, but rather either health care or access to health care. Part of this problem lies in the fact that he never really addresses the issue of the concept of health. At the very most, he seems to agree in at least a limited way with the the WHO definition of health. Green (1976:121) states:

> Added to this is the common sense consideration that health is thought to be a state of mental, physical, and social well-being and not merely freedom from disease. As such, a healthy existence presumably includes various opportunities for the desired exercise of many human capacities and excellences.

Now the World Health Organization definition of health is extremely similar to Green's common sense view of health. According to the WHO,

> [h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO, 1946. Preamble to the Constitution of the World Health Organization.)

Green's obvious deletion here is the word "complete"--but he does not really qualify how nearly complete an individual's health must be in a society so that a person may be described as "healthy." He simply goes on to state the

following regarding the kind of health wanted by people in a Rawlsian society when making their deliberations.

> Just where they draw the line is hard to say, but a reasonable test may be available. Since contract parties select principles in the original position they would be prepared to live with in any representative social position, the test of any actual choice made concerning degrees of health care or research is whether those who fall ill would regret the social decisions that rendered the therapy for their condition unavailable. (Green, 1976:121)

Two points are relevant here. First, Green is consistent in being inconsistent with Rawls' system. This is not an appropriate issue for original position reasoning. It is a legislative stage concern. Second, since it is a legislative stage concern, the parties would know a great deal more about their society--the available resources, the level of technology, and so on. They would not know their individual conditions, of course. They would know, however, the diseases that confronted many members of society and the society's ability (or lack of it) to deal with those diseases. Hence, Green's test would have to be somewhat expanded. Some diseases affect large segments of a population. Blacks tend to suffer from sickle cell anemia, for example. Green would have to account for examples like this or even examples like cancer where only a segment of the population is affected. Even from the standpoint of the least advantaged member of society--the correct Rawlsian standpoint--the answers to Green's test

will be difficult to derive. It would be, especially at the legislative stage where the veil of ignorance is thinner, easier to "cheat" and put a lower priority on these diseases in the hopes that, as a real person in a real society, one may not fall victim to one of these diseases. The standpoint of the least advantaged person, for all of its ambiguity, seems ultimately to be a better test to use.

Another problem with Green's approach centers on his concept of health. Even though his concept of health does not demand the complete physical, mental and social well-being like the WHO definition, it is still too broad and ambiguous. Now the ambiguity could be eased somewhat by some clarifications of his concept. For example, Green could clarify his notion of well-being to answer questions like "how well must one be to be in a state of well-being?" or "how does well-being deal with incurable chronic and degenerative diseases?" More seriously, Green's concept of health is too broad. The inclusion of social well-being is contrary to Rawls' theory since, without serious clarification, it would seem to encompass other social primary goods like power, wealth and even opportunities. People can have power without wealth, wealth without power, or opportunities without either wealth or power. Social well-being, on the other hand,

could be construed to mean that one needs all three to some significant degree. In working with Rawls, one always seems to be referring to those who are well-off or less well-off. I am not denying that there is a social aspect to health care. Daniels' points about non-medical rehabilitation are cogent in content--and his points are based on a purely physicalistic definition of health. Even if the distribution of wealth and income is relatively just in a well-ordered society, the people who are the least advantaged may not be able to be described as having social well-being. They may be as physically and mentally healthy as medicine and psychology allow, but they may only live at a just social minimum. In other words, they may have shelter, adequate nutrition, adequate physical and mental health care, adequate clothing, even adequate power and wealth. But since this would only be at a just minimum, it would be difficult to describe their situation as one of social well-being. Thus Green's concept of health needs clarification at the very least. He must also either make serious stipulations or drop his notion of social well-being.

Green, however, does not argue for health as a social primary good. He argues for health care or access to health care as his social primary good. Aside from the problems in his concept of health--which would determine

the scope of health care to a large extent--Green cannot limit health care to the issue of access as the social primary good. Admittedly, access is an important issue for a just system of health-care delivery. It is also a very complex issue. For example, Paul Starr, in "Medical Care and the Pursuit of Equality in America" (Securing Access, 1983b:6), distinguishes between issues that relate to access.

> If equal access to medical care is the product of at least four variables--(1) the availability of facilities, (2) the possession of the means of access, (3) nonexclusionary attitudes and conduct of professionals and institutions, and (4) various forms of individual competence, such as the capacity to recognize one's own medical needs--then one can construct a kind of "scale of actions" that equality of access might entail. On this scale, a key dividing point comes between the first pair, both of which involve resources, and the second pair, both of which involve behavior.

Starr also distinguishes between the notions of availability, access, and use. Starr (1983b:7) states:

> To make some service equally available is not necessarily to provide equal access, and to provide equal access is not to guarantee equal use when needed. Even where our society makes some kind of commitment to equality, it does not necessarily commit itself to equalize all three.

Obviously, from Starr's point of view, societal obligations may be directed at any or all of these problems. It does seem, however, that the thrust of Green's arguments are directed to access, with some consideration of

availability as well. Green (1976:116-117) states his position this way:

> As a result, we can expect the parties finally to opt for a principle of equal access to health care: each member of society, whatever his position or background, would be guaranteed an equal right to the most extensive health services the society allows.
>
> This equal right would extend, presumably, only to equal access to health services. It would not signify an equal distribution of health care attention (for example, the same number of hours of medical care each year for everyone). The interests of the contract parties indicate the meaning of "equality" in its various employments. In this case, since the parties are primarily interested in securing services as they need them, equality extends only to access to the health care system.

There is a question here as to whether Green is arguing for equal access or for a just minimum of access. He ambiguously refers to equality here, but the meaning is not particularly clear. If Green is arguing for health care as the social primary good, on the other hand, the distinctions Starr makes points out the scope of the issues that Green needs to confront.

There are other important distributional issues in health care beyond access. For example, the distribution of scarce resources is too important an issue to consider only in terms of access. Starr's distinctions about health care resources does not address this particular issue. Some kinds of research raise distributional issues in themselves. The issue of scarce resources is usually

treated in the following context: who shall be saved (or served) when not all can be saved (or served). In this context, access to health care can be seen as a subset of the larger issue of health care which encompasses all of the facets needed to achieve good health.

Traditionally, access to the health-care delivery system has been defined as primary care with appropriate follow-up care. Some of Daniels' arguments come into force here. His need-based notion of health care seems plausible enough if one ignores the other methodological difficulties.

Rawls' system does not ignore needs. The transfer branch of his background institutions is set up specifically to deal with needs. It may be that a just minimum of health care is all that can be provided. In other words, a least-advantaged member may have a right to traditional forms of health care--the accepted practices for a certain condition or disease--but not have a right to the newest, sometimes experimental, highly technologically advanced procedures.

Some types of health care are considered to be elective procedures. They are not necessary procedures in providing basic health care. For example, many plastic surgery techniques are considered "vanity" procedures.

They may make a person look better--remove some wrinkles, for example--but are not essential to good health.

Daniels' five levels of needs may in fact be an appropriate scale to apply in many cases even if his concept of normal versus effective ranges of opportunities sometimes seems unworkable. The person who wants a face-lift seems, on face value, to be easily classified as a case where effective range is the appropriate classification. Given over-all scarce resources in any society, some limitations need to be made in any determination of the scope of the health-care delivery system. Green certainly recognizes this but gives no workable guideline to make such a determination. Given these problems, Green's ultimate choice of access to the health-care delivery system as his social primary good seem undesirable at best, and unworkable at worst. Admittedly, Green does seem to use health care and access to the health-care system somewhat interchangeably. Yet his focus seems to be on access to the health care delivery system. His discussion of the limits of health care focus on health care resources. If Starr's distinctions between resources and behavioral aspects of the access issue are cogent here, then it seems that Green, with his focus on resources both in terms of availability and the possession of the means of access, ultimately chooses access to the

health-care delivery system as his social primary good as opposed to health care as the social primary good in his modifications to Rawls' theory.

Since Green does alternate between health care and access to health care as his social primary good, a discussion of the choice of health care as the social primary good is still in order, however. The major problem seems to be the fact that health care is derived from his concept of health. This may be problematic in that the definition of health itself has been shown to have problems.

Although Rawlsian limitations like scarcity of resources would be relevant at the legislative stage, it is not really clear that the maximin rule would take effect here as well. Rawls uses this rule in the original position while determining the principles of justice (Rawls, 1971:155). For Rawls, the maximin rule--a rule of thumb, actually--is applicable to the original position in three sets of combined circumstances: (1) when "knowledge of likelihoods is impossible, . . ."; (2) when risk is not to a person's advantage since it entails chances of greater losses; and (3) when "the rejected alternatives have outcomes that one can hardly accept" since the "situation involves grave risks" (Rawls, 1971:154-155). Now one reason that the maximin rule works in the original

position in the determination of the two principles of justice is the veil of ignorance. Only general knowledge is allowed so that all three features of the maximin rule work effectively together.

At the legislative stage, however, much more knowledge is allowed. At that point, much of the uncertainty of the original position is lifted. Thus the maximin rule is radically weakened in its use at this stage of deliberations.

In contrast to Rawls' use of maximin reasoning, Green (1976:121), makes the following point that can only be properly applied at the legislative stage of reasoning:

> the test of any actual choice made concerning degrees of health care or research is whether those who fall ill would regret the social decisions that rendered the therapy for their condition unavailable.

In stating this, Green is applying the maximin rule. (That this is his understanding is obvious since this statement is preceded by a direct appeal to the "maximin logic" of the deliberating parties.) Thus his test for determining the degree of health care, if applied at the appropriate stage of deliberations is weak and unwieldy. As a result, the degree of health care available to the citizens must instead be decided from the standpoint of the least-advantaged citizen.

A more important objection to using health-care as a

social primary good is that it is a derivation of the concept of health. This is unlike other social primary goods. They are not goods derived from other goods. Health, on the other hand, is not a derived good. In that sense, it is more like Rawls' other social primary goods. For example, there is no guarantee that one will have excellent health in a Rawlsian society even when one has equal access to all health-services, just as one has no guarantee that one will have enormous wealth in a Rawlsian society even when there is a just distribution of wealth.

What is demanded in a just society is that there be an acceptable and realistic minimum available to the least advantaged members of society. If health is the social primary good, then a just minimum of health-care services can be achieved through the derived right of health care in the same Rawlsian methodological way that if wealth is the social primary good, a just minimum of wealth can be derived through the appropriate application of Rawls' methodology. I would suggest, then, that health is the social primary good, and that health care is the subject of a derived right all members of society have in attaining that good.

Ultimately Green's modifications to Rawls' theory of justice are unworkable. First of all, his system has severe methodological problems. He is not consistent in

using Rawls' methodology in the four-stage sequence of deliberations. Worse, he seems to make health care a first principle concern that is prior to liberty. This violates Rawls' priority rules. On the other hand, Green is at least correct in arguing that Rawls is wrong in not including the issue of health among the social primary goods. His solution to the problem, however, is highly problematic. His inclusion of health care or, more accurately, access to health as the social primary good is mistaken. Health care is derived from the concept of health, while access to the health-care delivery system is a subset of health care itself. Hence both lack the foundational status of other social primary goods. Green also has problems in his definition of health. Like its slightly more inclusive counterpart, the WHO definition, Green's definition is too broad and too ambiguous to be acceptable for inclusion among Rawls' social primary goods in that other social primary goods, for example, could be enveloped by the aspect of social-well being. (This issue will be taken up more extensively in the next chapter.)

Both Green and Daniels attempt Rawlsian analyses of health care considered as a right in a well-ordered society. Although they present interesting analyses, both are methodologically and conceptually unsound. Although neither attempt is successful, it still seems likely that

a Rawlsian approach to health care as a right can be successful. Demonstrating this will be the focus of the next chapter.

CHAPTER V

HEALTH AS A SOCIAL PRIMARY GOOD

I. INTRODUCTION

In the previous chapter, two alternatives to Rawls' approach to health in his theory of justice were analyzed. Both Daniels' and Green's attempts to derive health care as a right in Rawls' theory were shown to have methodological and conceptual difficulties. In developing my own, third approach, these problems must be avoided. The best possible alternative to Daniels' and Green's in a Rawlsian scheme of health-care delivery must be one in which all arguments are as consistent as possible with Rawls' original development of the principles of justice. Conceptual difficulties must be avoided as well. All concepts employed must be as unambiguous as possible and must also be consistent with similar concepts employed by Rawls. Thus the method in this chapter will be to start out by developing an appropriate concept of health. This concept must then be shown to be a social good as well as a primary good. In other words, the criteria for any new social primary good must be satisfied. Finally the relation of health as a social primary good to self-respect will be shown in order to test its compatibility with one of Rawls' most important social primary goods.

Only then will the groundwork be laid for health to be properly considered a social primary good in a Rawlsian well-ordered society. At that point, health care will properly be considered a right derived in the second principle of justice.

II. THE CONCEPT OF HEALTH

The first step in dealing with this topic is to determine what is meant by health. Daniels conceives health in a non-normative, physicalist manner. Green, on the other hand, construes health almost as broadly as the WHO definition. Obviously, there are many controversial concepts of health. My objective is two-fold. Foremost on my agenda is to formulate a shared conception of health from which to start. Since the very meaning of the concept of health is controversial and disputed, my meaning of this concept must be clear. Furthermore, it is necessary to present a concept of health that is fully compatible with Rawls' other social primary goods. This is not an arbitrary decision. Since methodological consistency as well as conceptual consistency is needed for an acceptable Rawlsian analysis of health-care delivery issues, a concept of health which is compatible with Rawls' theory is not only useful but necessary. If there is a major weakness in Rawls' theory of justice, an analysis of

health-care issues using consistent methodological moves (which include a compatible conception of health as a social primary good) is the only means to show this weakness. If, on the other hand, a definition of health were used that would be incompatible, any weakness implied in Rawls' theory could be shown to arise as a result of a conception of health that is either too broad or too narrow.

Daniels' definition of health is a good example of one which will be shown to be too narrow. As such, it is incompatible with other social primary goods. Green's definition of health, on the other hand, will be shown to be too broad. The sharp differences between these two conceptions of health reflect the dispute in bioethics regarding the concept of health itself. A brief discussion of this controversy is helpful in that it points out some of the weaknesses which need to be avoided in any definition of health. At the most limited end of the spectrum of definitions of health is one which is purely physical and refers to the absence of lesions which can be detected or of disease organisms which cause an illness. At the other end of the spectrum is the World Health Organization's definition of health. I will restate that definition here:

Health is a state of complete physical, mental

> and social well-being and not merely the absence of disease or infirmity. (WHO, quoted from Beauchamp and Walters, eds., 1978:89)

This definition has been attacked by a number of authors--notably Daniel Callahan with whose criticisms I generally agree. Callahan, in "The WHO Definition of Health" [from Hastings Center Studies, Vol. 1, No. 3. 1973:77-87; quoted here from Beauchamp and Walters (eds.). 1978:90-95], claims that this definition is too broad, is an ideal, shifts the responsibility of problem-solving in health-care in both the mental and social realms as well as the physical realm to the medical profession, and finally, is a horrible abuse of language (Callahan, 1978:90-95). These criticisms cut into the initial appeal of such a broad definition. Furthermore, if health is this total composite of well-being, few people can ever be shown to be healthy. Yet, according to Callahan, there is still a kernel of truth in the WHO definition which accounts for its seductiveness. Somehow, we wish to claim that social and mental factors as well as physio-chemical factors do affect our health status.

This is where Callahan and Szasz and other "physicalists" who shy away from the social and mental factors seem to miss the boat when they focus on a purely physio-chemical definition of health. Szasz, in The Myth of Mental Illness, wants mental dysfunctions to be called

"problems in living" and wants to reserve the terms "health" and "disease" to functions of the body alone. He wants to keep individuals with mental dysfunctions responsible for their actions in a way that people with physiochemical dysfunctions are not considered responsible. Although sick people may be responsible for preventing their illnesses, once they are ill, they can be taken care of--they are allowed to enter into the sick role. Although in most cases responsibility for entering into the sick role is theirs, the treatment of their illness lies primarily with others--notably the medical profession. It should be noted, however that sick persons are responsible for cooperation and participation in the treatment process as well (Englehardt, "Human Well-Being and Medicine: Some Basic Value-Judgments in the Biomedical Sciences," 1981:220). On a physicalistic concept of health, however, people with problems in living must shoulder the responsibility for their problems and are not allowed to enter the sick role.

This kind of physicalistic position, however, ignores the interrelationship of physical and emotional problems. I will give only two examples here, but they indicate the problems with using a strict physical model to define health. One disease that shows this interrelationship between physical and mental problems is diabetes. In

fact, there is a type of diabetes known as stress diabetes. The following case is an example of this.

> A thirty-year-old man of normal weight is in good physical health except during emotional stress. When under unusual strain, he exhibits the cardinal symptoms of hunger, thirst, and urination. If he is sufficiently prudent to tell his doctor about these symptoms, his rather mild diabetes can be checked. Although he may need insulin only in times of severe stress, he will have to see his physician frequently, since his type of diabetes is unpredictable. This is necessary because such individuals often do not realize they are under strain and need insulin. If they neglect or ignore the symptoms, they can change to the totally insulin-dependent category. (Boylan and Weber, The New Way to Live with Diabetes, 1976:11)

Insulin-dependent diabetics commonly react to stress as well. During extremely stressful times, their daily need for insulin may increase dramatically. This is one of the reasons that makes daily (or more frequent) testing of urine or blood glucose so important. Without knowledge of one's "sugars," stressful times may be marked by a lack of control of the disease due to taking too-little insulin. Diabetes is thus a disease that cannot simply be defined on a purely physicalistic basis. Stress--emotional problems--affects the disease with sometimes disastrous results. To dismiss the stress factor as merely a problem in living for which the patient is responsible--therefore not relevant to the medical treatment of this disease--is callous, inhumane, and ultimately even ineffective. It is treating a disease, not a person who has diabetes.

Another example which shows the interrelationship of mental and physical functioning is alcoholism. The psychological factors are a "cause" of the drinking. Continued heavy drinking leads to physical addiction and withdrawal symptoms when alcohol is not available. Furthermore, chronic alcoholism can lead to liver dysfunction (cirhossis) as well as to Korsakoff's Syndrome--a brain dysfunction defined by Taber's Cyclopedic Medical Dictionary as follows: Korsakoff's Syndrome is

> characterized by a psychosis with a polyneuritis, disorientation, muttering, delerium, insomnia, illusions and hallucinations, painful extremities, rarely a bilateral wrist drop, more frequently bilateral foot drop with pain or pressure over the long nerves. (Taber, 1965:K-9)

The treatment of the physical lesions that arise from alcoholism is meaningless and useless unless the compulsion to drink--the psychological problem--is also dealt with in a positive way.

Problems like these lead me to reject a purely physical approach to the concept of health, but like Callahan I do not wish to embrace the WHO definition. There is, however, another objection to these concepts of health that is methodologically important. Neither of these types of a concept of health can effectively be used as a Rawlsian social primary good. Like Daniels' physicalistic concept of health, others of this type are too narrow.

Non-normative physicalist concepts of health differ from Rawls' social primary goods in that the social primary goods are general in nature and normative in content. Although physicalistic concepts of health are basic in the sense that they are primary, they specifically exclude social factors that are relevant to Rawlsian social primary goods. The differences between physicalist concepts of health and primary social goods are strong enough, then, to eliminate them from consideration as possible definitions of health to be used in modifying Rawls' theory to include health as a social primary good.

The other extreme--a definition like Green's or the WHO definition of health--is not practical to use in a Rawlsian modification either. First, even Green's somewhat limited concept of health was shown to be too broad. With the WHO definition describing health as the "complete" state of physical, mental and social well-being, it is certainly too broad for consideration as a social primary good. Any definition in this area of the spectrum of definitions of health must deal with the whole notion of well-being, qualifying it and limiting it so that it may end up as unrecognizable in order for this type of definition of health to be limited enough to be compatible with Rawls' social primary goods. Furthermore, the aspect of social well-being needs to be eliminated since it tends to

encompass all social primary goods. The main objection is that this type of definition is too inclusive, too general to be compatible with Rawlsian social primary goods. A definition of health must recognizably distinguish itself from the other social primary goods while still being compatible with them. Thus, using definitions of health from either extreme of the continuum of definitions available is methodologically unsound in developing a Rawlsian health-care delivery system.

Of the various existing concepts of health, the one proposed by Rene Dubos (1965, Man Adapting; hereafter quoted from Beauchamp and Walters, eds., 1978:97)--health as "the ability" of an individual "to function"--shows the most promise for compatibility with Rawls' social primary goods. This definition asserts that health is relative to a person's environment, mental status and physical condition. To avoid the criticisms against definitions like Green's or the WHO's, I would, however, like to modify Dubos' definition in two ways: (1) to include social and mental factors only as they relate to one's physical ability to function, and (2) to add the idea that health/unhealth consists of range of states along a continuum rather than being two specific and static physical states.

With regard to the first modification--the limitation of social and mental factors--two examples of the kind of

limitation I am speaking of will clarify my point. If a person is claustrophobic (a mental factor), few types of employment would affect that person's ability to function. Perhaps being an elevator operator would be one of them. Most occupations would not have an effect on that claustrophobic person, however. Furthermore being a member of the least advantaged group in a Rawlsian society (a social factor) would not affect the ability of that person to function (unless s/he attempts to function as one of the most advantaged persons). On the other hand, in an existing society, where being among the least advantaged members of society may also include gross nutritional deficiencies, there is a serious threat to that person's ability to function.

With regard to the second modification--adding the notion of a continuum to the concept of health--Dubos admits that health is individualistic and subjective. But there is an additional factor. Health is not a static state of being; it is not an absolute. The notion of a continuum is appropriate instead of an absolute. Health would still be individualistic and subjective, but a person's health could range along a continuum. For example, a controlled diabetic who is working and living in such a way that is not unrealistic can be healthy in our society. That is, her/his health status ranges very

high on a continuum of healthiness. Diabetes, as a disease, does not justify that person's entering a sick role when it is under good control. The diabetic is functioning within her/his full capacity as an individual who is aware of her/his limitations and accepts them. As Dubos points out, primitives are healthy only insofar as they can function in their society. Or in the same society, an athlete and a businessperson will have different relevant criteria for their personal health (Dubos, 1978:97-99). The addition of the notion of a continuum, then, is still consistent with Dubos' definition.

> [T]he words health and disease are meaningful only when defined in terms of a given person functioning in a given physical and social environment. The nearest approach to health is a physical and mental state fairly free of discomfort and pain, which permits the person concerned to function as long as possible in the environment where chance or choice has placed him. (Dubos, 1978:99)

This modification of Dubos' concept is minor in that "the nearest approach to health" would be read as "the nearest approach to perfect health."

Although the mental aspects of this definition of health are limited, it is important to note that psychological problems are still relevant to this definition of health. Crippling depressions, for example, can be perceived as dysfunctions or "unhealth." The depressed individual, with the characteristic physical

manifestations like loss of weight and so on, is not able to function effectively in society. As a result, s/he may be unable to carry out her/his rational plan of life. Engelhardt, in discussing a similar concept of health, expands upon this.

> One should also notice that the pattern of a syndrome can be such as to collect mental as well as physical signs and symptoms. Behavior patterns can be judged to be pathological as, for example, are schizophrenia and obsessive-compulsive neuroses, even though there are not well-established causal accounts of these phenomena. They count as diseases (at least as syndromes), not only because they are dysfunctional (untreated schizophrenics cannot do abstract thinking well, or participate well in the affairs of life; obsessive-compulsive neurotics find their compulsions interfering with their activities, goals, and projects), but also because people with these states find them unpleasant (painful in an extended sense). (Engelhardt, 1981:220)

Furthermore, within the context of this definition of health, psychological problems which can arise with the onset of catastrophic illnesses are relevant and important in attempting to restore functioning to the individual. The psychological component is not discounted in this model; quite the contrary, it is vitally relevant because it directly affects the ablility to function (or to regain functioning) in that person. Thus this definition overcomes some of the serious problems of the purely physicalist definitions of health. It accepts the kernel of truth in the WHO definition while allowing for a

meaningful, non-utopian concept of physical non-health (disease). The next step is to see if it successfully avoids the problems of the too-broad WHO definition.

In terms of responsibility, Callahan's objection to the WHO defintion can be overcome. The sick role may be entered when one is incapable of functioning. Unlike a purely physicalistic concept of health where psychological and social factors are excluded, a basis is provided for considering members of the corresponding mental health and social work professions as an integral part of the health-care team. Health care is not just medicine. It is an integrated field of disciplines which aim to restore or maintain functioning for the members of society. Moreover this concept of health keeps all members of the health-care team (including the patient) accountable for caring for the person (here the functioner), not merely for a physical disease. Awareness of the interrelation of psychological factors with one's ability to function thereby enters into health care instead of being treated as an intrusion on health care. This is consistent with the notion of a sick role.

> Siegler and Osmond give a summary of Talcott Parsons' sketch of the sick role that highlights the fact that though being sick is not a state of affairs for which one is immediately responsible, it is a state for which one is responsible for seeking treatment. "First, depending on the nature and severity of the illness, the sick person is exempted from some or all of his

> normal social role responsibilities. Second, the sick person cannot help being ill, and cannot get well by an act of decision or will. Third, the sick person is expected to want to get well as soon as possible. Fourth, he is expected to seek appropriate help, usually that of a physician, and cooperate with that help toward the end of getting well." (Englehardt, 1981:217. Siegler and Osmond, 1973:41, quoted by Engelhardt.)

Yet the individual is also responsible for the maintenance of her/his health. As Engelhardt (1981:217) points out, maintenance is the individual's responsibility before, during, and after entering the sick role. Since unhealth impairs one's ability to carry out one's rational life plan, the cooperation of the individual is necessary in order to either revise that plan in terms of different expectations (and the choice may not be entirely up to the individual) or to return to active life as soon as possible.

The abuse-of-language problem is also avoided in this definition. The opposite of health is not, strictly speaking, disease or sickness; it is unhealth seen as deficits in functioning. The additional notion of a continuum ranging from health to non-health is also a factor here. A person is relatively healthy or non-healthy according to his/her ability to function--according to her/his abiltiy to carry out her/his rational plan of life. Hence dysfunction can be viewed with alarm in any of these facets of integration.

These facets of integration also tie into concepts of

personhood. Moreover, all concepts of personhood seem to revolve around some notion of an individual's (at least, potential) integration as a social, psychological as well as physical being. Daniel Dennett's concept of a person, for example, which he claims parallels Rawls' contracting parties in the original position, contains these components. His conditions for personhood include six factors.

> The first and most obvious theme is that persons are rational beings. It figures, for example, in the ethical theories of Kant and Rawls, . . . The second theme is that persons are beings to which states of consciousness are attributed, or to which psychological or mental or intentional predicates, are ascribed. . . . The third theme is that whether something counts as a person depends in some way on an attitude taken toward it, a stance adopted with respect to it. . . . The fourth theme is that the object toward which this personal stance is taken must be capable of reciprocating in some way. . . .
>
> The fifth theme is that persons must be capable of verbal communication. This condition handily excuses nonhuman animals from full personhood and the attendant moral responsibility, and seems at least implicit in all social contract theories of ethics. . . . The sixth theme is that persons are distinguishable from other entities by being conscious in some special way: there is a way in which we are conscious in which no other species is conscious. Sometimes this is identified as self-consciousness. (Dennett, 1978:269-270)

Dennett's concept of a person, interestingly enough, is a normative as well as a metaphysical conception. This concept of personhood, as well as being compatible with Rawls, is compatible with the definition of health as the ability to function. In none of its conditions, as well

as in the set taken together, is there anything that would disavow health as the ability to function. The normative component is especially compatible with this definition of health as it has been developed.

The concept of health as the ability to function is also consistent with Rawls' thin theory of the good. Like all social primary goods, it is both general and relative to the individual. For example, as with income or wealth, which are general goods that are based on a continuum (i.e., a person can be relatively wealthy or poor, or can have a relatively high or low income), a person can also be relatively healthy or unhealthy. But in a sense, this is also an absolute concept. Just like one can add up all of one's assets and say, "my financial worth equals x dollars," one can say about one's health, "I have diabetes, but it's under control and I am x healthy, i.e., I am functioning at top capacity." Certainly there is a range of points in the middle of the continuum where one's health status is indeterminate, but a lot of middle-income people also feel a kind of indeterminacy regarding their wealth status as well. For the individual, then, health can also be an absolute at a certain time and place. This is important. It allows the individual to set up a realistic plan of life. If that person is relatively healthy, then s/he can carry out his/her rational plan of life.

Limitations in one's health, on the other hand, may result in the need to revise that plan.

These considerations of health as the ability to function are important in that they satisfy two of the criteria set for any addition to the list of social primary goods. Not only is this concept of health general and relative; but, in terms of its being an absolute to the individual, it is properly basic--that is, it satisfies the fundamental criterion of a primary good. Now health, defined as the ability to function, is "basic" in the sense that the other social primary goods are basic--i.e., not derivable from another social primary good or from a more basic concept. It is a concept separable from other social primary goods--yet sharing their defining characteristics--from which rights in terms of just distribution can be determined. The two criteria--generality and basicness--are directly related to Rawls' theory of the good. Other social primary goods as part of Rawls' theory of the good are also relative to the individual. In this concept of health, there is an aim at functioning to the best of the person's ability or capacity to perform. In this sense, the concept is also normative. Health as the ability to function has this component in that the sick role is not to be entered lightly and the individual shares in the responsibility to move out of

that role (if possible) and to return to or revise the path dictated by her/his rational plan of life. Furthermore, for Rawls (1971:408), the rational plan of life is the application of the "definition of the good to plans of life." Health factors certainly are relevant considerations in determining such a rational plan. "A rational plan must, for example, allow for the primary goods, since otherwise no plan can succeed . . ." (Rawls, 1971:410). Simply stated, the thin theory of the good for Rawls is delineated by the social primary goods. The full theory of the good entails the individual's rational plan of life, but it is not viable unless it includes the basic requirements of the social primary goods (and, I will concede, the natural primary goods as well).

Up to this point, this definition of health has been shown to avoid the problems of the narrow, physicalist definitions of health as well as broad definitions like the WHO definition. It has also been shown to be compatible to a large extent with other social primary goods. Before answering the question of whether this concept of health fits the rest of the criteria for being included as a social primary good, one other issue must be discussed.

This definition of health is also important in answering questions like: "is there a right to health care?" From this definition--health as the ability to

function--health is distinct from but related to health care. Health is a good--and will be seen as a social primary good. But, like self-respect, health cannot be provided directly by society. Only the bases of self-respect can be provided by society. Rawls (1971:544), in speaking of the basis of self-respect, states:

> The basis for self-esteem in a just society is not then one's income share but the publicly affirmed distribution of fundamental rights and liberties.

Since self-respect cannot be provided directly, the means for its provision lies in the distribution of the other social primary goods--especially liberty. By analogy, then, the bases of health can also be provided by society. The means for the provision of health, obviously, is health care (if that means is within society's control). Health care, as distinct from health, can be regulated. In other words, health care is directly at the disposition of society, while health is, in some respects, only indirectly affected by society.

Historically, health care has commonly been a concern of the institutions of society. The regulation of professionals in their work is an example of this. Codes of professional conduct have been in existence from the time of the Oath of Hippocrates to the present with its proliferation of codes governing the conduct of health-care

professionals in their work. These codes are internally imposed (like the AMA code) or imposed by regulatory bodies like legislatures or even by internal supra-national agencies (like the Helsinki Code). Public health has been an area of regulation as well. Governments consistently place restraints not only on health-care professionals, but also on the society itself to protect the health of its citizens (e.g., health codes for food handlers, etc.). When health is threatened, health care is regulated (if the means are available and if the threat to the members of society is perceived).

Thus health is distinct from but related to health care. The scope of health care is derived from the concept of health. Yet it must again be noted that health is a relative good--relative to the person in her/his relation to society and to her/his rational plan of life. This is the basis on which I would claim that health is a social primary good with a corresponding right to health care which should be subsumed into the second principle of justice. Thus health--actually the basis of health--is to be added to the list of social primary goods in the general conception of justice in Rawls' theory.

III. HEALTH AS A SOCIAL GOOD

In order to show that health is a social primary good, health as a primary good must be shown to be a social concept, not just a natural concept. Moreover, since those behind the veil of ignorance in Rawls' theory do not know their place in history, health as a social concept must be shown to be trans-historical. Thus, in this section, I will attempt to show that health is a social good, and, as such, it is trans-historical.

Health, like health care, is at the disposition of society, but in a different manner. Human beings are social beings. The structure of society in which people exist affects their lives and health at many levels. First of all, one of the basic needs of every human being is dependent on our being social beings--the basic need of food as adequate nutrition. The gathering of food is social by nature. Only rarely is there a period in history when each individual is totally responsible for the gathering, growing and hunting of food for his/herself. In fact, the development of agriculture--the means by which some people supply the nutritional needs of themselves and others--is usually the benchmark of a social organization even at the familial or tribal level. A drought, for example, affects the whole society, not just the producer of food. In fact, extended droughts that

result in famines affect the whole society, sometimes rendering it helpless. Consequently, the institutions of society regulate both the production and the saving of foodstuffs for the citizens. An adequate diet is necessary for people to function well. A society that is capable of providing for that adequately is usually able--barring plagues, wars or other catastrophes--to be viable and to progress. From this basic level of subsistence to the sophisticated levels of bureaucratic government (the FDA, for example), the health of the members of society is a valid concern of that society.

Environmental concerns are also social concerns related to health. The drought which causes food shortages or famines shows the inter-relationship between one's environment and one's health. Yet there are also other environmental concerns. The 19th and 20th centuries with the industrial revolution and the concomitant environmental problems are a prime example of this. Pollutants affect peoples' health. Some of these pollutants are carcinogenic; others are debilitating in other ways like the coal dust that causes black lung disease. Working conditions spread beyond the industrial revolution. Persons taking long ocean voyages or the ship's personnel were prime sufferers of scurvey before the relationship between this dysfunction and diet was discovered. People who painted

the radium on the dials of watches in watch factories were prone to lick the tip of the paint brush so that it would result in the finest possible line. These workers died by the hundreds before the cause--radioactive poisoning from radium--was discovered. But working conditions spread beyond even these concerns. The hours that one works affect one's health. These factors have affected the lives of human beings in all ages of history. Even slave owners--except for the worst of them--generally tried to maintain working conditions at a level that kept their slaves able to function. A healthy slave was capable of more work.

Concern for the disposal of waste is another time-transcending environmental concern of the institutions of society. Although primitive and even some later, more modern societies did not always connect waste disposal to health, regulations for waste disposal were imposed when the connections were inferred. Thus, for example, the typhoid organism was found to infect people through drinking impure water. The purity of the water supply was then regulated. As more was known about the sources of the disease, regulations became more specific. Now, the carrier of the typhoid organism can be detected by blood tests. Strict regulations forbid the handling of food for public consumption by carriers. Health cards are required

as a result--cards which state that the person working in this or that establishment neither is the carrier of a communicable disease nor has one.

Another example of regulation of waste disposal concerns disease-carrying pests like rats. Some species of flea-infected rats or ground squirrels carry the bubonic plague organism. As societies began to connect the infestation of rats with the occurrence of plague, waste disposal regulations then became important since garbage attracts rats. The point of all of this is that when problems in health arise as environmental concerns, society becomes legitimately involved. Regulations concerning solution(s) to those problems are, in this sense, health-care regulations.

People participate in a society at a level determined by their health. People who are starving, people who live in an environment that limits participation, people afflicted by non-health necessarily participate at a much more limited level than those who are not bound by these constraints. I am not denying that other factors are relevant. The point here is that the lack of health constrains those who would otherwise be prone to participate in their society. Accordingly, a society which has concern for the active participation of its members--whether in the political process or merely in the sphere

of production--has reason for concern for the health of its members. As awareness of health problems becomes an issue, society in turn, through its institutions, seeks to regulate causes of those problems or seeks to discover their source so that they may be eliminated (or severely curtailed). This has been the case with many physical illnesses, for example. Thus research and treatment of the dysfunctions of the members of the society is engendered. In this sense and to this extent, health is a social concern. The lack of health, i.e., unhealth, affects society at its core and is a factor in the vitality of a functioning social union.

IV. HEALTH AS A PRIMARY GOOD

There are, however, some people who would admit to the social nature of health, but would argue that health cannot be a primary good, i.e., a good that a rational person would want in any case and want more, rather than less (Rawls, 1971:62, 92). They claim that people do dangerous tasks in work and play quite willingly--being a test pilot, for example, or skydiving. Furthermore, they would claim that people do unhealthy things--like cigarette smoking when it is known that it causes cancer and is a significant factor in heart disease, etc. Sometimes people even refuse life-saving treatment in the face of a

catastrophic illness--even when the chance of recovery is excellent with that treatment.

This is a serious objection. It can, however, be confronted successfully. My answer to this objection will be based upon two points inherent in Rawls' theory of justice: (1) original position reasoning in terms of the veil of ignorance; and (2) the relationship of health to self-respect, another social primary good. Although the arguments that follow are somewhat sketchy in that numerous examples could be given to enhance them, they are sufficient to show that health is in fact a primary good, hence a social primary good.

A. Original Position Reasoning

The knowledge allowed in original position deliberations would do much to temper the objections to health as a social primary good. The veil of ignorance limits the particular facts one may have at one's disposal. Rawls (1971:137) states:

> First of all, no one knows his place in society, his class position or social status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like. Nor, again, does anyone know his conception of the good, the particulars of his rational plan of life, or even the special features of his psychology such as his aversion to risk or liability to optimism or pessimism.

What is known, on the other hand, includes general facts

about human society, political and economic principles, laws of human psychology and social organization (Rawls, 1971:137). Now, concerning the arguments for health as a social good, specific examples of arguments can be eliminated, but the basic points of the social nature of health would be allowable--i.e., the need for food or adequate nutrition, the interaction of the human organism with its environment, and so on. The fact that people are biological organisms who are prone to diseases, injuries, and other dysfunctions that constitute unhealth would also be allowable. The ability to participate in terms of the relationship of the health of the individual to society would be one of the general laws of psychology. Certainly Maslow (1968:3-5), in his list of primary needs, orders these and relates these concerns of health to one's propensity to participate socially. Likewise Daniels' (1981:158) list of health needs reflects the social nature of health (especially the needs for companionship and a mate).

The objections to health being accepted as a primary good, however, do violate the limitations of the veil. Certainly, a person in the original position knows that people do take risks--but one does not know one's own propensity for risk-taking. Furthermore, people are known to take risks with the other primary social goods like

power, income, and wealth. The important point, however, is this: one would not, according to Rawls, gamble inside the veil of ignorance that one would be a risk-taker outside the veil.

> As far as possible the choice of a conception of justice should depend on a rational assessment of accepting risks unaffected by peculiar individual preferences for taking chances one way or another. . . . What must be shown is that choosing as if one had such an aversion is rational given the unique features of that situation irrespective of any special attitude toward risk. (Rawls, 1971:172)

In original position reasoning, then, the standpoint would be the rational position--one in which it would be rational to want to be healthy. It would not be rational to assume that one would be a chronic daredevil, stuntperson or chain-smoker. Certainly one cannot change one's genetic heritage or be certain that an illness or accident will not occur. But an individual would rationally want to have the ability to function to the best of his/her normal, natural ability and want more--rather than less--of the opportunity to attain that ability if it were humanly attainable (within reasonable limits, of course). A possible counter-argument to my position may be that health--even defined as the ability to function--is contingent. One simply cannot guarantee health to all. Certainly. I agree. But then, so also is the place one is born into in society. Some people by virtue of being born

into rich and powerful families in affluent societies have more power and wealth than others--even in a just society. The argument, however, is that by including health as a social primary good, one has the right to a just distribution of health care in the same sense that one has the right to a just distribution of power and wealth. Inequalities in health care can be justified only when they are of benefit to the least-favored representative individual. This is why, of course, health care is to be subsumed into the second principle of justice rather than the first, and why health is to be added to the list of social primary goods in the general conception of justice.

B. Health and Self-Respect

The fundamental argument against those who would oppose including health as a primary good is based upon correct original position reasoning. It points out the need for consistency with Rawls' methodology. Yet a note about the relationship of health to self-respect, one of Rawls' most important primary goods, is helpful in bolstering the argument. This primary good has two aspects.

> First of all . . . it includes a person's sense of his own value, his secure conviction that his conception of the good, his plan of life is worth carrying out. And second, self-respect implies a confidence in one's ability, so far as it is within one's power, to fulfill one's intentions. (Rawls, 1971:440)

I would argue that without health being included as a

Rawlsian social primary good, this important primary good of self-respect may be unattainable in relevant measure for a large segment of even a Rawlsian well-ordered society. Accordingly, I will also be giving some other basic reasons why health is in fact needed as a social primary good--how it (or the lack of it through institutionally legitimated lack of an opportunity for health care) affects one in society. It affects a person's outlook on life in that it affects one's reaching or even striving for goals--Rawls' rational life plan.

An untreated treatable impediment is, I maintain, a serious injustice if one's opportunity for treatment is blocked or is non-existent as a result of societal lack of concern. For example, a paraplegic may be confined to a wheel chair. That is a given fact in his/her life. But when that person's mobility, thus perhaps his/her rational life plan, is systematically and pervasively thwarted or even denied by the imposition of barriers--curbs, stairs, narrow doorways, and so on--that health situation directly affects one's self-respect. One feels useless, thwarted. That person is effectively blocked from developing and carrying out her/his rational plan of life (which may include freedom from total dependence on another to provide that enabling mobility).

Health care is not simply treatment of disease.

Given the definition of health I presented at the beginning of this chapter, health care can now be defined as the enabling of a person to function--within the limits imposed by treatment possibilities--as an effective autonomous human being. In terms of the example of the paraplegic, health care includes not only physical treatment, but also a barrier-free environment so that mobility (hence, that person's rational plan of life) is possible.

V. SOME CONCLUDING NOTES

Another factor of health care is cost. If health care is a right, the distribution (not allocation) of health care must be carried out in a way that the least-advantaged citizen is able to gain access to the health-care delivery system consistent with the principles of justice. Details of a just system of distribution certainly need to be delineated. In fact, this is part of the task for later chapters.

In Chapter III, the unmodified Rawlsian health-care delivery system was delineated. A brief review of this chapter shows that the unmodified system is problematic. Rawls (1971:270) places health services into the category of "public goods." This is consistent within his perception of the placement of health as a natural primary good. Yet public goods are (1) indivisible and (2) public. "That

is, there are many individuals, a public so to speak, who want more or less of this good, but if they are to enjoy it at all must each enjoy the same amount" (Rawls, 1971:266). With issues in health care beyond the considerations of public health, i.e., access, research on specific illnesses and so on, Rawls' position simply becomes unmanageable. Furthermore, public goods are allocative. Issues like access to the health-care delivery system are distributional issues. By adding health as a social primary good to Rawls' theory of justice, these problems can be overcome. Health-care can then be viewed as a distributive issue where necessary and appropriate. Even with health included as a social primary good, allocational issues in health care would still be appropriately regulated by the principle of the common interest. Thus they would be acknowledged as part of a Rawlsian theory, but a modified Rawlsian theory would provide as well for the distributional issues that arise when health is considered a social primary good.

Many of the impediments to health as the "ability to function" that arise in society are not necessary. Nor are they just. Public priorities can be formulated for the retraining, the gaining of access, and the removal of stigmas attached to unhealth. The institutional level, the level of justice as fairness, is the obvious target

for these changes. The acceptance of health as a social primary good--when health is defined so as to be consistent with and fulfill the criteria necessary for social primary goods--leads to no methodological difficulties in accepting health care as a right.

The path to this move is now clear. This particular concept of health has been shown to fulfill the criteria for any social primary good. Furthermore, it has been shown to overcome possible objections for being treated as a legitimate concept of health. Finally, it is consistent with Rawls' theory of the good in the same way as other social primary goods. Health is a social good; it is a primary good; its relationship to self-respect is sound. Since health is a social primary good, health care can be considered as a right which is subsumed under the second principle of justice. Just as one must balance other second-principle rights in relation to one another to achieve reflective equilibrium, health care must also be balanced among those rights. In order to make this necessary inclusion of health and health care into Rawls' theory, the general conception of justice (Rawls, 1971:303) should be reworded in the following manner:

> All social primary goods--liberty and opportunity, income and wealth, and the bases of self-respect and health--are to be distributed equally unless an unequal distribution of any or

all of these goods is to the advantage of the least favored.

The methodology here is simple and consistent. It allows for a straight-forward Rawlsian approach without violating the veil of ignorance or any other of the constraints of the original position. In comparison with the approaches of both Daniels and Green, my approach to issues in health care delivery is thus superior since both of their approaches have conceptual and methodological problems.

A brief comparison between my modification of Rawls' theory and Daniels' modification will clarify this. Admittedly the second principle of justice refers to opportunities. Rawls states that principle and its priority rules as follows (with my modification of the general conception of justice included):

> Second Principle
> Social and economic inequalities are to be arranged so that they are both:
> (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and
> (b) attached to offices and positions open to all under conditions of fair equality of opportunity.
>
> First Priority Rule (The Priority of Liberty)
> The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty.
>
> . . . . . .
>
> Second Priority Rule (The Priority of Justice over Efficiency and Welfare)
> The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and

fair opportunity is prior to the difference principle. There are two cases:

(a) an inequality of opportunity must enhance the opportunities of those with the lesser opportunity;

(b) an excessive rate of saving must on balance mitigate the burden of those bearing this hardship.

General Conception

All social primary goods--liberty and opportunity, income and wealth, and the bases of self-respect and health--are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored. (Rawls, 1971:302-303, my modification to the general conception of justice included.)

Now Daniels buries health care needs as background concerns of the Rawlsian notion of opportunity. Yet it is the social primary goods that form the basis for any truly Rawlsian notion of opportunity. Since they are the content of the general conception of justice from which the two principles of justice are derived, they directly affect the institutions that are the concern of Rawls' theory of justice. By accepting health as a natural good, Daniels' position does not give health care the direct attention needed as an institution guided by the principles of justice. My position, on the other hand, achieves just that. Treating health as a social primary good leads to its placement in the general conception of justice. As such, health-care institutions are directly ruled by the considerations and priority rules relating to the second principle of justice as delineated by Rawls.

As such, injustices can be more directly perceived. Furthermore, the institutions of the health-care delivery system can now be analyzed and delineated for a well-ordered society. Thus, when the move into non-ideal theory is made, comparisons of the justice of health-care delivery alternatives can be made by appealing to a just system of health-care delivery in a well-ordered society.

In conclusion, the major block to using Rawls' theory of justice for issues in the health-care delivery system has been eliminated. In the course of the last two chapters, three alternatives--Daniels', Green's, and my own--have been analyzed for conceptual and methodological clarity and simplicity. Considerable problems were delineated in both Daniels' and Green's approaches. On the other hand, the concept of health I have developed has been analyzed for conceptual clarity and methodological consistency with Rawls' theory of justice. It has been found satisfactory up to its present point of delineation. Furthermore, health defined as the ability to function has been shown to be acceptable as a social primary good. As such, it has been included in Rawls' general conception of justice, and health care is subsumed into the second principle of justice. The steps taken in doing this have been methodologically sound and change Rawls' theory of justice only minimally. As a result, a true Rawlsian

approach to the issues of justice in health-care delivery systems can now be undertaken.

CHAPTER VI

THE FOUR-STAGE SEQUENCE AND THE INSTITUTIONS OF THE HEALTH-CARE DELIVERY SYSTEM

I. INTRODUCTION

In the last chapter, health was shown to be a social primary good, thus allowing it to be included in the general conception of justice as developed by Rawls in his theory of justice. As a result, health care can be considered a right under the second principle of justice. What remains to be shown, however, is why health care is a second principle rather than a first principle concern. That is the subject of the Section II of this chapter. Ultimately, however, since the purpose of this essay is to evaluate the justice of different models of existing health-care delivery systems, the development of the placement of health-care institutions in a Rawlsian system is needed. That development can only be accomplished by following the methodology set up by Rawls in his four stage sequence, which, he (Rawls, 1971:195) states, provides the "framework . . . needed to simplify the application of the two principles of justice." The considerations involved in using Rawls' four-stage sequence will be the subject of Section III of this chapter. The analysis in the final section will spell out in detail the

role of the background institutions set up by Rawls within the context of that four-stage sequence as well as their roles in a health-care delivery system. This section will conclude with a final critique and analysis of Daniels' modifications to Rawls' theory as well as a analysis of Robert Veatch's arguments against the practicality of using Rawls' theory for issues in the health-care delivery system.

II. HEALTH CARE AS A SECOND PRINCIPLE RIGHT

In Chapter II, the lexical ordering of Rawls' two principles of justice was discussed. Rawls argues that liberty has priority over second principle concerns like equality of opportunity and the distribution of goods. Given the connection of health to self-respect (shown in the previous chapter) some may wish to argue for health care as a first principle concern. It would seem that the bases of self-respect are fundamental to the first principle of justice--perhaps the only other social primary good beyond liberties and rights pertaining to those liberties of conscience and freedom of thought that can be truly a first principle social primary good. On the other hand, the institutions of the health-care delivery system would be more consistent with those institutions, which, according to Rawls, would be established as part of the

realm of the second principle of justice which encompasses opportunities and distributions of goods.

The issue is not as clear-cut as it would seem. As was seen in Chapter IV, Ronald Green (in "Health Care & Justice in Contract Theory Perspective") considers health care as a social primary good. Green states:

> Access to health care is not only a social primary good, in Rawls' sense of the term, but possibly one of the most important such goods. I have already indicated the central place Rawls believes contract parties would give to the civil liberties. But certainly the same can be said for health care. Even more apparently than governmental interference, disease and ill health interfere with our happiness and undermine our self-confidence and self-respect. Indeed, some who have disputed the priority that Rawls gives to the civil liberties have done so precisely because they believe that other values, especially physical well-being and security, are to be rationally preferred. (Green, 1976:117)

Now Green refuses to be drawn into this discussion, and does, in fact, back down on his claim that health care is as fundamental as the civil liberties embodied in Rawls' first principle. But Green backs down very little: "But there seems to be little question that in the priorities of rational agents health care stands near to the basic liberties themselves" (Green, 1976:117).

Robert Veatch, in A Theory of Medical Ethics (1981:270-271), argues that Green (1976:117) ultimately opts for at least special status for access to health care

as a right. According to Veatch, Green's argument is as follows:

> Green argues that rational people would treat health care more like liberty, as having a priority over other social goods so that trades between health care and other goods is impermissible. This tactic has the effect of escalating health care into a special, privileged status. "We can expect," says Green, "the parties finally to opt for a principle of equal access to health care: each member of society, whatever his position or background, would be guaranteed an equal right to the most extensive health services the society allows." (Veatch, 1981:270-271; quoting Green, 1976:117)

Although Green does make this statement, Veatch is incorrect in implying that Green makes access to health care a first principle concern. Green's argument leading up to this statement is indicative of his acceptance of only the civil liberties as first principle concerns.

First of all, he considers access to health care as fitting under a distributive principle. Although Rawls talks in terms of less equal liberties, which gives rise to distribution concerns, he focuses almost entirely on the second principle for distribution of the social primary goods. Thus Green's language is more indicative of second principle considerations. Secondly, even though Green maintains that equal access would be considered a right by the contracting parties it is not necessary that this right is delineated exactly in the original position. Clearly Green needs to elucidate the point in the four-

stage sequence at which such a right would be delineated, but that lack of clarity and lack of methodological consistency are not sufficient bases for concluding that Green sets access to health care as a right subsumed under the first principle of justice. Green uses original position reasoning, not constitutional stage reasoning (the stage appropriate for the delineation of first principle rights). Finally, although Green refers to issues like merit and desert, and opts for equality as the basis for choosing the right to health care, it must be remembered that Rawls himself notes and uses two conceptions of equality. Whatever Green's position is, it is his ambiguity and his methodological mistakes, not a firm position that leads to Veatch's interpretation of Green's Rawlsian analysis of health care as a right.

Veatch does make an important point, however. To place health care or access to health care among first principle concerns would change Rawls' theory in a major way. Health care is a right in the same way that income, wealth, and power are rights. In following Rawls' four-stage sequence, liberty is given priority as a first principle right. Self-respect as a primary good plays a more ambiguous role. Self-respect, in a well-ordered society, "is secured by the public affirmation of the status of equal citizenship for all . . . (Rawls, 1971:545). In

this sense, it is part of the first principle of justice. Furthermore, liberty serves as the basis for self-respect in the first principle.

> Of course, it does not follow that in a just society everyone is unconcerned with matters of status. The account of self-respect as perhaps the main primary good has stressed the great significance of how we think others value us. But in a well-ordered society the need for status is met by the public recognition of just institutions, together with the full and diverse internal life of the many free communitites of interests that equal liberty allows. The basis for self-esteem in a just society is not then one's income share but the publicly affirmed distribution of fundamental rights and liberties. . . . When it is the position of equal citizenship that answers to the need for status, the precedence of the equal liberties becomes all the more necessary. (Rawls, 1971:544-545)

The supreme importance of self-respect, then affirms the priority of the first principle of justice. In this sense, it is a first principle concern. Rawls (as shown on p. 38) includes self-respect in the sense that "the precedence of liberty entails equality in the social bases of esteem" (Rawls, 1971:546).

In the context of excusable envy--where "envious feelings are not irrational" and "the satisfaction of" the rancor of the least advantaged citizens "would make them better off" (Rawls, 1971:534)--Rawls unhappily adjusts the status of this primary good to a second principle concern.

> Whether some adjustment for self-respect has to be made is best decided from the standpoint of the legislative stage where the parties have more information about social circumstances and

> the principle of political determination applies. Admittedly this problem is an unwelcome complication. Since simplicity is itself desirable in a public conception of justice, the conditions that elicit excusable envy should if possible be avoided. I have mentioned this point not to settle it, but only to note that when necessary the expectations of the less advantaged can be understood so as to include the primary good of self-esteem. (Rawls, 1971:546, emphasis added.)

Self-respect, then, may be a second principle primary good only in the context of accounting for justifiable envy. If this is Rawls' final determination of the placement of this primary good, it should be noted that the issues concerned with it--here the issues of justifiable envy, not the issue of equal citizenship--are legitimately dealt with at the legislative stage of the four-stage sequence.

Issues that concern equal citizenship are still first principle concerns as is the social primary good of liberty. Rawls is consistent with his four-stage sequence. Liberty has priority over distributive issues. When self-respect is considered in the context of equal citizenship, it is properly considered at the constitutional stage of the four-stage sequence.

In the four-stage sequence, the two principles of justice are derived in the first stage; the constitutional stage, which concerns only the first principle of justice is determined next. Only second principle concerns are considered in the legislative stage--the third

stage of the four-stage sequence. Finally, there is a judicial, administrative stage. Each following stage is governed by the considerations and framework built in the previous stages--thus, ultimately, in a just society, the two principles of justice are the foundation of the framework of a social order. To place health care as a first principle right is thus a methodological mistake if one is attempting to do a true Rawlsian analysis of issues in the health-care delivery system.

Ultimately health care is a second principle right. First of all, it not only concerns opportunities, but also distribution of goods--social primary goods. Although I earlier argued that health as a social primary good has a strong effect on self-respect, one of Rawls' most important primary goods, it must be remembered that the other primary goods also can have such an effect on self-respect. Rawls' concern for justifiable envy is indicative of this. In this sense, self-respect itself ultimately may be a second principle concern. Health care also has distributional aspects in that issues like research, access to the health-care delivery system, quantity of health care available, and so on, are all determined by the institutions set up by a just society in the legislative stage of the four-stage sequence. Issues like these are ultimately accounted for in the background

institutions which are set up by Rawls at the legislative stage. Rawls (1971:276) states:

> The social minimum is the responsibility of the transfer branch. . . . The essential idea is that the workings of this branch take needs into account and assign them an appropriate weight with respect to other claims. A competitive price system gives no consideration to needs and therefore it cannot be the sole device of distribution. There must be a division of labor between the parts of the social system in answering to the common sense precepts of justice.

This branch of institutions and the others--allocation, stabilization, and distribution--are "charged with preserving certain social and economic conditions" (Rawls, 1971:275). Health as a social primary good certainly is a need. Institutions are thus set up to determine the minimum health-care needs of the members of a society and give health care appropriate weight with respect to claims made by the need to fulfill the other social primary goods through their concomitant background institutions.

Before analyzing Rawls' background institutions, however, the modifications to Rawls' four-stage sequence should be made to provide the framework for a well-ordered society that includes health as a social primary good. These modifications will be presented in a review of that four-stage sequence.

III. MODIFICATIONS AND METHODOLOGY: APPLICATION OF THE FOUR-STAGE SEQUENCE

The purpose of this section of this chapter is to define the parameters of a just society--a well-ordered society--in which health is a social primary good. This contrasts with Rawls' well-ordered society (described in Chapter III above) in which health is a natural primary good, therefore not directly affected by its institutions. Consistent with Rawls' methodology, I am only concerned here with the framework of a hypothetical, ideal society, not with any existing society. As a result, I am at this point only going to describe the structure of such a society very loosely, pointing out the relevant areas in the four-stage sequence in which the inclusion of health as a social primary good will affect the basic structure. Since my ultimate purpose in this study is to evaluate the existing proposals for the health-care delivery system in the United States, I will assume that the well-ordered society derived in this portion of this paper is a constitutional democracy similar to that of the United States (but as an ideal, well-ordered society) rather than a socialist society, for example.

A. The First Stage--The Original Position

An initial modification of Rawls' theory is necassary at this stage of the four-stage sequence. The two principles of justice with their accompanying priority rules and the general conception of justice as stated by Rawls do not allow for health-care concerns as part of the basic structure of society since only social primary goods (as viewed by Rawls) are included in original position determinations. In the previous chapter, I argued that health (properly defined) should be considered a social primary good, with health care as a right subsumed under the second principle of justice. In Section II of this chapter, I argued that health care is a second principle concern rather than a first principle concern. The result of my arguments for health being considered a social primary good was a change in the general conception of justice in which the social primary goods are specifically mentioned. That change from Rawls' (1971:303) original statement is as follows:

> All social primary goods--liberty and opportunity, income and wealth, and the bases of self-respect and health--are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favored.

Health is added to Rawls' list of social primary goods as he delineates them in the general conception of justice.

Health is included with self-respect because, like

self-respect, only the bases of these social primary goods can be directly provided by the institutions of society. Health (or, especially, unhealth) also has a direct impact on self-respect--although it can have an enormous effect on income, wealth, opportunity and even liberty as well. This inclusion gives health no special status, however. In other words, the right to health care is a right to be balanced among other second principle rights at the appropriate stage of the four-stage sequence.

Yet the inclusion of health as a social primary good into the general conception of justice at the first stage of the four-stage sequence does modify Rawls' theory. As a second principle right, health-care institutions can now be developed as part of the distributive institutions included in a just society. Hence, concerns for the justice of issues arising in the institutions of the health-care delivery system are now appropriate concerns in any form of a well-ordered, just society.

B. The Second Stage--The Constitutional Convention

This stage is not directly affected by the inclusion of distributive health care issues as legitimate concerns of a well-ordered society. Since this stage is devoted to the development of a just constitution as constrained by the principles of justice, and, specifically, to the

issues relevant only to the first principle of justice, no modifications of Rawls' theory are necessary in this stage. At this stage (and each succeeding stage), it must be remembered, the veil of ignorance is lifted so that information necessary to the deliberations can be used--enabling rational choices at each stage. It is sufficient to state, however, that this stage is where one would determine the form of the society--whether it is to have an economic system similar to that in the United States or in some Western European nations, or whether it is to have an economy based upon socialism.

As I stated earlier, we shall assume for the purpose of this argument that the constitution chosen here would be consistent with a constitutional democracy--hence roughly similar to that of the U. S. Constitution. The points that Rawls makes pertaining to liberty are acceptable here with little extrapolation or comment. His points are general enough to fit many societies, but also elucidate and generally parallel the U. S. Constitution and the Bill of Rights as they affect liberty. Since my focus with regard to the four-stage sequence is the effects and modifications needed to include health as a social primary good, the acceptance of a constitutional form similar to that of the United States (but in a

form for a well-ordered society, rather than an existing society) is the only issue that is important.

C. The Third Stage--The Legislative Stage

For the purposes of this study, this is the most important stage in Rawls' four-stage sequence (after the initial modifications are made) for it is in this stage that second principle issues are determined and the institutions which relate to that principle are devised. (The veil of ignorance is further partially lifted in order that the needed information can be used for making rational choices.) This is thus the appropriate point at which to begin developing the structure of the institutions of the health-care delivery system. The importance of justice as fairness here as in other economic areas cannot be evaded.

> From the beginning I have stressed that justice as fairness applies to the basic structure of society. It is a conception for ranking social forms viewed as closed systems. Some decision concerning these background arrangements is fundamental and cannot be avoided. In fact, the cumulative effect of social and economic legislation is to specify the basic structure. Moreover, the social system shapes the wants and aspirations that its citizens come to have. It determines in part the sort of persons they want to be as well as the sort of persons they are. Thus an economic system is not only an institutional device for satisfying existing wants and needs but a way of creating and fashioning wants in the future. (Rawls, 1971:259)

In Chapter V of A Theory of Justice, Rawls discusses the basic institutions and social forms that are inherent in

legislative stage reasoning. Rawls stresses that in justice as fairness, the general desires upon which these institutions are formed are the social primary goods.

> By assuming certain general desires, such as the desire for primary social goods, and by taking as a basis the agreements that would be made in a suitably defined initial situation, we can achieve the requisite independence from existing circumstances. The original position is so characterized that unanimity is possible; the deliberations of any one person are typical of all. (Rawls, 1971:263)

Rawls also distinguishes between the allocative and distributive functions of social institutions. Distributive functions are specifically those which are determined in second principle, legislative stage discussions governed by the difference principle once fair equality of opportunity has been established. Allocative functions are governed by those institutions designed to fulfill the public good. These are ruled by the principle of the common interest (as discussed in Chapter III of this study). The focus here is on the distributive issues and the institutions designed to carry out the functions and distributions of goods as second principle concerns governed by the difference principle.

In the legislative stage, one major task is to set up the background institutions that form a part of the structure of a well-ordered society. These background institutions are used to assure just distribution of the social

primary goods. Consistent with his four-stage sequence of deliberations, Rawls assumes at this point that the institutions which secure liberty have already been set up. He also assumes that appropriate measures have already been undertaken to secure fair equality of opportunity. As a result, the difference principle will play a heavy role in determinations at the legislative stage. Rather than go into a lengthy discussion of these institutions at this time, I will merely note that these background institutions are the appropriate vehicle to use in developing the institutions of the health-care delivery system. Full discussion of these background institutions will be undertaken in the next section of this chapter.

D. The Fourth Stage--The Judicial-Administrative Stage

This stage (which is also subject to the constraints and decisions made in the three previous stages of the four-stage sequence) is the only stage in which there are no longer any limitations to the veil of ignorance. It is at this stage that rules are applied to particular cases and people with full knowledge of their circumstances.

In terms of the health-care delivery system and its institutions in this modified Rawlsian version, this is the stage at which the citizens of a well-ordered society would function on a day-to-day basis. This is the stage

in which persons with particular problems--like, perhaps Daniels' blind person whose needs make a claim on the justice of the health-care delivery system--would appeal to the appropriate institutions for resolution of their difficulties. In the later chapters of this essay, Rawls' caveat with regard to working within this stage is important to remember. This is the stage in which the determinations of the earlier stages are tested.

> Of course, this test is often indeterminate: it is not always clear which of several constitutions, or economic and social arrangements, would be chosen. But when this is so, justice is to that extent likewise indeterminate. Institutions within the permitted range are equally just, meaning that they could be chosen: they are compatible with all the constraints of the theory. Thus on many questions of social or economic policy we must fall back upon a notion of quasi-pure procedural justice: laws and policies are just provided that they lie within the allowed range, and the legislature, in ways authorized by a just constitution, has in fact enacted them. (Rawls, 1971:201, emphasis added.)

This caveat is important to remember in that I have deliberately chosen to develop a concept of a well-ordered society that closely parallels a Western democracy like that of the U.S.A. (within the constraints of justice determined by a Rawlsian system). I have done this in order to evaluate effectively the various proposals as well as the existing form(s) of health care for this society in terms of their closeness to the justice

embodied in a well-ordered society. In other words, how just are we, and how just can we really be?

This then concludes the modifications needed for Rawls' theory of justice at the level of the four-stage sequence so as to include health as a primary good and health care as a second principle right. The remaining task for this chapter is to analyze the background institutions which are determined at the legislative stage of deliberations.

IV. A RAWLSIAN ANALYSIS OF HEALTH-CARE INSTITUTIONS AT THE LEGISLATIVE STAGE OF THE FOUR-STAGE SEQUENCE

This analysis of Rawls' background institutions will be quite extensive since it will form the backbone of the modifications of Rawls' theory to include health care as a second principle right. The first part of this analysis will include some preliminary distinctions. The second part will focus on specific background institutions and their roles in a Rawlsian health-care delivery system. The last part will first include a final argument against Daniels' modifications to Rawls' theory. An analysis of Veatch's criticisms regarding the practicality of using Rawls' theory for issues in health care as well as some concluding notes will complete this section.

A. Some Preliminary Distinctions

Before considering the background institutions themselves, a brief discussion of Rawls' second principle of justice and the distinctions relevant to it will be helpful. These distinctions should not only enhance the clarity of the discussion of background institutions, but should also clarify some of the technical terms Rawls uses here.

The second principle of justice focuses on social and economic inequalities. These inequalities must be arranged to the benefit of the least advantaged citizens. Now Rawls has two priority rules governing the second principle of justice. The first rule establishes lexical ordering--the first principle of justice is lexically prior to the second principle and "therefore liberty can be restricted only for the sake of liberty" (Rawls, 1971:302). The second priority rule stresses that justice is prior to efficiency and the "fair opportunity is prior to the difference principle" (Rawls, 1971:303). For Rawls (1971:87), fair equality of opportunity has the role of insuring that "the system of cooperation is one of pure procedural justice."

Rawls defines pure procedural justice by first distinguishing between perfect and imperfect procedural justice. Perfect procedural justice, for Rawls (1971:85),

is exemplified in fairly dividing a cake by having the person cutting the cake get the last piece (therefore not choosing the distribution of pieces). Imperfect procedural justice on the other hand is more like a trial where a wrong outcome is possible despite following the rules. The characteristics of perfect procedural justice are the following for Rawls:

> First, there is an independent criterion for what is a fair division, a criterion defined separately from and prior to the procedure which is to be followed. And second, it is possible to devise a prodedure that is sure to give the desired outcome. (Rawls, 1971:85)

Imperfect procedural justice is defined this way:

> The characteristic mark of imperfect procedural justice is that while there is an independent criterion for the correct outcome, there is no feasible procedure which is sure to lead to it. (Rawls, 1971:86)

Rawls then gives the characteristic features of pure procedural justice. It is typified by gambling for Rawls.

> [P]ure procedural justice obtains when there is no independent criterion for the right result; instead there is a correct or fair procedure such that the outcome is likewise correct or fair, whatever it is, provided that the procedure has been properly followed. This situation is illustrated by gambling. If a number of persons engage in a series of fair bets, the distribution of cash after the last bet is fair, or at least not unfair, whatever the distribution is. . . . [T]he background circumstances define a fair procedure. . . . What makes the final outcome of betting fair, or not unfair, is that it is the one which has arisen after a series of fair gambles. A fair procedure translates its fairness to the outcome only when it is actually carried out. (Rawls, 1971:86)

Rawls then relates this discussion to the basic structure of society. Pure procedural justice is what he uses in his account of his theory of justice. The principle of fair opportunity as used in the priority rule of the second principle of justice is thus an insurance principle. It is the fair procedure properly implemented that insures a fair outcome.

> In order, therefore, to apply the notion of pure procedural justice to distributive shares it is necessary to set up and to administer impartially a just system of institutions. Only against the background of a just basic structure, including a just political constitution and a just arrangement of economic and social institutions, can one say that the requisite just procedure exists. (Rawls, 1971:86-87).

To repeat and expand on the original point in terms of the principle of fair opportunity here:

> It is evident that the role of the principle of fair opportunity is to assure that the system of cooperation is one of pure procedural justice. Unless it is satisfied, distributive justice could not be left to take care of itself, even within a restricted range. Now the great practical advantage of pure procedural justice is that it is no longer necessary in meeting the demands of justice to keep track of the endless variety of circumstances and the changing relative positions o[f] particular persons. One avoids the problem of defining principles to cope with the enormous complexities which would arise if such details were relevant. (Rawls, 1971:87)

As such, fair equality of opportunity--as embodied in the second priority rule--forms a procedural umbrella for developing the background institutions that pertain to the

second principle of justice. Its role is to guarantee pure procedural justice. It thus insures a fair outcome.

One further distinction is required here. Rawls distinguishes between formal and fair equality of opportunity. Formal equality of opportunity requires that "all have at least the same legal rights of access to all advantaged social positions" (Rawls, 1971:72). Fair equality of opportunity, on the other hand, adds to the definition of formal equality of opportunity by adding the notion of careers that are open to talents. This, of course, embodies the need for education.

> The thought here is that positions are to be not only open in a formal sense, but that all should have a fair chance to attain them. Offhand it is not clear what is meant, but we might say that those with similar ablilities and skills should have similar life chances. More specifically, assuming that there is a distribution of natural assets, those who are at the same level of talent and ability, and have the same willingness to use them, should have the same prospects of success regardless of their initial place in the social system, that is, irrespective of the income class into which they are born. (Rawls, 1971:73)

This distinction is important in that fair opportunity as used by Rawls is keyed into issues of opportunities to develop talents and abilities as well as to have fair opportunity for the exercise of those talents and abilities regardless of the income class under which one is born.

Rawls also makes provision for the principle of fair equality of opportunity at the constitutional stage of the four-stage sequence. This is tied into Rawls' point that this is a procedural rule and is ultimately part of the second priority rule of the principles of justice. Without the guarantee of fair equality of opportunity, Rawls sees the danger of those who are better situated having all of the political authority, thus including particular desires--those consistent with their position on the social scale--in not only the constitutional stage but in the legislative stage as well. (A more complete discussion of the role of this principle at the constitutional stage will be undertaken in the next chapter.) The importance of this principle in further deliberations is thus emphasized.

B. Health-Care Institutions at the Legislative Stage

The legislative stage is the appropriate point for the development of the institutions designed to carry out the mandate of the second principle of justice. Rawls sees this as an important and difficult process in meeting the moral demands of distributive justice.

> The main problem of distributive justice is the choice of a social system. The principles of justice apply to the basic structure and regulate how its major institutions are combined into one scheme. Now . . . the idea of justice as fairness is to use the notion of pure procedural justice to handle the contingencies of

> particular situations. The social system is to be designed so that the resulting distribution is just however things turn out. To achieve this end it is necessary to set the social and economic process within the surroundings of suitable political and legal institutions. (Rawls, 1971:274-275)

In beginning this process of legislative stage reasoning, Rawls makes two assumptions. In keeping with his four-stage sequence, Rawls assumes at this point that the institutions which secure liberty have already been set up. Rawls also assumes that appropriate measures have been taken to secure fair equality of opportunity.

> This means that in addition to maintaining the usual kinds of social overhead capital, the government tries to insure equal chances of education and culture for persons similarly endowed and motivated either by subsidizing private schools or by establishing a public school system. It also enforces and underwrites equality of opportunity in economic activities and in the free choice of occupation. . . . Finally, the government guarantees a social minimum either by family allowances and special payments for sickness and employment, or more systematically by such devices as a graded income supplement (a so-called negative income tax). (Rawls, 1971:275)

Since the priority rule that fair equality of opportunity is prior to the difference principle is satisfied in this assumption by Rawls, the principle that will govern in developing these background institutions is the difference principle rather than the principle of fair equality of opportunity. Moreover, in assuming that the principle of fair equality of opportunity has been satisfied, the

requirements of pure procedural justice have been fulfilled.

Rawls now sets out to develop his background institutions. Again the purpose in this process is to determine the outcome of distributive shares in a just manner at the legislative stage of reasoning. In Chapter II, pp. 55-57 of this study, the full delineation of each of these branches is made. At this point, it is sufficient to note that Rawls assigns the task of the distribution of the second principle social primary goods to the following four branches of background institutions: (1) the allocation branch, (2) the stabilization branch, (3) the transfer branch, and (4) the distribution branch. The exchange branch, as was discussed in Chapter III, is governed by the principle of the common interest, not the difference principle as is the case for the distributional background institutions. With regard to the health-care delivery system as a second principle concern, the transfer branch is the most important since it is concerned with needs.

1. The Transfer Branch. The transfer branch is not set up simply to deal with all desires of a community. It is specifically set up to determine the minimum needs of a society and fulfill them according to the constraints of the original position and the constitution that has

already been derived in the constitutional stage. In this branch, needs are also balanced among one another. Thus any attempt to deal with one specific issue like the health-care delivery system must account for other second principle needs. Since, for example, income is intrinsically a part of both the allocation branch and even more specifically the stabilization branch, some minimal claims must be met in the transfer branch as well--even if it entails more taxation from the distribution branch in order to bring about full employment. Thus the resources available to a society must be balanced. Rawls states it this way.

> Different institutions meet different claims. Competitive markets properly regulated secure free choice of occupation and lead to an efficient use of resources and allocation of commodities to households. They set a weight on the conventional precepts associated with wages and earnings, whereas the transfer branch guarantees a certain level of well-being and honors the claims of need. . . . The relevant point here is that certain precepts tend to be associated with specific institutions. It is left to the background system as a whole to determine how these precepts are balanced. Since the principles of justice regulate the whole structure, they also regulate the balance of precepts. (Rawls, 1971:276)

Within the transfer branch itself, moreover, the needs of the community must be balanced. If the transfer branch is responsible for increasing the level of well-being to an acceptable level, income, power, wealth, and even issues of self-respect (i.e., second principle social

primary goods) will also compete with health-care needs. Furthermore, as part of the determinations of the legislative stage, the constraints of the veil of ignorance at this stage are still in effect. Any and all choices regarding the transfer branch must also be made from the standpoint of the least-advantaged representative citizen. Finally, although all of the priority rules which are part of Rawls' full delineation of the principles of justice obtain, it must be remembered that the difference principle plays a major role in the function of the transfer branch.

A discussion of this principle is in order, but before this is undertaken, it is important to note Rawls' caveat:

> But once a suitable minimum is provided by transfers, it may be perfectly fair that the rest of the total income be settled by the price system, assuming that it is moderately efficient and free from monopolistic restrictions, and unreasonable externalities have been eliminated. (Rawls, 1971:277)

This statement is consistent with the two principles of justice and their priority rules. Since the principle of fair equality of opportunity (thus pure procedural justice) is satisfied, the outcome is considered just. Thus once the minimum is set in a society, the price system is indeed fair so long as it is efficient and tends to be stable. The primary roles of the difference principle in

these deliberations, then, are to set the minimum--the just minimum--in society, and to "insure oneself and one's descendants against these contingencies of the market. Indeed, the difference principle presumably requires this" (Rawls, 1971:277).

a. The Difference Principle. Rawls favors a system of democratic equality wherein "the principle of fair equality of opportunity" is combined "with the difference principle" (Rawls, 1971:75). The principle of fair equality of opportunity, of course, regulates the use of the difference principle, according to the priority rules of the second principle of justice. The difference principle has a specific role, however.

> This principle removes the indeterminateness of the principle of efficiency by singling out a particular position from which the social and economic inequalities of the basic structure are to be judged. (Rawls, 1971:75)

Rawls' intuitive explanation of this principle sets its practical basis:

> Assuming the framework of institutions required by equal liberty and fair equality of opportunity, the higher expectations of those better situated are just if and only if they work as part of a scheme which improves the expectations of the least advantaged members of a society. The intuitive idea is that the social order is not to establish and secure the more attractive prospects of those better off unless doing so is to the advantage of the less fortunate. (Rawls, 1971:75)

A highly technical discussion follows wherein Rawls shows

that the application of the difference principle is more just than the principle of utility since the difference principle deals with the fact that the majority of the members of a society have fewer advantages, whereas the principle of utility only sets a median of advantages that does not account for the greater number of disadvantaged persons.

Rawls then develops a number of points about the difference principle. He first delineates what he considers the best arrangement--a perfectly just scheme wherein

> the expectations of the least advantaged are indeed maximized (subject, of course, to the mentioned constraints). No changes in the expectations of those better off can improve the situation of those worst off. (Rawls, 1971:78)

In the second case the "expectations of all those better off at least contribute to the welfare of the more unfortunate. . . . Yet the maximum is not yet achieved" (Rawls, 1971:78). This is still a just arrangement, according to Rawls, so long as the fulfillment of the higher expectations of the better off continue to be to the advantage of the less well off. Rawls then depicts an unjust scheme:

> A scheme is unjust when the higher expectations, one or more of them, are excessive. If these expectations were decreased, the situation of the least favored would be improved. How unjust an arrangement is depends on how excessive the higher expectations are and to what extent they depend upon the violation of the other principles of justice, for example, fair equality of opportunity . . . . The point to note here is

> that while the difference principle is, strictly speaking, a maximizing principle, there is a significant distinction between the cases that fall short of the best arrangement. A society should try to avoid the region where the marginal contributions of those better off are negative, since, other things equal, this seems a greater fault than falling short of the best scheme when these contributions are positive. The even larger difference between rich and poor makes the latter even worse off, and this violates the principle of mutual advantage as well as democratic equality. (Rawls, 1971:79)

Rawls then points out that the difference principle is consistent in general with the principle of efficiency.

> For when the former is fully satisfied, it is indeed impossible to make any one worse off, namely, the least advantaged representative man whose expectations we are to maximize. (Rawls, 1971:79)

Rawls does, however, point out the priority of justice over efficiency and claims that this "requires some changes that are not efficient in this sense. Consistency obtains only in the sense that a perfectly just scheme is also efficient" (Rawls, 1971:79-80).

Rawls (1971:83) finally introduces the notion of chain connection into the what he calls the "lexical difference principle." There are two assumptions involved in this notion:

1. that advantages to the least well off will also be advantages to those who are in between the least and best well off--"it raises the expectations of all positions in between" (Rawls, 1971:80); and

2. that close-knittedness will obtain--raising or lowering the expectation of any representative person will result in "raising or lowering the expectation of every other representative man, especially that of the least advantaged" (Rawls, 1971:80).

Although Rawls is aware that in reality these conditions may not obtain, he uses this notion as a simplifying device to express a more general principle:

> [I]n a basic structure with n relevant representatives, first maximize the welfare of the worst off representative man; second, for equal welfare of the worst-off representative, maximize the welfare of the second worst-off representative man, and so on until the last case which is, for equal welfare of all the preceding n-1 representatives, maximize the welfare of the best-off representative man. We may think of this as the lexical difference principle. However, I shall always use the difference principle in the simpler form. (Rawls, 1971:83)

This reasoning leads to Rawls' formulation of the second principle of justice. The difference principle is one of the most important principles developed by Rawls in his theory of justice. It role is pervasive throughout the theory, but it is most important in the legislative stage of the four-stage sequence in which second principle concerns are determined.

The remaining question regarding the difference principle and its application in the legislative stage

concerns Rawls' caveat: once the basic minimum is set and satisfied through transfers,

> it may be perfectly fair that the rest of total income be settled by the price system, assuming that it is moderately efficient and free from monopolistic restrictions, and unreasonable externalities have been eliminated. (Rawls, 1971:277)

This caveat, read in the context of the difference principle constraints, as well as in the context of the operation of the branches of allocation and stabilization, is not inconsistent with Rawls' general theory. The constraints of the first two stages of the four-stage sequence are in force. And, of course, the procedure itself is just from the standpoint of pure procedural justice since satisfaction of the principle of fair equality of opportunity is assumed at the beginning.

The difference principle in a perfectly just situation is efficient. Chain-connectedness, which leads to the lexical statement of the difference principle, applies. The price system is moderated by the allocation branch, constraining the unjust and uninhibited growth of a capitalist economy.

Rawls' caveat can then be restated: Given the assumptions of the constraints imposed by the first two stages of reasoning and fair equality of opportunity, and with suitable transfers, a minimum standard of well-being can be set consistent with the difference principle, and

as long as the market is just--being regulated by the allocation branch--and the stabilization branch assures full and free employment, the income beyond the minimum can be determined by the market. In other words, capitalism is allowed so long as it fulfills the requirements of justice as fairness.

Thus the difference principle is to play a major role in determining any and all deliberations concerning the background institutions at the legislative stage of Rawls' four-stage sequence. Moreover, it will be of prime importance in determining the minimum of transfers in the distribution of the relevant social primary goods within the institutions set up in this branch. Furthermore, it is the basis upon which the determinations at this stage are made from the standpoint of the least-advantaged representative citizen.

b. The Problem of Legitimate Expectations. Rawls sets one basic criterion which helps to elucidate how the institutions of the transfer branch can fulfill their tasks.

> Whether the principles of justice are satisfied, then, turns on whether the total income of the least advantaged (wages plus transfers) is such as to maximize their long-run expectations (consistent with the constraints of equal liberty and fair equality of opportunity). (Rawls, 1971:277)

What are legitimate expectations? Rawls explains it this way.

> In a well-ordered society individuals acquire claims to a share of the social product by doing certain things encouraged by the existing arrangements. The legitimate expectations that arise are on the other side, so to speak, of the principle of fairness and the natural duty of justice. For in the way that one has a duty to do one's part when one has accepted a position in them, so a person who has complied with the scheme and done his share has a right to be treated accordingly by others. They are bound to meet his legitimate expectations. Thus when just economic arrangements exist, the claims of individuals are properly settled by reference to the rules and precepts (with their respective weights) which these practices take as relevant. . . . [I]n the traditional phrase, a just scheme gives each person his due; that is, it allots to each what he is entitled to as defined by the scheme itself. (Rawls, 1971:313)

The criterion of legitimate expectations used in the legislative stage tempers a too-egalitarian determination of one's social status. As long as the difference principle and the principles of justice are not violated, those better off as well as those who are worst off have legitimate expectations according to the scheme decided upon in the four-stage sequence. If the contracting parties meet their commitments, they have a right to have met for themselves the expectations arising from the social structure which was agreed upon.

2. The Transfer Branch and the Health-Care Delivery System. With these clarifications finished, a brief sketch can now be delineated incorporating the

institutions governing a health-care delivery system into the transfer branch. Since health--as the ability to function--is a social primary good, then institutions must be provided through the transfer branch to accomodate the health-care needs of citizens. Consistent with the difference principle, these deliberations are to be made from the standpoint of the least-advantaged representative person. These institutions must make provisions for access to the health-care delivery system, determine the range of health-care services to be provided, and make enough professionals available to provide these basic health-care services. The range of services would include providing the care necessary to maintain health, treating diseases, illnesses or accidents as well as deformities, and/or providing the services necessary for a person whose health situation is such that s/he can no longer fulfill a previous rational plan of life, but is still able to have alternative plans of life fulfilled. These institutions would probably also provide for catastrophic illnesses or accidents so that long-term financial burdens for health care would not be devastating. Health-care institutions would also provide for the elderly and those suffering from terminal illnesses. Some environmental considerations may also be included under the institutions of the

health-care delivery system--e.g., regulations providing for health-care compensations for high-health-risk jobs.

The precise range of services provided by the institutions concerned with health care under the transfer branch is nebulous at this point. This list may be too inclusive--or it may be incomplete. What I have attempted to do in developing this list is try to delineate those health-care services that could be conceived of as distributive needs--basic needs that an ideal legislator, reasoning from the standpoint of the least advantaged representative citizen, would consider it necessary to meet in order to fulfill the right to health care. The range of services to be specified here is also general to the extent that it is derived from general facts about health care--and not the particular needs of particular people. Given the fact that any society faces limited resources and must balance these health-care related second principle concerns with other needs derived from the social primary goods, the fulfillment of these basic health-care needs may be more minimal than one would initially expect. The difference principle must obtain as well--and, I would maintain, at least to some extent, the lexical form of the difference principle. Thus the least advantaged cannot have their health-care needs fulfilled at the expense of the fulfillment of the health-care needs

of those who are only somewhat better off (as is the case in our existing society where indigent care is provided, but those who are only slightly better off "fall through the cracks" of our health-care delivery system because of lack of money and third-party assistance).

Another determination that needs to be made is the evaluative framework for the health-care delivery system in a well-ordered society. Even in existing societies, constitutional democracies have different models of health-care delivery systems ranging from fee-for-service to socialized medicine.

Consideration of all of these issues is necessary and justified from the standpoint of the legislative stage of the four stage sequence. The task of developing such a framework will be completed in the next chapter.

3. The Role of the Distribution Branch. Since the distribution branch will also play an important role in determining the scope of the institutions which comprise the health-care delivery system, a brief summary of this fourth type of Rawlsian background institution is necessary. The distribution branch is important in that it provides the resources necessary to implement a just health-care delivery system. The distribution branch and its concerns must be considered in setting up the transfer branch so that the amount of resources available to the

health-care delivery system is known. In essence, this is the branch from which the funding for the transfer branch is made. The constraints on the legislative stage and the assumptions relevant to the background institutions themselves are all operative here. Taxes would be levied through this branch to provide the funding for the institutions developed through the transfer branch.

A further possibility--not mentioned by Rawls--may exist here. In all probability, it would be from the standpoint of this stage that regulations could be developed that could be considered "opportunity" taxes. For example, it may be that, rather than simply tax income, property, and so on, a society might determine that professionals (whose services are direly needed by the least advantaged and whose educational needs were provided through fair equality of opportunity) have a duty to provide their services (with pay) to the transfer branch in lieu of direct taxation during that period. After this limited term of duty, the professional may then enter exclusively into private practice. Applying this to health-care institutions, these professionals would, in return for the education (i.e., their opportunities) provided, serve--for a limited period of time--the health-care needs of the least-advantaged or serve those who live in out-of-the-way locations where there are few health-

care professionals. There is an analogous situation in our existing society which seems to make such an alternative tax in a well-ordered society more plausible. Many medical students have their tuitions and expenses paid for by the armed services. After they complete their studies (and sometimes their specialty residencies), they serve in the armed forces as officers and physicians and nurses for four years. After that time they are free to leave government service and enter into private practice. In a well-ordered society, the higher expectations of these professionals provided for by fair equality of opportunity is not just a gift. Since they are already being "taxed" by their government service (i.e., by not being in private practice at a possibly much higher income), they should not be taxed twice for their services by also having to pay standard income and property taxes and so on. This suggestion of an opportunity tax is an alternative to those taxes. Since the expectations of the least advantaged would be raised--without lowering the long term expectations of these professionals (they will be able to go into private practice and fulfill those expectations)--the scheme seems, on the face of it, just.

The discussion of the institutions provided for in a well-ordered society through the legislative stage deliberations is now complete. The basic types of

institutions and their roles in providing for health care in a Rawlsian well-ordered society have been roughed out. The importance of the legislative stage of Rawls' four-stage sequence cannot be denied. The constraints within that stage of reasoning have been delineated and followed throughout. Methodological consistency has been maintained. Thus, the modifications to Rawls' theory of justice which would allow the inclusion of health-care issues are, to this point, feasible.

Before completing the task of developing the basis for a Rawlsian health-care delivery system in a well-ordered society, a discussion of Daniels' and Veatch's position on these issues is in order. That is the task of the last part of this section.

C. Other Philosophers on Legislative-Stage Health-Care

In this section, earlier discussions of Daniels' modifications of Rawls' theory will be clarified in light of the analysis of Rawls' four-stage sequence and development of background institutions. In the second part of this discussion, Veatch's criticisms of the use of Rawls' theory for a just system of health-care delivery will be raised and discussed.

1. Daniels' Modifications Revisited. In his essay, "Health-Care Needs and Distributive Justice" (1981:146-179), Daniels argues that health-care should not

be considered a social primary good. He further argues that health-care issues can be incorporated into the principle of fair equality of opportunity as background institutions. My own modifications to Rawls' theory, which were developed in Chapters V and VI, may now lead to a extension of my criticisms of Daniels' essay in Chapter IV.

First of all, it is now clear that health must be considered a social primary good. The arguments in the last chapter--those focusing on the nature of the two principles of justice--show that only the social primary goods are rightly considered as issues directly under the principles of justice. On the other hand, it was also shown that Daniels' conception of health was not a viable candidate for inclusion of health as a primary good. These, however, are not the prime issues at stake in this discussion. The second issue, Daniels' treatment of the principle of fair equality of opportunity is the more important issue here.

Daniels' argument for including health-care as a legislative stage concern involves expanding Rawls' principle of fair equality of opportunity to include health care. Daniels' position is repeated here:

> Insofar as meeting health-care needs has an important effect on the distribution of health, and more to the point, on the distribution of

> opportunity, the health-care institutions are plausibly included on the list of basic institutions a fair equality of opportunity principle should regulate. (Daniels, 1981:165)

In Chapter IV, I argued that Daniels was inflating Rawls' principle of fair equality of opportunity. That argument can now be clarified. For Rawls, the principle of fair (as opposed to formal) equality of opportunity is a simplifying device--a rule, as it were--used to insure pure procedural justice. Earlier in this chapter, Rawls' position regarding pure procedural justice was analyzed. It was noted that in pure procedural justice, it is the fair procedure that insures a fair outcome. As Rawls uses the principle of fair equality of opportunity (included in this is its role as a priority rule governing the second principle of justice), it is clear that this principle is a procedural rule designed to incorporate pure procedural justice into the system as a whole. Furthermore, Rawls' formulation of the principle of fair equality of opportunity is an attempt to avoid the complexities of redefining principles at each stage of deliberations.

Rawls defines the principle of fair equality of opportunity so that the notion of careers open to talents (which embodies the need for education) is included. Now Daniels does acknowledge Rawls' definition of the principle of fair equality of opportunity.

> Rawls is primarily concerned with the opportunity to pursue careers--jobs and offices--that have various benefits attached to them. So equality of opportunity is strategically important: a person's well being will be measured for the most part by the primary goods that accompany placement in such jobs and offices. . . . [A]dvantages from the "natural lottery" are morally arbitrary, and to let them determine individual opportunity--and reward and success in life--is to confer arbitrariness on the outcomes. So positive steps, for example, through the educational system, are to be taken to provide fair equality of opportunity. (Daniels, 1981:165-166)

Since health is a natural primary good for Daniels, it is included as one of those arbitrary features of life thus included under the umbrella of the principle of fair opportunity. Daniels does this by drawing an analogy between health needs and educational needs in a society. He then includes health care issues--by virtue of their similarity to educational issues--into the principle of fair equality of opportunity. By doing this, health-care issues are to be included as background institutions in his modification of Rawls' theory of justice at the legislative stage of deliberations.

What Daniels does not recognize is Rawls' use of the principle of fair equality of opportunity. He sees the principle as strategically important, while Rawls uses this as a procedural device to insure pure procedural justice. Moreover, Rawls considers this principle--as one of the priority rules--to be part of the constitutional

stage of deliberations. Including fair equality of opportunity as a first principle consideration guarantees the worth of liberty for Rawls:

> Turning now to the worth of political liberty, the constitution must take steps to enhance the value of the equal rights of participation for all members of society. It must underwrite a fair opportunity to take part in and to influence the political process. (Rawls, 1971:224)

Rawls here includes the political form of the principle of fair equality of opportunity in the constitution just as liberty itself is transformed into the principle of participation at this point.

Moreover, fair equality of opportunity is one of the assumptions that Rawls makes before developing his background institutions. Rawls, it must be remembered, makes two assumptions before developing his background institutions: (1) that the institutions which secure liberty have already been set up; and (2) that the appropriate measures which secure fair equality of opportunity have already been taken (Rawls, 1971:275).

What needs to be emphasized in Rawls' use of the principle of fair equality of opportunity is that this is a procedural device used to insure pure procedural justice. Furthermore, fair equality of opportunity is a priority rule embedded in the constitutional stage, which gives it precedence over the difference principle, it

governs the deliberations made in setting up the background institutions (where the difference principle itself is used). In other words, Rawls is consistently using the principle of fair equality of opportunity to insure that the outcome in setting up the background institutions applicable to the second principle of justice is fair.

Although Rawls "combines" the principle of fair equality of opportunity with the difference principle at the legislative stage, he does not subsume either principle into the other--in other words, they are not merged together as Daniels seems to want to do. The principle of fair equality of opportunity is, at all times, separate from and prior to (i.e., governs) the difference principle. By "combining the principles," Rawls means only that they work in concert.

In modifying Rawls' theory, Daniels is tampering with an important principle with specific uses (which he ignores). As a result, he is running the danger of seriously damaging Rawls' requirement of pure procedural justice. He is also altering its content by making it too inclusive which may endanger its role as an important priority rule. Let me explain.

By including heath care here, he is giving it a special constitutional-stage status not shared by other second principle considerations--the social primary goods

like income, wealth, and so on. Veatch, in his objections against Green's giving health care some kind of special status, states the problem this way:

> This makes Rawls a health care egalitarian in spite of himself, or so it seems. Health care is, according to this view, so important that reasonable people would not permit trades of one's fair share of health care for other social goods. (Veatch, 1981:271)

According to Veatch, this point of view ignores the issue of access to the health-care delivery system based on health-care needs. Daniels, as has been shown in Chapter IV, argues for access on a need-based system. Furthermore, it has been shown that the transfer branch (governed by the difference principle) accounts for needs in Rawls' theory. By giving special status to health-care as part of the principle of fair equality of opportunity, Daniels is muddying the distinction between this principle and the social primary good, "opportunity," which, like other second principle social primary goods, is ruled by the difference principle. By adding the element of need into this principle, he is seriously altering its nature; thus its purpose in insuring pure procedural justice may be seriously thwarted.

It is up to Daniels to show more than an analogy between education needs and health-care needs if he is to include health-care needs in the principle of fair equality of opportunity. The biggest problem here is that

education as part of the principle of fair equality of opportunity is subtly changed from guaranteeing a fair procedure to being a need-based social primary good governed by the difference principle when Daniels turns his discussion to the strategic importance of the principle of fair equality of opportunity. Daniels must justify this shift. In doing so, he must also show that such an inclusion will not damage Rawls' requirement of pure procedural justice for which this principle plays the primary role. Furthermore, he must show that his inclusion will not affect the role of this principle as an important priority rule which affects the constitutional stage of deliberations. Finally he must show how, if this much of the role of the difference principle is to be incorporated into the role of the principle of fair equality of opportunity, the other second principle social primary goods (governed by the difference principle) must not also be included as part of the principle of fair equality of opportunity and given the same status as education needs and health-care needs. In other words, he must explain why income, wealth, power, and some aspects of self-respect are considered social primary goods and not just aspects of the principle of fair equality of opportunity.

Since this principle governs the deliberations made

in setting up the background institutions, there is no legitimate reason--if health were considered a social primary good--that health care considerations be included at their appropriate point of the transfer branch. If Daniels' concept of health were modified and included as a social primary good and thus health care included as a right subsumed into the second principle of justice, his concept of health care needs would be compatible with the transfer branch of background institutions--and, more importantly, methodologically consistent with Rawls' theory of justice. The discussion just completed in the previous section of this chapter shows that the transfer branch, with its focus on needs, is the methodologically appropriate background institution to deal with health-care needs.

Thus Daniels' best approach for salvaging his theory is to make the following modifications. First, he must properly distinguish between the principle of fair equality of opportunity and the social primary good of "opportunity" by acknowledging the special role of the prior and treating the social primary good in a consistent manner with other second principle social primary goods. Second, he must properly use the background institutions by keeping the principle of fair equality of opportunity separate from and prior to the difference principle.

Finally, health care considerations, which must be correctly considered as rights related to the social primary good of health, must be dealt with by the background institutions--with special emphasis on the role of the transfer branch since it specifically deals with needs.

2. Veatch and the Legislative Stage. At the other end of the discussions of applicability of Rawls' theory of justice to issues in health-care delivery is Veatch's position. Veatch claims that since inequalities are allowed in the second principle of justice, the result voted on by the contractors can be strange but still be considered just. Veatch poses a number of these situations that embody such a decision by these contractors.

> What, for example, of basic health care institutional arrangements that systematically single out elites with unique natural talents for developing medical skill and services and gives these individuals high salaries as incentives to serve the interests of the least well off? What if a special health care system were institutionalized to make sure these people were always in the best of health, were cared for first in catastrophes, and were inconvenienced least by the normal bureaucratic nuisances of a health care system? (Veatch, 1981:263; emphasis added).

It sounds very much like rhetoric, rather than argument here. But, rhetoric aside, it seems that Veatch is attacking the principle of fair equality of opportunity itself. This seems strange, at best. He seems to be saying that using the opportunities afforded the citizens

of a well-ordered society to develop their abilities and skills makes them "elites." This flies in the face of the first principle of justice which seeks to enhance liberty and equality of citizenship. Certainly Rawls would not deny the fact that some people are better off than others in a well-ordered society. Yet the whole concept of the social primary good of self-respect is an objection to the notion of elitism in Rawls' theory. The institutions set up would not enhance any notion of elitism, either.

More importantly, Veatch is using maximin reasoning at this stage of deliberations. He couches the above scenario in terms of maximin reasoning:

> Nevertheless, the interpretation of justice that attempts to maximize the minimum position in the society (and is hence sometimes called the "maximin" position), still permits inequalities and even labels them as just. (Veatch, 1981:263)

The analysis of maximin reasoning done in Chapter IV in discussing Green's use of it at the legislative stage shows that this is a methodological mistake. There is simply too thin a veil at the legislative stage to use this kind of reasoning effectively. In setting up the arguments for this stage--and especially in setting up the background institutions for a well-ordered society during the legislative stage of deliberations--one assumes, like Rawls, that the institutions preserving liberty have been

set up and that the requirements of the principle of fair equality of opportunity have been met.

The appropriate principle to use in these deliberations (given all of the constraints involved) is the difference principle. In a sense, Veatch does use language indicative of the difference principle. In claiming that the above scenario is conceivable, Veatch goes on to claim that such contractors, taking the moral point of view,

> could justify the special gains that would come to the elites by the improved chances thus created for the rest of the population (who would not have as great a gain as the favored ones, but would at least be better off than if the elite were not so favored). The benefits, in lesser amounts, would trickle down in this plan to the consumers of health care so that all, or the least advantaged, would gain. The gap between the elite of the health profession and the masses could potentially increase by such a social arrangement, but at least all would be better off in absolute terms. (Veatch, 1981:264)

Before going into the discussion of Veatch's use of the difference principle, I would like to stress again the use of Veatch's rhetoric here. In the sense that he is exaggerating class distinctions in a way contrary to Rawls' theory of justice--especially the first principle of justice--Veatch is setting up a "straw person" argument. He is making exaggerated claims, then pressing his arguments against the exaggerations.

Veatch's use of the difference principle is also

questionable here. His scheme is an example of what Rawls still calls just, "but not the best just arrangement" (Rawls, 1975:79). The example of a perfectly just arrangement for Rawls, remember, is different.

> The first case is that in which the expectations of the least advantaged are indeed maximized (subject, of course, to the mentioned constraints). No changes in the expectations of those better off can improve the situation of those worst off. The best arrangement obtains, what I shall call a perfectly just scheme. The second case is that in which the expectations of all those better off at least contribute to the welfare of the more unfortunate. That is, if their expectations were decreased, the prospects of the least advantaged would likewise fall. Yet the maximum is not yet acheived. Even higher expectations for the more advantaged would raise the expectations of those in the lowest position. . . . A scheme is unjust when the higher expectations, one or more of them, are excessive. If these expectations were decreased, the situation of the least favored would at least improve. (Rawls, 1971:78-79)

Now, given these examples by Rawls, it is obvious that Veatch is--at the very least--using the second type of case (i.e., raising the expectations of those who are better off proportionally much further than those who are less well off in order to maximize the expectations of those who are less better off). Furthermore, his excessive use of rhetoric leads one to wonder if he is not close to an unjust scheme in that the decrease in the expectations of the "elites" would still result in improved expectations by the least favored. In

deliberating at the legislative stage, the parties would be charged with setting up institutions using the best arrangement possible. Even if they are not able to come up with a perfectly just scheme, there may be others that are more nearly perfectly just than Veatch's depiction. (This only leads me to conclude that Veatch is setting up the weakest depiction of Rawls' theory possible and attacking it, while ignoring and refusing to argue against the strongest possible depictions).

Veatch is also ignoring Rawls' further assumptions about using the lexical form of the difference principle--chain-connectedness and close-knittedness. Chain-connectedness obtains when the raising the expectations of the least advantaged also raises the expectations of all those positions in-between. Close-knittedness obtains when any raise or lowering of the expectations of any representative person results in raising or lowering the expectations of all. Veatch's scheme ignores both of these features of Rawls' difference principle. In the depiction of the scenario, Veatch ignores close-knittedness; in his less-than-perfectly-just use of the difference principle, Veatch ignores chain-connectedness as well.

Veatch may be right that his depiction of health care institutions of a Rawlsian well-ordered society leads to a

"trickle-down" theory of justice in health-care delivery. He has not shown that a strong Rawlsian theory of health-care delivery is a "trickle-down" theory as well. In fact, since Rawls uses the standpoint of the least advantaged representative person in his deliberations, the most just scheme would be one in advantages "trickle up" the spectrum (in terms of advantages) of representative citizens.

Veatch's depiction of Rawls' theory is problematic at the very least. His use of rhetoric (incorporating informal fallacies) as well as his methodological problems of application of Rawls' principles leads me to question the cogency of his criticisms against using Rawls at the legislative stage of the four-stage sequence for issues concerning the health-care delivery system.

3. Conclusion. This discussion of Daniels' and Veatch's positions on using Rawls' theory at the legislative stage of deliberations concludes the tasks set out for this chapter. The analyses have shown that Rawls' theory can be successfully modified to include health care as a second principle right. Modifications (after including health as a social primary good in the general conception of justice in the first stage of the four-stage sequence) focused on the legislative stage of deliberations in this chapter since health care was shown to be

a second principle right. In the analysis of the background institutions (appropriate to the legislative stage), the transfer branch was shown to be the primary branch for developing the institutions for the health care delivery system that deal with distributional issues. The issues that are appropriate to this branch were roughed out as well.

The next task is to develop the best possible framework for a health-care delivery system in a well-ordered Rawlsian society. That is the task to be taken up in the next chapter.

CHAPTER VII

THE HEALTH-CARE DELIVERY SYSTEM IN A WELL-ORDERED SOCIETY

I. INTRODUCTION

In the last two chapters, Rawls' theory of justice has been modified in order to include health as a social primary good and health-care as a second-principle right. Close allegiance to Rawls' methodology was maintained so that the modifications would not alter Rawls' theory in a damaging way. As a result of these modifications, distributional issues in health care can now be seen as among the legitimate concerns of the institutions of a well-ordered society. Hence, one role of Rawls' conception of justice can ultimately be fulfilled--evaluating existing institutions and their policies to see how just they are.

> A conception of social justice, then, is to be regarded as providing in the first instance a standard whereby the distributive aspects of the basic structure of society are to be assessed. (Rawls, 1971:9)
>
> . . . . . .
>
> Viewing the theory of justice as a whole, the ideal part presents a conception of a just society that we are to achieve if we can. Existing institutions are to be judged in the light of this conception and held to be unjust to the extent that they depart from it without sufficient reason. (Rawls, 1971:246; emphasis added.)

In order to accomplish this task, however, some developmental work is needed to provide a framework for

evaluating existing and proposed health-care delivery systems. That will be the task for this chapter.

II. A FRAMEWORK FOR EVALUATING TYPES OF HEALTH-CARE DELIVERY SYSTEMS

The task set for this section is theoretical and, in a large part, intuitive. While maintaining consistency with the modified version of Rawls' theory of justice, the framework for an ideal, hypothetical health-care delivery system shall be developed for a well-ordered society. Some preliminary notes are necessary here.

First, the only distributive issue that I will discuss regarding the health-care delivery system is just access. The program that is followed here should be readily adaptable to other distributional issues in health care--such as research on diseases not affecting the whole population, and so forth. If, however, institutions other than those I introduce here are involved, there will certainly be distributional features which are unique to those particular institutions.

Second, since the focus in the next chapter is on the evaluation of health-care delivery systems developed within the social system in the United States, the well-ordered society to be considered in this section will be the well-ordered counterpart of the United States. In

other words, it will be basically a capitalistic society that is a constitutional democracy. The reason is simply this: in order to evaluate the justice of existing and proposed models of health-care delivery systems fairly, the framework for a well-ordered society must be similar to that of its existing counterpart.

There will be differences between this well-ordered society and existing U. S. society, however. Beyond the general fact that a well-ordered society is a just society, Rawls' methodology (which includes the four-stage sequence and his background institutions) demands that there will be initial and structural differences between a well-ordered society that is a capitalistic constitutional democracy and any existing society with its particular historical development.

Before beginning the tasks set for this section, I would like to set the stage with some cautionary remarks. In Chapter II, a number of distinctions used by Rawls are pointed out. The differences between a well-ordered society and an existing society are extremely important. A well-ordered society is, for Rawls, a hypothetical ideal. Strict compliance (as opposed to partial compliance) is maintained in developing the framework of such a society. As a result, such features as the veil of ignorance and the other constraints on the original position (and

corresponding constraints on the rest of the four-stage sequence) reasoning are maintained. Rawls moves into partial compliance only when discussing issues related to that framework. As a result, strict compliance must be maintained when developing the framework for the health-care delivery system. When issues related to just access (the focus of this study) are relevant, partial compliance theory is then appropriate.

One other cautionary note is necessary here as well. The health-care delivery system in this modified Rawlsian well-ordered society is only one of a number of second principle concerns. Others include power, income, wealth, and so forth. Ideal legislators cannot thereby devote all resources to the health-care delivery system. Furthermore, even in a just society, resources are limited, which will limit the amount of resources that can be apportioned to the health-care delivery system. Finally, justice between generations (a part of Rawls' priority rules--just savings) demands that some resources be saved for future generations.

This section shall consist of two parts. The first part will focus on Rawls' development of the constitutional stage of the four-stage sequence since this will provide a framework for developing the legislative stage considerations needed to construct the framework for a

Rawlsian health-care delivery system. Comparisons between Rawls' development of the constitutional stage and the existing U. S. Constitution will be made to emphasize the differences and similarities between a well-ordered society and our existing society. The second part will focus on the framework for the Rawlsian health-care delivery system. Relevant legislative stage constraints will be pointed out. The criteria for a just system of health-care delivery that will be developed in the next section will then provide the framework for that system.

A. The Constitution of a Well-Ordered Society

The hallmark of a well-ordered society is its shared conception of justice developed in the original position--the first stage of Rawls' four-stage sequence. In an existing society, the lack of this shared conception of justice leads to many problems, among them the problems of coordination, efficiency and stability (Rawls, 1971:6) (These were discussed here in detail in Chapter II, pp. 57-59.) Rawls conception of justice, starting with the two principles of justice (the first stage of the four-stage sequence) derived in the original position is developed to address these problems that plague existing societies. The second stage is the constitutional stage. It is at this stage that the constitutional framework of a well-ordered society is developed by Rawls (consistent

with the two principles of justice, of course). The framework Rawls develops at this stage will provide the constitutional model for the modified Rawlsian system that includes health as a social primary good.

A review and deeper analysis of second stage considerations is appropriate at this point. In the constitutional stage, the type of society that will "exist" as a well-ordered society is to be delineated. For Rawls, the principles of justice do not determine whether a society will be socialistic, capitalistic or embody some other form of government and/or economic system. The veil of ignorance is only partially lifted at this point. Particulars about one's place in society, or about particular individuals, or even one's conception of the good are still not known (Rawls, 1971:197). But Rawls does allow for certain knowledge beyond that allowed in the first stage:

> But in addition to an understanding of the principles of social theory, they now know the relevant general facts about their society, that is, its natural circumstances and resources, its level of economic advance and political culture, and so on. . . . (Rawls, 1971:197)

At this stage, Rawls is also still using the standpoint of the representative equal citizen. He is clearly working in strict compliance--in moral theory. Rawls states:

> The idea of the four-stage sequence is part of a moral theory, and does not belong to an account

> of the working of actual constitutions, except insofar as political agents are influenced by the conception of justice in question. In the contract doctrine, the principles of justice have already been agreed to, and our problem is to formulate a schema that will assist us in applying them. The aim is to characterize a just constitution and not to ascertain which sort of constitution would be adopted, or acquiesced in, under more or less realistic (though simplified) assumptions about political life, much less on individualistic assumptions of the kind characteristic of economic theory. (Rawls, 1971:197n)

This note points out two major differences between Rawls' scheme and constitutions developed by historically existing societies. First of all, although issues surrounding a concept of justice may play a role in the development of existing constitutions (e.g., the notion of liberty is intrinsic in the U. S. Constitution), for Rawls the principles of justice are the first stage in the sequence and cannot be overridden by social or economic necessity. In other words, the constitution for Rawls must be first and foremost a just constitution. Furthermore, first principle concerns are the appropriate area of focus in the constitutional stage, although the constitution must also contain the guidelines which are necessary for developing the legislative stage concerns. Thus the task here is not to write a constitution with full knowledge about one's society and individual concerns. Rather, the task is to delineate the framework of a just

constitution given the limited knowledge available from the standpoint of the representative equal citizen.

The main focal point of a just constitution, then, is the basic liberties that are to be guaranteed subject to the constraints of the first principle of justice. Rawls states this as a procedural issue--i.e., a "just constitution would be a just procedure arranged to insure a just outcome" (Rawls, 1971:197). Thus a just procedure is needed.

> To do this the liberties of equal citizenship must be incorporated into and protected by the constitution. These liberties include those of liberty of conscience and freedom of thought, liberty of the person, and equal political rights. The political system, which I assume to be some form of constitutional democracy, would not be a just procedure if it did not embody these liberties. (Rawls, 1971:197-198)

The other important issue at the constitutional stage, according to Rawls, is

> to select from the procedural arrangements that are both just and feasible those which are most likely to lead to a just and effective legal order. (Rawls, 1971:198)

These guidelines together with the appropriate lifting of the veil of ignorance should lead to the development of a framework of a just constitution.

A well-ordered society that is the just counterpart to the existing U. S. society would have a somewhat similar constitution. There are some important differences, however. Since Rawls perceives the need for a just

procedure, the basic liberties would be embedded into the basic structure of the constitution. In the U. S. Constitution, by comparison (after including liberty in the Preamble), the basic liberties are delineated in the first amendments to the constitution (primarily in the first amendment). In a well-ordered society, those liberties would be fundamental and would be embedded into the constitutional document itself.

Guaranteeing liberty or basic liberties without definition and elucidation of its roles is not enough, however. Rawls describes liberty "by a reference to three items: the agents who are free, the restrictions or limitations they are free from, and what it is that they are free to do or not to do" (Rawls, 1971:202). Given these three elements of liberty, Rawls defines it:

> The general description of liberty, then, has the following form: this or that person (or persons) is free (or not free) from this or that constraint (or set of constraints) to do (or not to do) so and so. Associations as well as natural persons may be free or not free, and constraints may range from duties and prohibitions defined by law to the coercive influences arising from public opinion and social pressure. (Rawls, 1971:202)

In terms of constitutional and legal considerations, Rawls (1971:202) describes liberty as "a certain structure of institutions, a certain system of public rules defining rights and duties. Set in this background, liberty always has the . . . three-part form."

In the U. S. Constitution, the basic liberties as embodied in the Bill of Rights and other amendments to the Constitution are generally perceived as more individualistic--i.e., they are personal liberties. They apply to institutions in a derivative way--that is, when institutions affect persons' liberties, they are constrained or limited (or in some cases, freed) in carrying out their roles. Liberty as used in the U. S. Constitution seems, on the face of it, to embody Rawls' three-part definition, but this form is not spelled out. A brief glance at the amendments to the U. S. Constitution shows the fact that the institutions of government and society are regulated by the basic liberties which protect personal freedom. These liberties--like freedom of religion--enhance the separation of church and state by preventing religious laws from being enacted by Congress (thereby protecting religious freedom). In this respect, then, Rawls' description of liberty in its constitutional form is similar to that of the U. S. Constitution.

Rawls also considers three points regarding liberty. First of all, "the basic liberties must be assessed as a whole, as one system" (Rawls, 1971:203). Taken this way, the liberties must be balanced against one another at the constitutional stage of deliberations for, according to

Rawls, to take each liberty separately is to risk the collision of these liberties against one another.

> Thus the delegates to a constitutional convention, or the members of the legislature, must decide how the various liberties are to be specified so as to yield the best total system of liberty. They have to balance one liberty against another. The best arrangement of the several liberties depends upon the totality of limitations to which they are subject, upon how they hang together in the whole scheme by which they are defined. (Rawls, 1971:203)

The second consideration for Rawls is expressed by the priority rule for the first principle of justice and the extent of certain liberties as opposed to others. However, for Rawls (1971:204), liberty can only be limited for the "sake of liberty itself, that is, only to insure that the same liberty or a different basic liberty is properly protected and to adjust the one system of liberties in the best way." Finally, Rawls distinguishes between equal liberty as expressed by equal citizenship and the worth of liberty.

> Thus liberty and the worth of liberty are distinguished as follows: liberty is represented by the complete system of the liberties of equal citizenship, while the worth of liberty to persons and groups is proportional to their capacity to advance their ends within the framework the system defines. (Rawls, 1971:204)

As opposed to equal citizenship, the worth of liberty is less for those who are disadvantaged in their possession of other social primary goods. However, if the difference principle is satisfied, this lesser worth is "compensated

for, since the capacity of the less fortunate members of society to achieve their aims would be even less were they not to accept the existing inequalities" (Rawls, 1971:204).

Continuing the comparison between Rawls' constitutional stage and the U. S. Constitution, it is obvious at this point that radical differences are beginning to emerge. There is no real balancing of the liberties embodied in the amendments to the U. S. Constitution although the Bill of Rights seems to have judicial priority in civil liberties cases. In fact, it has traditionally been the U. S. Supreme Court which has accepted the task of balancing the liberties embodied in the amendments to the U. S. Constitution. Furthermore, the distinction between the liberties of equal citizenship and the worth of liberty is not a part of the U. S. Constitution at all. The fact that Rawls' theory makes this distinction is the result, I believe, of his embodiment of the principles of justice into the heart of the basic structure of society. In the existing U. S. Constitution, on the other hand, there was no shared conception of justice with which to begin the deliberations. Issues regarding liberty were thus ultimately decided by the Supreme Court as injustices were perceived--or new amendments were added to the Constitution as needed (e.g., the

Thirteenth and Fourteenth Amendments). Thus, there are major differences between Rawls' well-ordered society and the existing U. S. society at this point.

At the constitutional stage, liberty is reshaped by Rawls into the principle of participation. This principle moves the notion of justice as fairness from the original position to the constitutional convention stage "as the highest-order system of social rules for making rules" (Rawls, 1971:221-222). This principle applies to institutions for Rawls (1971:227). Rawls defines this principle as requiring

> that all citizens are to have an equal right to take part in, and to determine the outcome of, the constitutional process that establishes the laws with which they are to comply. (Rawls, 1971:222)

In applying this principle at the constitutional stage, the constitution must embody provisions for a legislature; affirm the position of one person, one vote; and, finally, delineate and guarantee the best system of total liberties, like freedom of conscience, speech and assembly (Rawls, 1971:222-223). The constitution must also guarantee equal access and equal representation in the political process (formal equality of opportunity). Finally the constitution must have provisions to guarantee the worth of liberty--it must provide for fair equality of opportunity as embodied in the second priority rule

concerning the principles of justice. (This priority rule gives the second principle of justice priority over efficiency and affirms the priority of fair equality of opportunity over the difference principle.) Rawls states:

> Turning now to the worth of political liberty, the constitution must take steps to enhance the value of the equal rights of participation for all members of society. It must underwrite a fair opportunity to take part in and to influence the political process. The distinction here is analogous to that made before . . . : ideally, those similarly endowed and motivated should have roughly the same chance of attaining positions of political authority irrespective of their economic and social class. (Rawls, 1971:224-225)

Rawls argues that the fair value of the liberties must be protected in the political arena since those who would start out with more advantages would otherwise end up dominating the political process. This could lead to unjust consequences for those with less advantages in that the decisions made from the standpoint of those with more advantages would favor their better circumstances (Rawls, 1971:225). Rawls uses an example of a capitalistic society here to enhance his point.

The difference between Rawls' theory and existing societies is quite wide at this point. Rawls himself draws the comparison.

> Historically one of the main defects of constitutional government has been the failure to insure the fair value of political liberty. The necessary corrective steps have not been

> taken, indeed, they never seem to have been seriously entertained. Disparities in the distribution of property and wealth that far exceed what is compatible with political equality have generally been tolerated by the legal system. . . . Political power rapidly accumulates and becomes unequal; and making use of the coercive apparatus of the state and its law, those who gain the advantage can often assure themselves of a favored position. . . . These questions, however, belong to political sociology. I mention them here as a way of emphasizing that our discussion is part of the theory of justice and must not be mistaken for a theory of the political system. (Rawls, 1971:226-227)

Rawls gives other examples of comparison between ideal theory and existing societies. What is quoted above, however, indicates the disparities between ideal theory and the conditions in existing societies.

Rawls recognizes that the principle of participation has its limitations, and that unrestricted application can violate first principle considerations. Unlimited majority rule is one such instance. Persons may weigh certain liberties over others. It is in such instances that the first priority rule (which calls for the lexical ordering of the two principles of justice and maintains that liberty can only be constrained for the sake of a greater liberty) plays a major role. Furthermore, the standpoint here must be that of the least advantaged representative citizen. As Rawls states:

> An inequality in the basic structure holds whatever the primary social good and especially for liberty. Therefore the priority rule requires

> us to show that the inequality of right would be accepted by the less favored in return for the greater protection of their other liberties that results from this restriction. (Rawls, 1971:231)

Thus the principle of participation in the constitutional stage is governed by the first priority rule.

The constitutional stage in Rawls' theory again differs from the constitutions of existing democracies (including the U. S. Constitution). Majority rule is considered as one of the "sacred tenets" of democracy. Unless laws developed in our society violate the Constitution and its amendments (especially the Bill of Rights), unjust laws may be enacted and enforced--especially in cases where the majority of the population desires them. Rawls' use of the priority rules is a radical departure. In the case of the first priority rule, the standpoint of the least advantaged citizen is adopted. This prevents the desires of the majority being enacted into laws where the rights of equal citizenship are abrogated, and minorities oppressed. In the case of the second priority rule, fair equality of opportunity is embedded into the constitution in a way that provides for equal participation in a substantive manner. Because of the first priority rule, the standpoint is again that of the least advantaged representative citizen. Both priority rules, then, represent major departures from existing political

processes. Their presence in Rawls' theory--and their role in guaranteeing equal citizenship at the constitutional stage--are a reflection of the original position reasoning and the principles of justice governing the later stages of the four-stage sequence. In other words the principles of justice and especially their concomitant priority rules are, as Rawls maintains, an independent standard defining both procedure and outcome (Rawls, 1971:197) for the constitutional stage of the four-stage sequence.

The framework for the constitutional stage of the four-stage sequence is now complete. No actual constitution has been derived. As Rawls points out, that is not the task of moral theory in the four-stage sequence. Rather the task is to develop the framework of such a constitution guaranteeing not only a just procedure but also a just outcome. This framework presents no problems to the modified portion of Rawls' theory which I have undertaken. In the last chapter, it was shown that the constitutional stage of deliberations was not affected by the inclusion of health as a social primary good and health care as a second principle right. The former affects the deliberations of the first stage of the four-stage sequence; the latter affects the third stage.

B. The Legislative Stage Framework for a Health-Care Delivery System in a Well-Ordered Society

Before developing the framework for a health-care delivery system in a well-ordered society, a brief review of Rawls' legislative stage seems appropriate. The format will be similar to the format of the just-completed constitutional stage review--i.e., comparisons to existing societies will be made when appropriate.

In the legislative stage of development for a well-ordered society, the task set for the ideal legislators is to develop those institutions which will distribute the social primary goods embodied in the second principle of justice consistent with the constitution set up in the second stage of development. Rules and regulations governing the social order are also developed. The important point to be remembered in such a task is that all of the remaining social primary goods must be balanced among one another. Therefore no single social primary good--like wealth or even health--can have so great an emphasis that other social primary goods cannot be realized. (In fact, if a truly extensive analysis were to be done, each primary good should be developed to the extent that it has the same framework in dealing with its appropriate distributional issues. That task, however, is too large for the scope of this study. For the sake of brevity, then, I

shall assume that this developmental work is completed, the burden on limited resources is accounted for, and the balancing between the social primary goods has been properly undertaken.) Given this constraint, and the constraints of Rawls' methodology, the framework for the health-care delivery system in a well-ordered society can be developed.

1. Constraints on the Ideal Legislators. The third stage of the four-stage sequence is governed by a number of constraints. A major constraint--unchanged from the original position--is on the nature of the legislators themselves. They are still representative citizens, not individuals with particular interests, plans of life and places in society. This constraint on the ideal legislators is what remains of the veil of ignorance. At this stage, as has been shown, for the ideal legislators, the "full range of general economic and social facts is brought to bear" (Rawls, 1971:199).

In comparing these ideal legislators with the legislators in existing societies, one can easily see the major differences between the two. The veil of ignorance constraints on ideal legislators have just been delineated. They are also constrained not only by the constitution, but also by the principles of justice derived in the original position. As a result of the these constraints,

they make their determinations from the standpoint of the least advantaged representative citizen. Existing legislators, on the other hand, are not bound by such constraints. While they are constrained by the constitution of their society (which they sometimes even try to circumvent), they are also people with the full range of knowledge about themselves, their plans of life and the particular interests that affect their legislation. As a result, existing legislators may tend to make their determinations from the standpoint of their own place in society and their own interests or that of their particular constituencies. For example, in redistricting, one of the problems that is encountered is gerrymandering whereby political districts are set up so as to favor the majority party. Another example is the political "pork barrel"--a practice whereby political representatives attach special amendments to (sometimes unrelated) bills which substantially favor their own districts or interests in return for their support in passing the particular piece of legislation.

2. Background Institutions. In a well-ordered society, Rawls envisions four branches of background institutions developed at the legislative stage by the ideal legislators in order to insure a just social system. He assumes, prior to the establishment of these

institutions, that "the basic structure is regulated by a just constitution that secures the liberties of equal citizenship" (Rawls, 1971:275), and that "fair (as opposed to formal) equality of opportunity" (1971:275) has been provided for. [This involves, as has been previously shown, providing for equal education for similarly endowed persons, and provides for equal opportunity in both the political and economic arenas (Rawls, 1971:275).] Rawls maintains that these background institutions are to be understood to have different functions than traditional (existing) concerns and institutions of government. They address the problems of coordination, efficiency and stability in a just society. (These branches and their specific roles will be discussed in the last section of this chapter when the comparative work is completed.) The background institutions which are established in Rawls' theory are legislative stage concerns. The ideal legislators must provide for these branches of background institutions as well as the more traditional branches of government since the proper employment of these branches enhances justice in the society. These branches also provide the key to the development of the framework of a just health-care delivery system in Rawls' well-ordered society. Each branch will play a part in terms of its

function, but the most important branch will be the transfer branch since it provides for health-care needs.

The disparities between Rawls' well-ordered society and existing societies continue to grow. Rawls' conception of the background institutions which guarantee the precepts of justice are not a part of the structure of existing societies. Although existing societies may have (and generally do have) concerns with their treatment of the least advantaged in their societies, there is no scheme of background institutions which attend specifically to this problem. As a result, there are greater disparities of wealth, power, income and sometimes provisions for health care in existing societies between the more well-off citizens and those who are the least advantaged.

3. Application of the Legislative Stage Considerations to the Basic Structure of a Well-Ordered Society. The discussions of both the constraints on the ideal legislators and the background institutions to be established point out the basic structure of the well-ordered society that can be seen as the just counterpart to the existing U. S. society. It is now proper to introduce some of the general facts which need to be considered by the ideal legislators if a well-ordered one is really to

be considered that just counterpart to our existing society.

The ideal legislators know that their well-ordered society is a constitutional democracy with a capitalistic economic system. They also know that their society is a late 20th Century technological society. The scarcity of natural resources like oil and other minerals is known. Because of the scarcity of these resources and the need to provide for future generations, technological development of alternative types of resources is needed. Furthermore, the ideal legislators are aware of any environmental facts which will affect their deliberations. They further know that in order to provide for fair equality of opportunity the educational level of its citizens must be relatively high.

> This means that in addition to maintaining the usual kinds of social overhead capital, the government tries to insure equal chances of education and culture for persons similarly endowed and motivated either by subsidizing private schools or by establishing a public school system. (Rawls, 1971:275)

This provision is guaranteed at the constitutional stage for Rawls so that the worth of liberty is enhanced in a well-ordered society. Ideal legislators, then, need to know the general facts which would make their well-ordered society a just counterpart to our existing social system.

Coupling the general facts known by these ideal

legislators with both the legislative stage constraints and structure leads to the following framework for the health-care delivery system in a well-ordered society. Since health is to be a social primary good in this society, the legislature, working from the standpoint of the least advantaged representative citizen and using the structure of the background institutions which is governed by the difference principle, makes provisions for the regulation of a just health-care delivery system. The scope of this health-care delivery system is, of course, limited by the competing claims of the other social primary goods. Each branch, however, will have a specific role in constructing the framework of the health-care delivery system.

The role of the allocation branch may be to mandate a health-care delivery system that is not purely based on capitalism. The market place of the health-care delivery system would not, however, be based upon the ability of the citizens to pay the "going rate," but rather on a just, but efficient mixture of capitalism and socialism. (Examples of the application of the functions of this branch will be given in Chapter VIII, where different types of health-care delivery systems are evaluated.)

The role of the stabilization branch--which has the goal of full employment--could be seen as having the

responsibility of retraining those whose health problems lead to alterations of their plans of life (including their chosen careers). Another responsibility consistent with the functions of this branch would be the provision of a barrier-free environment so that those who have disabilities can still carry out their rational plans of life.

The transfer branch would be primarily responsible for insuring access to the health-care delivery system for all citizens since it is concerned with the needs of the citizens. The just minimum of health care would have to be determined by this branch. The needs of the least advantaged representative citizen are particularly important for this branch. (Since I will return to these issues in the next section of this chapter, I will not elaborate further on the role of the transfer branch.)

The distribution branch will also play a major role in forming the framework of the health-care delivery system in a well-ordered society since it will provide--through taxation--the funds needed to insure a just health-care delivery system. It will provide the funds for the transfers that will supplement the income of the least advantaged members of society.

Since the deliberations in formulating the framework of a health-care delivery system as part of the background

institutions are carried out from the standpoint of the least advantaged representative citizen, the completion of this framework continues to be a legislative stage operation. The facts known at the legislative stage of deliberations are sufficient to carry out this task.

4. A Final Comparison. Before completing the development of the framework of a just health-care delivery system, a comprehensive comparison between Rawls' well-ordered society and existing societies should be made. This will give an overall picture of the discussion up to this point.

First of all, Rawls' well-ordered society has, as the heart of its system, a shared conception of justice--the two principles of justice derived at the first stage of the four-stage sequence. Our existing society does not even have a shared conception of justice, much less two principles of justice which govern all aspects of our social order. Both the well-ordered society and our own existing society have a constitution, however. Although both constitutions share a concern for liberty, Rawls' well-ordered society has a constitution which focuses primarily on issues of liberty (while still providing for the institutions which will play later roles). The major difference between the two constitutions is Rawls' concern for a just constitution which not only guarantees the

greatest possible system of liberties for all, but also manifests a concern for the worth of liberty. As a result, Rawls includes the two priority rules which not only guarantee a just procedure, but also a just outcome. The inclusion of the priority rules simply is not a consideration in our existing constitution. Moreover, in Rawls' system, the delegates to the constitutional convention are constrained by the veil of ignorance. Thus their deliberations are made from the standpoint of the least advantaged citizen rather than the full knowledge of interests, plans of life, position in society and so forth which affect the content of our existing constitution.

The differences between Rawls' well-ordered society and our existing society are greater at the legislative stage of deliberations. Although the ideal legislators have more information for their deliberations, they still must reason from the standpoint of the least advantaged citizen since they are still unaware of their particular position in society, their plans of life, and so forth. They are also constrained by the decisions made in the two earlier stages of the four-stage sequence. Real, existing legislators, although they have constitutional, hence judicial limits on their activities, do not have these constraints. The major differences, however, emerge with Rawls' background institutions which are concerned with a

just minimum for the least advantaged members of society. Incorporating these institutions into the structure of a well-ordered society not only provides a just minimum but also limits the disparities of wealth, power, income that can emerge between the least advantaged members of a society and those who are better off. The role of these institutions thus insures a just system of institutions which regulate the society. In fulfilling these tasks, they enhance efficiency, coordination and stability in a well-ordered society. In our existing society, on the other hand, there are no such background institutions. Although there may be bureaucratic departments concerned with the needs of the least-advantaged members of our society, their finances are controlled by the vagaries of capitalism and other perceived governmental priorities (which may have no concern for justice whatsoever). Thus, depending on whoever is in political power at the time, and whether the economy is booming or depressed, the needs of the least advantaged members of society are met (or not met) with varying degrees and concern.

Thus, though there are many surface similarities between Rawls' well-ordered society and our existing society, the major divergence between the two focuses on the fact that Rawls' theory is, at its heart, a moral theory. There is an abiding concern for justice in a

well-ordered society which is based upon a starting point in which a shared conception of justice is derived. Although justice is a concern of our existing society, the lack of a shared conception of justice leads, as Rawls states, to a lack of stability, efficiency and coordination--and injustice is all too often the result.

In conclusion, the path to the development of a framework for a health-care delivery system in a well-ordered society is now laid out. It is obvious that the background institutions will play the major role in developing such a framework. The next stage, completion of that framework for a just health-care delivery system in a well-ordered society is the next and last task of this chapter.

III. EVALUATIVE CRITERIA AS THE FRAMEWORK OF THE HEALTH-CARE DELIVERY SYSTEM IN A WELL-ORDERED SOCIETY

The role of Rawls' background institutions as well as the legislative stage considerations will play a major part in the deliberations in this section. Since all second principle social primary goods are part of these deliberations, I accept the fact that these background institutions must also balance all of these primary goods among one another so that the basic structure of this well-ordered society is seen as a coherent scheme. At the

same time, however, for the sake of brevity, the focus here will only be on the development of the framework for a just health-care delivery system--in other words, on the social primary good of health.

The analysis of Rawls' use of the legislative stage considerations (including the background institutions)--both in Chapter VI, and Section II of this chapter--shows a focus on three particularly important considerations: (1) the role of the difference principle in working with the background institutions; (2) the constraints on the ideal legislators at the legislative stage of deliberations; and (3) the roles of the background institutions in enhancing efficiency, stability and coordination in a well-ordered society. All legislative stage deliberations are dependent on these three considerations.

It may be that the preliminary work already done provides an adequate framework for a just health-care delivery system. Thus these three considerations--if properly re-formulated--may provide not only a framework of a Rawlsian health-care delivery system but also criteria for evaluating all second-principle social primary goods. I shall state these criteria in their general form at this point. When applying these criteria in evaluating health-care delivery systems, the framework for the health-care delivery system will be apparent as well.

1. Satisfaction of the difference principle (subject to the constraints of equal liberty and fair equality of opportunity) which demands that the standpoint of the least advantaged person be used and that the difference principle's components of chain-connectedness and close-knittedness, at least to some extent, do obtain--i.e., that increases in the advantages for the least advantaged (or any group of) persons results at least minimally in greater advantages for all persons;
2. Satisfaction of the constraints on the ideal legislators in that particular information and desires not be included as considerations and that the constraints of the first two stages are in force; and
3. Satisfaction of the specific roles of the background institutions--by enhancing efficiency, coordination, and stability--by determining the just minimum and limiting unnecessary and unjust disparities in the possession of second principle social primary goods in a well-ordered society.

If these criteria perform their function, a major problem can be avoided in that the alternative--developing a just health-care delivery system and using it for evaluation--may lead not only to methodological problems but

also possible conceptual problems. In other words, by using the alternative method, the lack of the best possible health-care delivery system would result in having to continually adjust evaluations when even more just health-care delivery systems are proposed. Evaluations could then be skewed. Furthermore, evaluations would be skewed toward the author's preference of a form of health-care delivery system rather than the justness of a system. These criteria, then, seem to be the best way for using Rawls' theory to evaluate existing and proposed forms of health-care delivery systems.

This development of criteria--rather than development of a Rawlsian health-care delivery system seems, at first glance, to be an unusual--even if practical--move. This move is actually more consistent with Rawls. In discussing the constitutional stage, Rawls states:

> In the contract doctrine, the principles of justice have already been agreed to, and our problem is to formulate a schema that will assist us in applying them. The aim is to characterize a just constitution and not to ascertain which sort of constitution would be adopted . . . . (Rawls, 1971:197n)

Rawls points out that he is working in moral theory, not writing a constitution. The legislative stage should fall under the same umbrella. Hence, developing criteria for evaluation of the justness of the institutions governed by the legislative stage is proper for that stage. (I do not

doubt that issues could be carried further, and that ideal legislators could "pick" the most just health-care delivery system, but that is not fundamental to this project.) Thus, although this move is somewhat unusual and different from other Rawlsian authors like Daniels, Green, and Veatch, it is justifiable--and conceptually and methodologically consistent with Rawls.

One other distinction needs to be made at this point. A question can be raised: who are the least advantaged representative citizens when one is dealing with issues of health-care? There is a strong temptation to respond by saying that the least advantaged representative citizen in this case is that person with the greatest health-care needs. This flies in the face of other second principle social primary goods, however. A very wealthy person may have enormous health-care needs. But that person also has the wealth to attend to those needs without seriously affecting his or her wealth. On the other hand, minimal health-care needs may not be satisfied without serious strain on the level of wealth of people who are closer to being the least advantaged members of society. As a result of considerations like these, the least advantaged members of society will be those who possess the least of all of the social primary goods taken together as a combination. This seems much more consistent with the spirit

of Rawls' theory of justice and his own definition of the least-advantaged member of society (Rawls, 1971:97). Regarding the choice by the parties of who is the least advantaged, Rawls (1971:98) further states:

> They interpret it from the first as a limited aggregative principle and assess it as such in comparison with other standards. It is not as if they agreed to think of the least advantaged as literally the worst off individual and then in order to make this criterion work adopted in practice some form of averaging. Rather, it is the practicable criterion itself that is to be evaluated. . . .

In light of Rawls' own position, then, the reasoning behind my choice of this aggregative least advantaged person is reasonable.

The tasks of this chapter have been completed with the development of these criteria for evaluation of second principle social primary goods. The focus of this chapter has been to outline the just counterpart of our existing society. Comparisons at each stage of deliberations in Rawls' theory point out not only the differences but also the similarities between these two societies. Finally, criteria have been developed which we will employ in carrying out the evaluative task--the task of evaluating the justness of proposed and existing health-care delivery systems. This completes the work that is to be done in ideal theory--that is, in strict compliance--for evaluation is the task proper to the fourth stage of Rawls'

four-stage sequence, the judicial/administrative stage. That is the task for the next chapter.

CHAPTER VIII

THE RAWLSIAN TASK COMPLETED: EVALUATION OF EXISTING AND PROPOSED MODELS OF HEALTH-CARE DELIVERY SYSTEMS

I. INTRODUCTION

With the modifications of Rawls' theory of justice completed, and with the development of criteria for evaluating existing and proposed schemes for health-care delivery systems, the task of applying Rawls' theory to distributional issues in health care can begin. In fulfilling this task, the focus of this study will change. I will no longer be constrained by the limitations of ideal theory; hence I will no longer be in strict compliance theory. Thus, where appropriate, cases can be considered in illuminating my arguments.

There are actually two major tasks to be fulfilled in this chapter. First of all, the evaluation of existing and proposed schemes of health-care delivery systems is to be completed. In doing this, I will examine two types of models of health-care delivery systems: (1) two Rawlsian models, and (2) two non-Rawlsian models. The issue that I will focus on in this evaluation is access to the health-care delivery system. The second task of this chapter, which is to be accomplished at the time of evaluation, is a "hot test" of the criteria I have developed--

i.e., actually using them to see if they are manageable as evaluative tools.

II. EVALUATION AND TESTING: FOUR HEALTH-CARE DELIVERY SYSTEMS

Before starting the evaluation procedure, however, it must be noted that--in terms of Rawls' theoretical framework, i.e., his four-stage sequence--the work of the first three stages is now complete. I will now be working from the standpoint of the judicial/administrative stage of deliberations. This stage has been largely ignored in previous discussions of Rawls' theory of justice. Since this stage is governed by the decisions made in the previous three stages, its role is indeterminate until the deliberations of the first three stages are completed. Once these have been completed, its role appropriately begins in adjudicating the claims against the distributional aspects of the health-care delivery systems. One aspect of this role is obviously to evaluate the justness of existing and proposed health-care delivery systems. They can only be addressed at this stage since this is not a part of ideal theory. Rawls, if consistent in his methodology, must also use this stage when he is discussing problems pertaining to liberty--e.g., toleration of

the intolerant--since he is admittedly in partial compliance in discussing issues like these.

This stage also plays a primary role in governing allocational health-care issues--like public health. Since allocational issues in health care are public goods in this modified Rawlsian theory, they are governed by the principle of the common interest. The exchange branch is also governed by this principle. Since the deliberations in setting up this branch are done with complete knowledge--no veil of ignorance remains here--it would be the task of the judicial/administrative stage to make the decisions which concern this branch. Thus, as the results of Chapter III show, socialized medicine (where all health care needs are provided for all citizens equally) may be chosen in the exchange branch. This branch would also be responsible for public health items, like epidemic prevention. Thus this stage would also play a role in a complete scheme of health care in a well-ordered society.

In the next four parts of this section, four models of health-care delivery systems will be evaluated. The first two will be Rawlsian proposals. In using these first, any problems in applying the evaluative criteria can be worked out. This will also give a fleshed-out conception of how a health-care delivery system in Rawls' theory would look. The second two health-care delivery

systems to be evaluated will be non-Rawlsian (and considered by many to be lacking in justice). The use of these two health-care delivery systems will test the criteria's applicability for use in evaluation of non-Rawlsian health-care delivery systems. Analysis of any problems with the criteria and with Rawls' theory in general will be the focus of the next chapter.

Before beginning the evaluations of existing and proposed health-care delivery systems, however, the three criteria for evaluation should be restated with a focus on issues of health-care delivery--i.e., in terms of health as a social primary good.

1. Satisfaction of the difference principle (subject to the constraints of equal liberty and fair equality of opportunity) in determining the justness of a health-care delivery system. In doing this, the standpoint of the least advantaged person must be used; furthermore, according to the lexical form of the difference principle, any increase in health-care advantages for this group of persons must result (at least minimally) in an increase in health-care advantages for all while still satisfying the conditions of chain-connectedness and close-knittedness.
2. Satisfaction of the constraints on the ideal

legislators in that particular information and desires not be included as considerations in developing a health-care delivery system. Furthermore, the constraints of the first two stages of the four-stage sequence are still in effect.

3. Satisfaction of the specific roles of the background institutions (in enhancing efficiency, coordination and stability in the health-care delivery system of a well-ordered society) by determining the just minimum of health-care and limiting unnecessary and unjust disparities of health care in a well-ordered society.

A. Daniels' (Modified) Health-Care Delivery System

Of the two Rawlsian proposals for a health-care delivery system, Daniels' proposal, which is discussed in Section II of Chapter IV, and Section III of Chapter VI is the only one which has already been discussed and analyzed. In the course of the analysis, certain methodological and conceptual problems have been pointed out. As a result, in presenting Daniels' proposal for a Rawlsian health-care delivery system, his theory will be modified so as to present it in a methodologically and conceptually consistent Rawlsian manner. However, since Daniels' proposal is familiar material to the reader, both

presentation and evaluation will be undertaken at the same time.

In Daniels' (1981:146-179) essay, "Health-Care Needs and Distributive Justice," he distinguishes between health (a non-normative physicalistic definition, as we have seen) and health-care needs.

> Health-care needs will be those things we need in order to maintain, restore, or provide functional equivalents (where possible) to, normal species functioning. They can be divided into:
> (1) adequate nutrition, shelter
> (2) sanitary, safe, unpolluted living and working conditions
> (3) exercise, rest, and other features of healthy life styles
> (4) preventive, curative, and rehabilitative personal medical services
> (5) non-medical personal (and social) support services
> Of course, we do not tend to think of all these things as included among health-care needs, partly because we tend to think narrowly about personal medical services when we think about health care. But the list is not constructed to conform to our ordinary notion of health care but to point out a functional relation between quite diverse goods and services, and the various institutions responsible for delivering them. (Daniels, 1981:158)

Daniels also develops four layers of health-care institutions which he subsumes under the opportunity principle. These layers are of interest even though his description erroneously situates them in Rawls' theory. Because of their inherent interest, I will place them in the proper context of Rawls' background institutions and determine whether they are appropriate for the structure of a

health-care delivery system. These layers of institutions are the following:

1. Institutions which are concerned with preventive health measures. "Included here are institutons which provide for public health, environmental cleanliness, preventive personal medical services, occupational health and safety, food and drug protection, nutritional education, and educational and incentive measures to promote individual responsibility for healthy life styles" (Daniels, 1981:167-168).
2. Institutions which attempt to correct health-care problems. "It includes those which deliver personal medical and rehabilitative services that restore normal species functioning" (Daniels, 1981:168).
3. Institutions which treat long-term or chronic disabilities. "Institutions involved with more extended medical and social support services for the (moderately) chronically ill and disabled and the frail elderly would fit here" (Daniels, 1981:168).
4. Institutions which treat catastrophic and terminal illnesses. These institutions are involved in "health care and related social services for those

> who can in no way" be brought to functional levels of health. (Daniels, 1981:168) Included here are institutions which care for the seriously and incurably mentally ill members of society.

Daniels admits that these layers may not be exhaustive of health care issues--and that layer four in particular goes beyond the demands of justice. The list--with some modification--is, however, sufficient for the purposes of this section.

An interesting note in comparing Daniels' list of health-care needs to his layers of health care is that the first layer of health-care institutions is responsible for the first three levels--and part of the fourth level--of needs [(1) nutrition, etc., (2) working conditions and environment, (3) healthy life styles, and even the first part of (4) preventive medical services]. The curative aspect, and in some respects, the rehabilitative aspect of level four is given over to the second layer of health-care institutions. The third layer of health-care institutions deals with long-term health needs which are somewhat a part of the rehabilitative aspect of level four but also includes level five--the non-medical social and personal services. Daniels' layers of health-care institutions thus considers all health-care needs but with no

serious attempt to pair those needs each to a specific health-care institution.

Daniels also merges allocative health-care issues with distributive health-care issues. Level one of his layers of institutions contains many elements of health-care that could be considered allocative--e.g., exercise, rest, unpolluted living conditions, safe working conditions, and nutritional education--although some of these will have distributive aspects as well. Without getting into an argument over which issues are allocative and which are distributive, I shall let the four layers of health-care institutions stand as basic types to see how they would work as a Rawlsian health-care delivery system.

The first question is: do Daniels' layers of health-care institutions satisfy the demands of the difference principle? These demands require that the standpoint of the least advantaged representative citizen be used in determining the level of long-term expectations and advantages subject to the constraints of liberty and fair equality of opportunity. Furthermore any advantages gained by the least advantaged citizens must also show at least minimal gains in advantages of those better off.

Daniels' first level of health-care institutions--excluding allocative categories, of course--seems to satisfy the demands of the difference principle in some

respects. Institutions aimed at providing preventive personal medical services and providing educational and incentive measures which promote personal responsibility for maintaining good health (Daniels, 1981:168) are of particular interest here. If these programs were heavily aimed at those who are the least advantaged members of society (while also being available to the rest of society) the difference principle would be satisfied.

Daniels' next two layers are more attuned to issues concerning the difference principle, however. These health-care institutions help to correct health problems or attempt to treat (or take rehabilitative measures for) chronic and degenerative health conditions and disabilities. The standpoint of the least advantaged representative person is quite useful here. These are the people who are the most affected by illness and disability in terms of their long-term expectations. Without institutions to provide (or assist in the provision of) these health-care needs, the expectations of the least advantaged would be lowered, i.e., their rational plans of life may, even with appropriate modifications, not be attainable. For example, compare the lives of two paraplegics:

> (1) a rather affluent person who can afford to build his/her own barrier-free environment in the home, can provide the means of transportation so

that s/he can work at (rationally chosen and satisfying profession), and so on; and

(2) a poor person who may be provided with a wheelchair but whose home is not modified for its effective use, and must depend on public transportation that is not adapted for use by the handicapped to get to work (if s/he can even find a job in that income bracket that is manageable for a handicapped person), and so on.

Except for the actual physical condition and possible modifications to his/her rational plan of life, the rather affluent person does not have his/her expectations dramatically reduced. The poor person, on the other hand, is constantly barraged by problems that the rather affluent person does not have to confront (barriers in the home, transportation, etc.). The poor person, beyond the actual physical problems, does have seriously reduced life expectations. In terms of problems like this, the difference principle would be satisfied if health-care institutions provided for the needs of the least advantaged citizens while assisting from greater to lesser measures those who are somewhat better off to those who are capable in one way or another of providing for most of their own health-care needs. In other words, expectations for fulfilling a

rational plan of life need not be drastically reduced if the difference principle were satisfied.

Daniels' fourth layer of health-care institutions is a bit more complicated. Expenses in the care of the terminally ill can be enormous if the most expensive and aggressive therapies and procedures are used. Daniels acknowledges this:

> Terminal care and care for the seriously mentally and physically disabled fit here, but they raise serious issues which may not just be issues of justice. Indeed, by the time we get to the fourth layer moral virtues other than justice become prominent. (Daniels, 1981:168)

Perhaps the difference principle would be satisfied here by introducing the concepts of palliative care--certainly an issue of justice--and standard treatments. In the case of standard treatments, the accepted standards of treatment would be provided (or assistance given in providing for them), but exotic and aggressive therapies which only extend life minimally without enhancing quality of life would not be considered issues of justice. These exotic and aggressive therapies, being extremely expensive thus putting an enormous drain on limited resources, simply do not fill the demands of the principles of justice. The second principle, in particular, sets a just minimum for the social primary goods. Treatments like these are on the other end of the spectrum of health care--the maximum available. Provision of palliative care, on the other

hand, serves the demands of justice (i.e., the just minimum of health care), but still avoids the expenditure of enormous resources (i.e., providing the maximum care possible) at the expense of other social primary goods or the needs of future generations.

Daniels' levels of institutions for health care thus are able to satisfy the demands of the difference principle. Although there are some problems with the first and fourth level, the demands of justice can be roughly met in this respect.

The next question is: do Daniels' levels of health-care institutions satisfy the constraints of the legislative stage of deliberations? The considerations that are relevant here are that particular information and desires not be included and that the constraints of the first two stages of the four-stage sequence are in force. No real in-depth analysis is required to show that Daniels' levels of health-care institutions satisfy this requirement. All four levels of institutions deal with information that is allowed to the ideal legislators. No particular desires are included. Furthermore, these levels of health-care institutions satisfy the difference principle. If that principle is used correctly, it is subject to the constraints of the first two stages of the four-stage sequence. In other words, the principles of

justice are satisfied and the just constitution--which provides for the limits and the worth of liberty, thus the principle of fair equality of opportunity--is assumed before deliberations begin. Daniels specifically tries to include his layers of health-care institutions in the content of the principle of fair equality of opportunity. Although this is a methodological mistake on his part, he is careful not to violate the constraints of the principles of justice or the priority of liberty over second principle considerations. Thus this requirement--that the legislative stage constraints are satisfied--is fulfilled in Daniels' conception of his four layers of health-care institutions.

The final question is: do Daniels' layers of health-care institutions satisfy the specific roles of the background institutions in Rawls' theory? These roles, while providing efficiency, coordination and stability to a well-ordered society specifically determine the just minimum and limit unnecessary and unjust disparities between the least advantaged citizens and those who are better off in the possession of the social primary goods.

Since Daniels' approach to Rawls' theory is to modify the principle of equality of opportunity, the arguments he uses are keyed into that principle rather than into the background institutions themselves. This is a serious

problem in making judgments of the justice of existing health-care delivery systems as well since they do not account for the roles of these non-existent (for them) institutions (nor can they be expected to do so). As a result, I will use only those arguments of Daniels that can apply to these background institutions. This type of argument may thus be helpful in later deliberations as well.

Daniels, in dealing with the issue of access to the health-care delivery system, refers to a multi-tiered system. The basic tier would include the most important health-care needs (which he again ties to opportunity, but which can be construed as an effort to satisfy the assumption of fair equality of opportunity that governs background institutions). Although Daniels does not refer to his levels of health-care institutions here, it would seem safe to assume that he is specifically referring to levels two and three which account for preventive, curative and rehabilitative medical services and non-medical support services. Daniels claims that "other tiers would include services that meet less important health-care needs or other preferences" (Daniels, 1981:175). The basic tier, however, should be financed to the extent that "there should be no obstacles, financial, racial, sexual, or geographical to <u>initial access</u> to the system as a whole"

(Daniels, 1981:75). Daniels calls this the equality of initial access.

> The equality of initial access derives from basic facts about the sociology and epistemology of the determination of health-care needs. The "felt needs" of patients are (unreliable) initial indicators of real health care needs. Financial and geographical barriers to initial access--say to primary care--compel people to make their own determinations of the importance of their symptoms. Of course every system requires some patient self-assessment, but financial and geographical barriers impose different burdens in such assessment on particular groups. Indeed, where sociological barriers exist to people utilizing services, positive steps are needed . . . to make sure unmet needs are detected. (Daniels, 1981:75)

Daniels further argues that these barriers can be removed without violating the basic liberties. In fact he claims that the following system for fulfilling the health-care needs of a society actually lessens the disparities between health-care professionals and those who have careers that are subject to market constraints.

> Suppose that the basic tier of a health-care system is redistributively financed through a national health insurance scheme that eliminates financial barriers, that no alternative insurance for the basic tier is allowed, and that there is central planning of resource allocation to guarantee needs are met. To achieve a more equitable distribution of physicians, planners <u>license those eligible for reimbursement</u> in a given health-planning region according to some reasonable formula involving physician-patient ratios. Additional providers might practice in an area, but they would be without benefit of third-party payments for all services in the basic tier (or for other tiers if the national insurance scheme is more comprehensive). Most

> providers would follow the reimbursement dollar and practice where they are most needed. (Daniels, 1981:176)

In arguing that this scheme does not infringe on basic liberties, Daniels notes that the freedom of health-care professionals to practice where they choose is a historical accident especially in the United States. This freedom, "namely, that physicians have been more independent of institutional settings for the delivery of their skills than many other workers . . . shall pass" (Daniels, 1981:176-177).

These kinds of arguments are quite compatible with the role of the background institutions in Rawls' theory in providing the just basic minimum and limiting unjust disparities between those who are more advantaged and those who are the least advantaged. The role of the allocational branch is perceived in limiting the health-care market place so that geographical and financial barriers to health care can be overcome. The role of the stabilization branch is perceived in attending to the rehabilitative needs of the citizens. The role of the transfer branch in providing for important health-care needs is perceived in the plan for a limited national health insurance program providing the third-party payments for the basic tier of the health-care delivery system. (If anything is askew here, Daniels may be

setting the minimum too high by providing third party payment to all citizens at the basic tier of health-care delivery. Since he is not specific on how much would be contributed to this system by those at different levels of advantages, it is difficult to judge this.) Since this multi-tiered system of health-care delivery must be financed, there would also be a role for the distribution branch in Daniels' scheme. Thus it would seem that Daniels' health-care delivery system satisfactorily answers the question of whether the roles of Rawls' background institutions have been provided for.

Daniels' somewhat modified system of health-care delivery has been shown to satisfy all three legislative stage considerations. It is thus an adequate candidate for a model for a Rawlsian health-care delivery system. Furthermore, and more importantly for this study, the legislative stage considerations have served as adequate criteria as the framework for a just, Rawlsian health-care delivery system. If they continue to do so, they will be acceptable for use in judging the justice of existing and proposed health-care delivery systems. (If we were to take this evaluative project to completion, we could then choose the best model for a health-care delivery system for this nation--and argue for its adoption by our government, of course.)

B. The HMO as the Basic Tier of the Health-Care Delivery System.

1. Preliminary Considerations. This model for a Rawlsian health-care delivery system has been specifically designed to accomodate my modifications to Rawls' theory. Although it has similarities to existing programs, its specific features are tailored to meet the demands of a health-care delivery system in a well-ordered society. Since the fundamental purpose of this chapter is to evaluate existing and proposed health-care delivery systems (thereby testing the practicality of using the evaluative criteria), any detailed comparison between the similarities and differences of this model and existing models is superflous to my purposes.

I would like to start this presentation of a model for a Rawlsian health-care delivery system, however, by referring back to one of the cases presented in Chapter I--the subsidized HMO as a particular type of HMO designed to serve the health-care needs of the poor. Although this is a hypothetical case used to illustrate types of access to the health-care delivery system, HMOs similar to these do, in fact, exist. Harold Luft, in "Health Maintenance Organizations and the Rationing of Medical Care" (Securing Access, 1983c:313-346) provides an interesting study of different types of HMOs including those that provide care

for the indigent and lower income people. According to Luft (Securing Access, 1983c:314-315), HMOs are normally self-sufficient health-care institutions serving those who pay for their services either directly or through the their employment benefits. On the other hand, the subsidized HMOs--sometimes described as "demonstration project" HMOs (Luft, Securing Access, 1983c:326-327)--are ones in which the government, through grants or other financial means, assists in funding (or completely takes on the burden of funding) the health-care costs of lower-income people by means of a geographically accessible pre-paid group practice HMO. The people served by these HMOs may contribute to the funding by paying on a sliding scale basis which is proportional to their income plus considerations like the size of the family served and so forth. Unless a member of these HMOs is indigent (a case where there would be no contribution, perhaps), each person is financially responsible--to a certain extent--for his or her health-care costs.

The HMO system is based on providing quality care at the lowest cost. One of the ways of achieving this goal is to focus on preventive health care in the hope of avoiding costly health-care after the patient is already sick. It also enhances other social primary goods by preventing disabilities, and generally improving a

person's quality of life. Since it is a pre-paid plan, patients are also encouraged to use the system when health problems occur--rather than waiting until their problem has degenerated into something more serious (thus, more costly to treat). Needed health services are provided, however, including hospitalization, surgical procedures, therapies, and whatever non-medical social services are necessary to rehabilitate the patient.

In contrast, traditional fee-for-service health care (whether paid directly or through third-party payment--like insurance) is traditionally approached on the basis of immediate health-care needs. People hesitate to pay additional amounts for preventive health-care. As a result, health-care costs may ultimately be more expensive. Furthermore, unless there are direct subsidies like Medicaid or Medicare, the traditional fee-for-service form of health-care generally does not treat those who are unable to pay.

Those who do not qualify for fee-for-service health care must look for other alternatives. These unfortunate people may receive indigent care (if they meet the qualifications) through special clinics provided by federal, state or local governments. Those who do not qualify for indigent care usually end up attempting home treatment until the health problem is either cleared up or until it

has degenerated to the extent that emergency care is needed. If the health-care costs are beyond those peoples' ability to pay, either they are financially devastated or their bills go unpaid.

Admittedly, HMOs have problems as well. Since they are designed to be cost-effective, the decision-making role of the physician may be influenced in factors regarding hospitalization (i.e., like admissions, types of services rendered and length of stay) and follow-up care (Luft, Securing Access, 1983c:317-322). Furthermore, the enrollment through services to business may be controlled by not offering the option to employers whose workers and families are at higher risk or by attracting only certain employees within a company. Geographic location of facilities for group practice HMOs is another way of limiting enrollment to a targeted group (Luft, Securing Access, 1983c:322-324). Unless controls are initiated on HMOs, they can be as problematic as the traditional fee-for-service model in providing access to the general population. In other words, HMOs are not necessarily a panacea to the problems of access to the health-care delivery system.

The HMO system does provide an interesting model, however, and with the proper controls, may provide a possible solution to the problem of just access to the

health-care delivery system for a Rawlsian well-ordered society which is to serve as a modern, high-tech, capitalistic counterpart to our existing society. A more complete sketch of the structure of this health-care delivery system follows. After this model is developed, the legislative stage considerations--which will hopefully be the criteria which form the framework of a just health-care delivery system--will be used to test this model's applicability as a just Rawlsian health-care delivery system.

2. The Subsidized HMO as a Model. The structure of this model of a Rawlsian health-care delivery system is a multi-tiered one. At the level of the basic tier is the subsidized HMO. This HMO--with all of its services--would be available to all citizens. The subsidized portion of these HMO's would be mandated by the transfer branch. In determining a just minimum, this branch would determine the level of financial contribution to the HMO by the members of society. Its tool in making these determinations would be the difference principle. As a result, the standpoint in making these determinations would be that of the least advantaged representative person. In a Rawlsian well-ordered society, I seriously doubt that there would be any people who could be classed as indigent. Attention to other social primary goods would by these background institutions eliminate that condition.

Yet the least advantaged would only have a just minimum in income, hence additional costs like health care would have to be provided by the mandate of the transfer branch. The financial contribution of the least advantaged to the HMO system would thus be minimal if not entirely subsidized.

Those who are better off, however, would be expected to contribute a portion of their income directly to the HMO system--or to have some or all of that portion contributed through their benefit program at the work place. That portion would be in direct proportion to the level of advantages they have in society. No person, however, would be allowed to be worse off than those who have less initial advantages. That result would be a violation of the lexical form of the difference principle.

The HMOs would be geographically positioned so that access to the health-care delivery system would be assured for all citizens. Responsibility for this positioning would rest with the allocation branch. As in Daniels' plan, this plan would limit the free market of the health-care delivery system. Physicians and other health-care professionals would not have the freedom to practice where they please and still have the higher advantages of wealth and income. The allocation branch would redistribute the market demand in this sense.

Concerning efficiency, the allocation branch would

also alter some traditional methods of health-care--e.g., the focus on the physician as the primary care provider. Other health-care professionals would play a greater role in the functioning of the HMOs. Licensed nurse practitioners, for example, would assume much of the burden of primary care. Only in cases where a physician's highly trained skills are needed would physicians be directly involved with patient care. They would also be primarily responsible for the preventive health programs. These alterations of traditional health-care practices would enhance the efficiency of the HMOs and relieve some of the enormous burden on available resources that the provision of health-care would place on a society. The need for additional health-care programs like Medicare and Medicaid would also be eliminated since all persons would have access to the health-care delivery system.

The stabilization branch would be in charge of providing the training for those who have the ability and desire to enter the health-care professions. It would also contribute to the HMO system by providing rehabilitative care to those whose health problems require alterations in their plans of life. It would also be in charge of programs which engender a barrier-free environment.

The distribution branch would, through taxation, provide for the subsidization of the HMO program as well

as providing for the funding of programs that assure fair equality of opportunity. If there is a problem in the distribution of the HMO program--e.g., not enough professionals who care to practice in the HMO plan--this branch could also engender the "opportunities tax" mentioned in Chapter VI.

This "tax" would work by requiring professionals to "pay back" their subsidized training, by through service in their profession. Regarding the HMO system as the basic tier of the health-care delivery system, the health-care professionals, after having completed their training, would be required to spend a number of years working in the HMO system in places where there may be a shortage of health-care professionals. As I stated earlier, this scheme is not unlike that presently used when the military pays for medical school costs in return for a minimum of four years service in the military as a health-care professional. This opportunities tax would fulfill both aspects of the purpose of the distribution branch (as does the taxation aspect). The first aspect lessens the disparities of wealth and power between those who are well-off and those who are the least advantaged that emerges with a capitalistic society. The second provides for needed revenues.

Since the HMO system provides only the basic tier of

the health-care delivery system, other types of health-care services would also be available to those who prefer them. Fee-for-service as a type of health-care would not be eliminated. Third party payment may include either membership in an HMO or an insurance program to pay for the more traditional forms of medical practice. Benefit programs at the work place could thus be optional in providing for the health-care needs of employees. People thus would not be limited in their choice of available health-care programs. Since the taxation program of the distribution branch still provides the funds to subsidize the transfer branch's mandate for an HMO system, this would not be a major problem. Furthermore, once the period of service to the HMO system is completed by the health-care professionals, they would be free to set up private practices on the traditional fee-for-service model.

As a capitalistic scheme, those HMOs which were the most successful in preventive health care, while assuring quality care when needed for illnesses, accidents, and disabilities, would draw more members who are better off. This in turn would tend to make them more profitable. This profit could then be shared by the medical and support personnel who practice in that particular HMO. This would tend to allow for stability of the HMO program. The staff, after serving their time for paying off their

opportunities tax, would tend to stay with their HMO rather than setting up private practice since it is a profitable venture. Furthermore, if HMOs can be shown to provide quality health care while being less costly than private fee-for-service health care, individuals would tend to opt for the HMO programs to satisfy their health-care needs.

One other aspect of this program needs to be discussed. How much health care is needed? Is the most exotic and experimental and aggressive treatment necessary? My answer here tends to be that it is not. Again I refer to the notion of standards of accepted practice. If there is a therapy, procedure, etc. that fulfills the health care needs of the patient that is an alternative to the most exotic and experimental and aggressive treatment, it should be used. Even if no such standard treatment exists, I would tend to disallow these treatments unless they are shown to be effective, not merely extend life without measurable quality of life. (The determination of who would be treated under conditions of scarce resources is another issue to be treated as part of health care as a right, not as part of the issue of access to the health-care delivery system.) Experimental procedures may be funded through allotments to research (another health-care issue separate from the issue of access)--with the costs

for patients treated under these conditions being considered as part of the research "budget." I maintain that exotic treatments are not part of the just minimum for health care, but are to be considered as being part of the other end of the spectrum. The purpose of this scheme is to set a basic minimum of health care while remaining efficient, not to provide the fullest extent of health care that is technologically possible whatever the cost. As new therapies become accepted standards of practice, they would then be incorporated into the basic minimum.

The basic model of a Rawlsian health-care delivery system is now complete enough to see whether it fulfills the requirements of the legislative stage. If additional delineation of this model is needed in the following discussion, it will be provided at that point.

3. Evaluation of the Subsidized HMO Model. The three requirements for developing a framework of a just health-care delivery system will now be used to "test" this Rawlsian model of a health-care delivery system. Even though these requirements are built into my health-care delivery system, they may not be properly satisfied. Furthermore, if these requirements are going to be used as the criteria for evaluating existing and proposed models of health-care delivery systems, further testing of their adequacy through their application here is necessary.

The first requirement is the satisfaction of the difference principle (subject to the constraints of liberty and fair equality of opportunity). In order to satisfy this principle, the standpoint of the least advantaged person must be used. Furthermore, any advantages gained by the least advantaged must also result in some minimal gains by those who are better off.

The subsidized HMO program is developed with the difference principle in mind. Each of the four branches of the background institutions operates from this standpoint. The role of the transfer branch cannot even begin to be fulfilled unless the standpoint of the least advantaged representative person is used. The difference principle is also satisfied in that the benefits to the least advantaged in providing access to the health-care delivery system also provide benefits to those who are better off. Although those who are better off must contribute to the program on a direct financial basis (and/or through benefit programs at the work place) as well as through taxation through the distribution branch, their contribution is proportionally based to their position in society. Thus they are not unduly penalized for their higher level of advantages. The sliding scale rate of direct payment contributes to this result.

Although some of the traditional freedoms of the

health-care professions would be limited in fulfilling this scheme, the opportunities tax scheme mitigates the perceived problems to some extent. Furthermore, like Daniels, I believe that limiting the freedom of health-care professionals reduces the disparities of wealth and power that arise in situations of unlimited freedom to practice anywhere (the most lucrative geographic locations) in any model of health-care delivery (the traditional fee-for-service model) that is chosen. Thus I do not see that liberty, in Rawls' sense, has been violated. Nor has the principle of fair equality of opportunity been violated. Health-care professionals, after serving their term of mandatory (but paid) service to the HMO system (i.e., after fulfilling their legal obligations), are free to choose their type and geographical area of service. Since their opportunities to practice (in terms of education and training) are thus not limited, the principle of fair equality of opportunity is satisfied.

Furthermore, since the HMO scheme only provides the basic tier of a health-care delivery system, alternative health-care options (and careers for the professionals) are available to those who are better off. The HMO scheme is also efficient in that accepted standards of care set the basic minimum of care. As a result, expensive and exotic as well as aggressive therapies which have little

positive effect (e.g., on the terminally ill) are not included in this system. Thus the difference principle is satisfied in this model of health-care delivery system.

The second legislative stage requirment is that the constraints of the ideal legislators are satisfied. This means that particular information and desires are not to be included as considerations.

Furthermore, the constraints of the first two stages of the four-stage sequence are in effect. This requirement also is satisfied by the subsidized HMO model as the basic tier of a Rawlsian health-care delivery system. The information used in developing this theory would be available to ideal legislators. For example, the basic information about HMOs, fee-for-service, crisis medical care and indigent care would be available to the ideal legislators enabling them to choose among available types.

Since health is a social primary good in my modification of Rawls' theory, health care is a right subsumed into the second principle of justice. As such, it is legitimately treated as a second principle concern. Considering health as a social primary good makes distributive issues in health care properly a part of Rawls' moral theory. Thus using Rawls' background institutions--which are legislative stage institutions--for developing a just health-care delivery system is consistent with the

modified version of Rawls' theory. Since the difference principle--with its constraints--is satisfied, the other constraints of the first two stages of the four-stage sequence are also satisfied. Thus the subsidized HMO scheme is consistent with legislative stage constraints.

The third requirement is that this model for a Rawlsian health-care delivery system satisfies the specific roles of the background institutions. These institutions provide efficiency, coordination and stability to a well-ordered society by determining a just minimum and limiting unnecessary and unjust disparities in the possession of the second principle social primary goods. As a result, they are an integral part of ideal theory in Rawls' system.

Since the elaboration of the subsidized HMO model specified the particular roles of the background institutions in specifying a just minimum and limiting unnecessary disparities in the distribution of the social primary goods, there is no need to see if these roles are fulfilled in my scheme. They obviously are fulfilled. This leaves open the question of whether the requirements of efficiency, coordination and stability have also been fulfilled.

The subsidized HMO plan does fulfill the requirement of efficiency. The adoption of this plan would provide for multi-layered tiers of health-care delivery. However,

this plan would also eliminate the need for additional programs to provide for medicare, medicaid, indigent care and so forth. The health-care needs for the society would be provided for without appeals for additional programs which would tend to overlap with the HMO system. Furthermore, by adopting the accepted practices standards, the costs of the program could be efficiently maintained.

Coordination between the four background institutions is also seen with each branch accepting responsibility for differing aspects of the HMO scheme. The allocation branch responds to geographical barriers, for example. The stabilization branch responds by contributing to the HMO system the programs necessary to fulfil the rehabilitative needs of the citizens. It also provides for the training of health-care professionals. The role of the transfer branch is obvious since it is in charge of developing the basis of the subsidized HMO. The distribution branch provides funding and limits the disparities of the possession of social primary goods through taxation and the opportunities tax scheme. Thus the requirement that the problems of coordination in a well-ordered society be addressed in this scheme is fulfilled.

The stability requirement has already been addressed in the sense that the HMO scheme is still capitalistic. As a result, the health-care professionals may choose to

remain members of particular HMOs since their profit motive is fulfilled through continued participation. The system as a whole tends to be more stable as well. Since the great disparities in wealth and power that occur in existing societies are mitigated, there is less dissatisfaction among the least advantaged citizens--i.e., the worth of liberty is enhanced for them. Thus the acceptance of this model into a Rawlsian well-ordered society fulfills the stability requirement as well.

In conclusion, this model of a health-care delivery system in a Rawlsian well-ordered society has been shown to be adequate. The requirements of the legislative stage have been fulfilled. Like Daniels' modified theory, it is methodologically consistent and acceptable for use as a health-care delivery system. Since neither model will be actually used as the health-care delivery system in a Rawlsian well-ordered society (unless we would wish to take the final steps and choose one), no comparisons between the two proposals will be done to see which is the more adequate or just model. The point is not to have a "perfect" model, but to be able to evaluate existing and proposed models of health-care delivery systems to see how just they really are.

The actual purpose of analyzing these models is to see if the legislative stage considerations could be used

as criteria for evaluating existing and proposed health-care delivery systems. I have chosen to work first with Rawlsian schemes to test the criteria themselves. If either Rawlsian scheme were to be demonstrated as unjust--or even relatively unjust--it would be clear that these criteria are unworkable (and that, perhaps, even Rawls' modified theory is unworkable in evaluating the justness of existing and proposed health-care delivery systems). To the extent that these criteria work with Rawlsian health-care delivery systems, they are acceptable evaluative tools. The next stage is the task of the following two sections--to apply these criteria to non-Rawlsian existing and proposed health-care delivery systems. If these criteria prove adequate, then Rawls' theory is indeed an appropriate theory to evaluate distributive issues in health care.

C. The Health-Care Delivery System in the United States: An Evaluation

1. The Description.

Our existing health-care delivery system consists of a number of private, semi-private, and governmental programs that attempt to provide for the health-care needs of the citizens (and visitors as well as semi-permanent residents) of the United States. In brief,

the pattern of the health-care delivery system in this country is the following.

The primary form of health care is the traditional fee-for-service arrangement. Payments for this type of health care are usually made through some form of insurance (generally with some small percentage of co-payment by the insuree).

HMOs are becoming more wide-spread as an alternative form of health care. In this country HMOs provide the following services in an attempt to maintain adequate health care (as mandated by the Health Maintenance Organization [HMO] Act of 1973 [Pub. L. No. 93-222]). This includes:

> physician services, inpatient and outpatient hospital services, emergency health services, short-term outpatient mental health services (up to 20 visits), treatment and referral for drug and alcohol abuse, laboratory work and X-rays, home health services, and certain preventive health services. (President's Commission, 1983a:41-42, quoting the Health Maintenance Organization Act of 1973)

The pre-payment plan can include direct payment by the patient (and his/her family) or the financial burden can be undertaken (or shared) by the employer of the patient.

The health-care needs of the poor are served to some extent by indigent care programs and Medicaid, while the needs of the elderly are served by Medicare (which also

requires an initial deductible payment and a co-payment for many of the services rendered).

In a more detailed description of our existing health-care delivery system, it will be useful to set some parameters. First of all, since the focus of the evaluation is on the issue of access, the following description will be limited to that issue. Secondly, in order that this material can be presented in a coherent manner, I will follow Dan W. Brock's pattern of organization presented in his essay, "Distribution of Health Care and Individual Liberty," (Brock, Securing Access, 1983b:240-244). Brock sets up three distributional issues that he (Securing Access, 1983b:240-244) claims affect access to the health-care delivery system: (1) Income, (2) Location, and (3) Maldistribution of specialists. In developing these three distributional issues, additional data and examples from other sources may be used for illustration.

a. Income. According to Brock (Securing Access, 1983b:240-241), the poor generally receive fewer medical services and are less healthy than those who are better off despite the fact that they actually have a slightly higher rate of physician visits. Brock states:

> In particular areas of care such as preventive care--including prenatal exams, pap smears, breast exams, and childhood immunizations--as well as dental care, the poor are much less likely to receive care than the nonpoor. The poor are also much less likely to have any or

> adequate insurance coverage. In general, significant inequalities remain, disfavoring the poor in access and utilization of health care relative to their health care needs. (Brock, Securing Access, 1983b:241)

These problems remain, according to Brock, despite significant gains in health care and access to health care in the last 15 years.

The great disparities in access to the health-care delivery system between those who are better off and the poor have a number of contributing factors. Government programs generally set qualifying limits on eligibility to receive these health-care benefits. Many of these limits include available income. Furthermore many lower income persons are uninsured. As a result of factors like these, there are many people in the United States for whom access to the health-care delivery system entails an enormous financial burden--or even financial disaster. The President's Commission cites this as a serious problem facing the United States.

> Despite the prevalence of insurance coverage, a sizable number of people--estimated from 22 to 25 million--are uninsured. . . . The number of people without health insurance during a 12-month period is substantially larger than the number of uninsured at a particular time, for many people are covered only during a portion of the year. For example, factory workers covered under group plans may find they are not protected against the cost of medical care when they are laid off; low-income single parents become ineligible for Medicaid once their earnings exceed the state's income cutoff limit. Thus, there are two groups of uninsured people--

> the never-insured and the part-time insured. (President's Commission, 1983a:92-93)

Cases of uninsured people facing financial disaster when faced with the direct payment of enormous medical bills abound in this society. These are the people who "fall through the cracks" of the health-care delivery system because of financial burdens.

b. Location. Another barrier to access to the health-care delivery system in the United states is geographical. The most obvious form of a geographical barrier is exemplified by rural and remote communities in sparsely populated areas. There are, however, other kinds of geographical barriers. One is the lack of inner city health-care professionals and facilities. The President's Commission notes that physicians tend to set up practice in the more affluent suburbs rather than inner city areas (President's Commission, 1983a:82). The difference, then, in physician to patient ratio can vary enormously even in densely populated areas. According to Brock, these problems affect nearly 52 million Americans. He states:

> The Department of Health and Human Services (DHHS) estimates that about 52 million Americans live in medically underserved areas, largely inner-city and isolated rural areas; about 20 million of these persons are considered to be a high-priority underserved population. (Brock, Securing Access, 1983b:241)

Thus even when people have the ability to pay for the

costs of their medical care, that care may not be readily accessible to them.

There are federal programs designed to counter geographical barriers to health care. According to Brock (Securing Access, 1983b:241-242), they are successful in a limited way.

> [These programs] have included education loans to medical students with forgiveness conditions for practice in underserved areas, rural preceptorships for medical students, efforts to increase the total number of physicians, the National Health Service Corps (operating in largely rural areas), and Community Health Centers (aimed at both rural and inner-city areas). . . . The reasons for the limited impact of these programs . . . are complex and varied, and include the important factors of inadequate political support coupled with inadequate funding.

Thus geographical barriers to access continue to be a major problem in our health-care delivery system.

c. Maldistribution of specialists. According to Brock, this is a two-pronged problem. The first aspect of this problem is the over- and under-supply of physician specialists. Over-supply of a specialty can lead to unnecessary treatments in that particular specialty, according to Brock, while under-supply can lead to under-utilization of health-care services.

> It is generally conceded that the U.S. has an oversupply of general surgeons, and that a strong case can be made that the oversupply of surgeons is implicated in the high rates of unnecessary surgery. . . . On the other hand, between 1930 and the early 1970s the proportion

> of physicians engaged in primary care, which is the principal point of initial access to the health care system, declined by over 50%, while the population per primary care physician more than doubled; both these trends were reversed in the latter half of the 1970s. . . . Oversupplies and undersupplies of physician specialists contribute to a general reduction in the matching of appropriate medical care to medical needs. (Brock, Securing Access, 1983b:242)

According to Brock, this aspect of the problem of maldistribution of care remains despite the reverse in the trend against primary care specialties.

Cost escalation is the second aspect of the problem of maldistribution of specialists for Brock. Because of the escalation of medical costs, there have been serious attempts at cost containment in health care services.

> A number of programs instituted in the last decade, including state Health Planning and Development agencies and local Health Systems Agencies, Professional Standards Review Organizations, Health Maintenance Organizations (HMOs), have had cost control as one of their aims. A different source of pressure for cost containment derives from political pressures to reduce the role of government in the health care system generally, and to reduce government outlays for public health care programs in particular. (Brock, Securing Access, 1983b:242-243)

Brock cites Medicare and Medicaid as two federal programs which are slated for significant cuts in spending.

Volumes could be written in depicting our existing health-care delivery system and some of the problems it faces. The above description is sufficient for the purposes of this study, however. It is, I hope, a brief, but

fairly accurate description of our health-care delivery system in terms of the issue of access. The next task is to evaluate this health-care delivery system to see how just it really is.

2. The Evaluation. Since our existing health-care delivery system is not pre-designed with issues of justice in mind, the format of using legislative stage considerations as criteria for determining the justice of a particular will have to be slightly modified. The questions will have to be couched in the form of "how closely does this approximate X." Still this should not be an overwhelming problem in evaluating existing and proposed health-care delivery system since Rawlsian theory admits that no existing society is a just society like a well-ordered one.

The first question, then, is as follows: How closely does our existing health-care delivery system satisfy the requirements of the difference principle? These requirements include judging the system from the standpoint of the least advantaged representative citizen subject to the constraints of equal liberty and the worth of liberty and satisfying to some extent Rawls' notions of chain-connectedness and close-knittedness (i.e., that advantages received by the least advantaged also result in advantages

by those who are better off, and that all shall gain in advantages if any one group gains in advantages).

From the standpoint of the least advantaged representative citizen, our health-care delivery system is woefully inadequate even with our provisions for indigent care. Many indigent care programs do not provide adequate health-care, for example.

> The term "physician" visit can mean many things. It can be a hurried visit to a 'Medicaid mill' in which a patient is ping-ponged among a series of doctors, nurses and others to maximize reimbursement income. It can be hours spent waiting in a crowded, noisy hospital outpatient clinic for a few minutes with a doctor you've never seen before. At the other end of the scale--and far more desirable personally and medically--is the kind of visit you and I are accustomed to: seeing a doctor we know by name and who knows us and our families. [David E. Rogers, Statement before Subcomm. on Health and Scientific Research, Comm. on Labor and Human Resources, U.S. Senate (Sept. 24, 1980) at 3-4. (Quoted from President's Commission, 1983a:76.)]

> [The public hospital] is about the only place we had the opportunity to go. I know personally if I had not had to deal with the public hospital, I wouldn't have realized how bad it was. I might be one of the persons out there saying, "Well, there is a place for them to go." . . . But if you haven't been there, you don't know what it's like. [Commission testimony. (Quoted from President's Commission, 1983a:77.)]

The President's Commission (1983a:49-113) draws attention to the inadequate general care received by many members of our population--especially the poor.

Geographical barriers are a problem for the least advantaged members of this society as well. Many rural

areas are populated with poor people who receive little or no health care. Inner city residents are also subject to geographical barriers, due not only to the poor patient-to-physician ratio but also from lack of transportation to and from facilities that provide indigent care.

Maldistribution of specialists contributes to the problems of the least advantaged as well. Even though there is now a trend toward primary care specialists, the existing gap between these specialists and other specialties still remains. This contributes toward the lack of access faced by the least advantaged. Brock's second aspect of this distributional issue, expanding medical costs with the concomitant private and governmental attempts at cost containment, has an even larger negative effect on the least advantaged representative citizen. With planned cuts in spending programs like Medicare and Medicaid, as well as cuts in indigent care and public health programs (through redefining the class of truly needy persons), not only the least advantaged persons but also the working poor and the elderly are facing increased personal financial burdens to satisfy their health-care needs. All too often, this results in no care being provided.

Thus, from the standpoint of the least advantaged person, our existing society--even though it attempts to

provide for the health-care needs of the poor--is not a very just society in terms of its health-care delivery system. In that our society attempts to provide for the health-care needs of the poor, it is at least not an unjust society.

The other aspects of the difference principle show up similar injustices in our health-care delivery system. Those who do not qualify for federal, state or local assistance in providing for their health-care needs are often uninsured as well. These members of our society are faced with enormous or even disastrous financial burdens when there is a health-care crisis. As I noted earlier in describing our existing health-care delivery system, these are the people who "fall through the cracks" of our health care delivery system. If the difference principle--with its aspects of chain-connectedness and close-knittedness--is applied to our society, it is obvious that these people who are somewhat better off in terms of income are worse off than the least advantaged members of our society in terms of their access to the health-care delivery system. At least the most disadvantaged members of our society have some (even if minimal and of poor quality) access to the health-care delivery system. Thus of the two aspects of the difference principle, neither chain-connectedness

nor close-knittedness can be effectively applied to our health-care delivery system.

Thus our health-care delivery system is only minimally just when the criterion of the difference principle is applied in evaluation. Rawls' use of the difference principle in his deliberations results in minimal disparities of the possession of social primary goods in a well-ordered society. The lack of this as a tool (as well as the lack of a shared conception of justice) in our response to the health-care needs of those who are poor and indigent can be seen in the resulting enormous disparities in health-care delivery and quality of that health-care delivery in the United States.

The second criterion of this evaluation process can now be applied to our existing health-care delivery system. How closely does our society's health-care delivery system achieve the constraints on the ideal legislators in developing health-care policies? Are particular desires and preferences used in making these decisions? Is there a conception of justice behind some of the decisions that affect the programs involved in our health-care delivery system? (I am unhappy with the rephrasing of this criterion, but this seems to most closely parallel the issues as they were presented in the last two sections in dealing with Rawlsian health-care delivery systems.

This criterion seems to focus on the policies that affect the health-care delivery system, rather than the actual provision of health care through the health-care delivery system.) The answers to these questions will be approached in reverse order, so that by the time I reach the answer to the overall question, I have the basic features of the main question at hand.

There is no doubt that the issue of justice is part of the deliberations and policies that affect the structure of our health-care delivery system. If questions of justice were not involved, the existence of health-care programs like indigent care, Medicare and Medicaid, would be in doubt. The concern for justice certainly spurred the formation of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research--and especially their three volume report: Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services. This commitment to justice is reflected in Commission Chairperson Abram's letter of transmittal to Congress (the same letter going to both the House of Representatives and the Senate) and to the President. Abrams (Securing Access, 1983a:cover letter) states:

> This report responds to the mandate that we report on the ethical implications of "differences in the availability of health services" among various groups in the United States. As

> we have examined the problems people face in obtaining health care, we have nonetheless been mindful of the system's notable accomplishments.
> . . .
> In examining the special nature of health care, we discern in our country's traditional commitment to fairness an ethical obligation on the part of society to ensure that all Americans have access to an adequate level of care without the imposition of excessive burdens.

The concern for justice is not necessarily the same as having a shared conception of justice, however. Rawls' theory reflects a particular conception of justice--a deontological theory of justice--that contains two principles in lexical ordering. Indeed, as Rawls notes in the beginning of A Theory of Justice, one of the differences between a hypothetical, ideal, well-ordered society and existing societies is that his well-ordered society starts out at the beginning of its structure with a shared conception of justice while existing societies have many--even conflicting--conceptions of justice.

Yet, our existing society is concerned with the justice of the health-care delivery system (among other concerns of justice). Perhaps a better Rawlsian way of stating the question, then, is this: is justice given priority over efficiency and conflicting claims when making institutional policies concerning the health-care delivery system? Unfortunately, the answer to this question is "no, or perhaps only rarely when the needs of the society are perceived as fundamental issues of justice."

One only has to look at presidential budgetary priorities to see the truth to this answer. One only has to look at the Medicare program as an example of this point.

Medicare started out as a result of the just demands for health-care for the elderly members of society. Originally the funding was such that very little co-payment was required by eligible citizens. As a result of the increasing demands on the system without concomitant budget increases and with corresponding raises in the percentage of co-payment, the co-payment is now so great that many elderly people are forced either to bear an enormous financial burden for their health care or to pay for additional third-party protection through supplemental insurance policies. (Rising health-care costs in general have also contributed to this problem.)

Case number four in Chapter I--the Medicare case where the elderly couple did not have additional third-party protection--reflects some of the consequences of policy-making and the priority (or lack of priority) of concerns for justice at the top levels of government. It also delineates much of the co-payment pattern. This couple still has access to the health-care delivery system, but can it be considered <u>just access</u>?

Thus the answer to this first question really seems to be that there is a concern for justice in our policy-

making regarding the health-care delivery system, but this concern is not given priority to concerns of efficiency or other budgetary priorities.

The second question seems to focus on special interests in that the constraints on the ideal legislators involve the veil of ignorance considerations that these legislators do not know their own place in society or any particulars about themselves or their desires. Indeed, there are many "special interests" that are involved in the decision-making process in government--especially in the health-care arena. The American Medical Association (AMA) has traditionally been opposed to programs that hint of socialized medicine. Its special interest is in maintaining the capitalistic and even somewhat monopolistic basis of medical practice in the United States. This point can be illustrated by the problems encountered in developing and passing the programs for Medicare and Medicaid.

Paul Starr (The Social Transformation of American Medicine, 1982:367) discusses this power structure.

> The structural impact of postwar policy . . . had been to create an immense new system of medical schools, teaching hospitals, and other allied institutions that now, to some extent, counterbalanced the private practitioners. This system demanded to be fed. Its representatives saw an inescapable role for themselves in solving the problems of society. Self-interest and noble aspirations both dictated that they

> begin a new chapter in the history of social reform. The community hospitals, though tied to private physicians, had their own independent interests, represented by the AHA and Blue Cross. They, too, demanded support under any new program.

This power structure--especially the AMA--opposed Medicare again and again. Although Medicare was originally conceived as a modest program for social security recipients, Starr (1982:368-370) notes that the opposition by the AMA was such that it was not until the AMA introduced its own form of a Medicare bill in 1964 that passage of the bill in any form was assured. Thus while many Western constitutional democracies have moved toward one form or another of socialized medicine during the last half of this century, the United States has steadfastly maintained its capitalistic health-care delivery system.

Part of the reason behind this is the powerful lobby of entrenched health-care establishments (including the AMA). Starr also notes that passage of the Medicare-Medicaid package did not mean that the medical lobby was satisfied. Accomodations to their interests were deemed necessary by Congress. First, Congress created buffers "between the providers of health care and the federal bureaucracy" by allowing the "option of nominating 'fiscal intermediaries,' instead of dealing directly with the Social Security Administration" (Starr, 1982:375). Secondly, Congress adopted rules of payment similar to the

Blue Cross plan by allowing costs to be determined by the hospitals' own costs--i.e., payment through reimbursement (Starr, 1982:375). It seems reasonable to assume that our resulting hodge-podge of health-care services is a consequence of this adherance to capitalistic forms of health-care delivery while also being concerned with the justice of our system--thus instituting programs like Medicare and Medicaid to fulfill the claims of justice but accomodating their structures and payment plans to the interests of the medical establishment.

The answer, then, to the question of whether special and particular interests govern the health-care policies and institutions is yes. In our society, there are particular interests--lobbies--that affect our health-care policy-making. Thus, insofar as the answer is yes to this question, our health-care delivery system is relatively unjust.

The final question--how closely do the policies which mandate our health-care delivery system parallel the policies which would be instituted by an ideal legislature--can now be answered. Although justice is certainly a consideration in governmental policy-making and budgeting for the health-care delivery system, it does not have priority over efficiency or other budgetary considerations. Furthermore, policy-making is governed by special

interests (lobbies) in the health-care arena. As a result, the existing system of institutional policy-making does not parallel the constraints on the ideal legislators very closely at all. As a result, starting at the very top of the institutional level, injustices arise in the health-care delivery system. Again, the existing system is only minimally, if somewhat, just.

The third criterion in evaluating our existing health-care delivery system is this: How closely do the institutions of our health-care delivery system come to achieving efficiency, coordination and stability in our society by determining a just minimum of health-care for all of its citizens and by limiting great disparities of both the quality and quantity of health-care in this society? Again, I shall start with attempting to answer the second part of the question before attacking the broader issues of efficiency, stability and coordination.

Regarding the setting of a just minimum of health care, part of the question has already been answered in discussing the difference principle criterion. There are certainly institutional attempts to provide access to the health-care delivery system to the indigent, the elderly and to those whose health-care burden is so great that their available finances (even with third-party payment) cannot begin to accomodate payment. However, many people

do not qualify for these programs, nor do some of these latter people have insurance. These are the people for whom there is no just minimum of health-care. Furthermore, there are people for whom there are geographical barriers in achieving access to the health-care delivery system.

The issue of quality of available health care has also been illuminated with testimony to the President's Commission. It has been found that, although there may be health-care available to the least advantaged members of our society, there is a great disparity between the least advantaged persons and those who are even considered "middle class" citizens in the quality of care available. Although attempts have been made to improve the quality of care, these have not always been successful even when the health-care professionals are as conscientious as possible because of the poor ratio between the great number of patients and the low number of health-care providers that serve the least advantaged members of our society.

Because of the problems inherent in our health-care delivery system, it is difficult for these institutions to address the problems of efficiency, stability and coordination. Our health-care delivery system evolved; it was not designed. As a result, it is a conglomeration of competing and over-lapping institutions that have been

developed to correct some of the enormous injustices that arise in a purely capitalistic system of health-care delivery. Each program competes with other programs for funding. When there are not specific institutions that receive payment for health-care delivery, those services (hence those payments) go into the free health-care market. Some of the health-care providers for services like Medicare and Medicaid have been found to be cheats who provide limited health-care (or none at all) while charging outlandish fees to the governing institutions. Medicare and Medicaid fraud are continuing problems. Since these problems drain funding, even less funding is available for provision of legitimate health-care needs to those who qualify for the programs. Hence access to the health-care delivery system is even more curtailed. Such problems affect efficiency, coordination and stability to a great extent. As a result, the existing health-care delivery system is not very just.

In concluding this evaluation of our existing health-care delivery system, it has been shown that there are considerable injustices in the system as a whole. Each criterion pointed out areas of injustices. While our system of health-care delivery is not completely unjust, it is also not very just. It certainly is concerned with issues of justice in the provision of health care for many

of the citizens who would not otherwise receive any care at all. The problem is that this system does not respond to all the people who need health care and are unable to afford it. There is no just minimum of health care set for our society in this respect. Special interests continue to influence policy-makers at the highest levels to maintain the status quo--not limiting the free market place so that the structure of the entire health-care delivery system remains, at its heart, a purely capitalistic scheme. As a result, our health-care delivery system contains a number of competing and over-lapping institutions developed to address some of the issues of justice while adhering as closely as possible to traditional capitalistic forms of health-care delivery.

Those of us who are in the middle class benefit greatly from such a health-care delivery system. Most of us have never seen a clinic that provides health-care to the indigent. If we think our health-care delivery system is relatively just, we should spend some time in one of these clinics. We should talk with a family that has no insurance and is not eligible for medicaid about how their health-care needs are provided for in an emergency. We should talk with an elderly couple on medicare whose nest-egg for their retirement has been eaten up by huge co-payments for inadequate health-care services. Then we

would agree with this evaluation of our health-care delivery system that concludes that there are pervasive injustices in it. True, it is not a completely unjust system--totally lacking in the concerns of justice--it is only minimally just. As the testimony to the President's Commission states:

> [I]f I had not had to deal with the public hospital . . . I might be one of those persons out there saying, "Well, there is a place for them to go." (President's Commission, 1983a:77)

D. Enthoven's Consumer-Choice Health Plan (CCHP)--The Competition Strategy: An Evaluation

Because of the problems of the cost of health care and the failure of our existing health-care delivery system not only to contain these costs but also to provide adequate health care to the poor, a number of proposals to change its structure have evolved. A proposal that has generated enormous interest and debate is Enthoven's Consumer-Choice Health Plan--to be referred to in this study as either "the CCHP" or as the "competitive solution"--which addresses both problems in a particularly capitalistic manner. This proposal came about as the result of a request by Joseph Califano, at that time the Secretary of the Department of Health, Education and Welfare (DHEW)--a department now known as the Department of Health and Human Services (HHS). Enthoven's proposal was not adopted by

the Carter Administration, but interest in and debate about it has continued. During the early part of the Reagan Administration, this proposal has gained its support, but opposition to its adoption is wide-spread--ranging from lobbyists for the medical establishment to lobbyists for the union movement. Because of the interest and debate this proposal has generated, it seems appropriate to evaluate this proposal for changing the scope (and, as a result, possibly even the structure) of our existing health-care delivery system.

1. The Description. In the CCHP, Enthoven proposes four areas of change in our present health-care delivery system in response to the problems inherent in our existing health-care delivery system. Calling this the "competitive strategy," Enthoven (1981:109) calls for "four principles of health-care financing" which are the following: "multiple choice, the fixed-dollar subsidy, the use of the same rules for all competitors, and organization of physicians into competing economic units." Enthoven further defines these principles:

> Under the multiple-choice provision, each consumer would be offered the opportunity to enroll each year for the coming year in any of the qualified plans for health-care financing and delivery that are operating in the area. With a fixed-dollar subsidy, each consumer would receive a fixed sum toward the purchase of a health-plan membership, and the amount would be independent of the plan chosen. The person who chose a more costly health plan would pay the

> extra cost and therefore would be conscious of cost. The emphasis is placed on cost consciousness at the time of choice of health plan rather than at the time of medical need. The same rules would apply to all qualified health plans; rules would govern premium-setting practices, minimum-benefit packages, catastrophic-expense protection, and so on. Such a system would prevent preferred-risk selection, excessive costs for high-risk persons, and deceptive or inadequate coverage. Finally, physicians would be in competing economic units. The market would include "limited-provider," "preferred-provider," or "closed-panel" plans, in which a health-care financing plan is associated with a limited set of physicians. The premium charged by each plan would then reflect the ability of its associated physicians to control costs. (This method of organization can be contrasted with today's scheme, in which nearly all plans offer a "free choice of doctor.") (Enthoven, 1981:109-110)

According to Enthoven, this plan addresses not only the problem of rising costs in the health-care delivery system, but also addresses inequities in third-party payment plans (which discriminate against high-risk individuals). Furthermore, it addresses the health-care needs of the disadvantaged members of our society. The plan also moves away from the concept of employment-related health-benefit programs in that, although employers would still provide alternative kinds of policies for the employees to enroll in, the subsidies are directed toward the individual.

> The reason for this change is to achieve universal coverage in the context of a competitive system. The link between jobs and health insurance is an important barrier to the entry of new health plans into the market, and it

> greatly complicates the problem of insuring persons who are not regular members of employment groups. (Enthoven, 1981:110)

Enthoven goes so far as to call his plan one of universal health insurance based on a capitalistic scheme.

All people would receive subsidies which are related to predicted health-care needs and low-income persons would further have their subsidies adjusted (upward) based upon their income as well. Enthoven does not recommend dismantling programs like Medicare and Medicaid, however. Since these programs define specific classes of health-care users who already have subsidies, he proposes rather to divert these funds to the available health programs like HMOs for example.

Enthoven's plan is consistent with and suggestive of heavier implementation of HMOs into our health-care delivery system. He recommends "coverage of the basic health services as defined in the Health-Maintenance Organization Act," but admits that the "system could also work with a less costly definition of 'all the care one needs'" (Enthoven, 1981:110). He recommends HMOs for recipients of Medicare which would "allow Medicare beneficiaries to direct that an amount equal to their 'adjusted average per capita cost' to Medicare be paid to the HMO" or another qualified health-provider (Enthoven, 1981:110). He also

approves of incorporating an HMO plan for medicaid recipients into their health-care alternatives.

Enthoven's plan is a minimalist plan, on the other hand, based on the premise that wanting more health care services is equivalent to paying more to get it. Thus, on his plan, co-payments for more expensive programs would be greater than they presently are. This is not to say that he approves of any plan which does not provide for adequate health-care needs. His recommendation of adopting the coverage of basic health services specified in the HMO Act shows this. This list includes:

> physician services, inpatient and outpatient hospital services, emergency health services, short-term outpatient mental health services (up to 20 visits), treatment and referral for drug and alcohol abuse, laboratory work and X-rays, home health services, and certain preventive health services. (President's Commission, 1981:41-42, quoting the law.)

Enthoven admits that this is a costly definition and does allow for some minimal sort of redefinition of health-care needs.

Ginzberg (1980:1112-1115), in an article generally critical of Enthoven's plan, outlines the reforms in our health-care delivery system that would take place if that plan were to be adopted. This outline will cover aspects of the program not yet delineated, thus giving a final over-view in my description of this proposal for a health-care delivery system.

> -Congress should alter the tax laws so that a ceiling is placed on the total amount of health-insurance premiums that employers may deduct as a business expense, as well as on the value of nontaxable benefits that employees may receive.
> -Employers must offer their workers a choice of at least three different health-insurance plans, all of which must meet minimal standards for coverage. An employee who chooses a plan costing less than the most expensive plan that the employer offers will be entitled to pocket the difference.
> -To make consumers of health care more cost conscious at the point of use, the plans should rely on co-insurance or deductibles.
> -Special provisions should be made for enrollment and health-insurance coverage of people with low incomes. (Ginzberg, 1981:1112)

Although I have many concerns with the implementation of Enthoven's plan in this society--e.g., policy-makers and legislators cutting out the provisions for low-income persons, or defining health-care needs in such a way that cost of health care is prior to the concerns of justice in defining those needs--fairness to Enthoven demands that his plan (not derivations of it) be evaluated to see how just it really is. Thus, for the sake of that fairness, I will not bring in any of the criticisms of his program unless the evaluation process finds it necessary in order to determine the issue of just access. The above description of Enthoven's proposal is now sufficiently complete so that the evaluation process can begin.

2. The Evaluation. The evaluation process will follow the same format as used in evaluating our existing

health-care delivery system. Each of the criteria for evaluation will be applied, followed by a comprehensive discussion of the conclusions that are derived.

The first question, then, is as follows: How closely does Enthoven's proposed health-care delivery system satisfy the requirements of the difference principle? These requirements include judging Enthoven's proposal from the standpoint of the least advantaged citizen subject to the constraints of equal liberty and the worth of liberty and satisfying to some extent Rawls' notions of chain-connectedness and close-knittedness (i.e., that advantages received by the least advantages also result in advantages by those who are better off, and that all shall gain in advantages if any one group gains in advantages).

From the standpoint of the least advantaged person, Enthoven's CCHP proposal does provide for the health-care needs of those who are not as well off. Since Enthoven defines those needs in terms of the list of services required by HMOs by law, the provision of health-care may indeed be adequate for the least advantaged members of society. On the other hand, since he allows for a less costly definition of needs--but does not elaborate on what health-care services this might entail--there is a danger that this weaker definition would not provide adequate health-care services to the least advantaged.

In the sense that Enthoven's plan is a universal health-care scheme--one that moves away from employment-related health-care benefits to a subsidy for individuals to use (and supplement, if they so choose)--it would seem that this plan would also account for those people who presently do not have third-party assistance in paying for health-care services. In this respect, then, Rawls' conditions of chain-connectness and close-knittedness would be satisfied in applying the difference principle to Enthoven's plan. Although he chooses to keep existing programs like Medicare and Medicaid (since they already define eligible health-care user groups), it would be plausible to assume that since this is a program based on individual subsidies, the health-care needs of the uninsured, non-eligible (for assistance programs like Medicare and Medicaid) people would also be accomodated.

Enthoven's preference for HMOs as an alternative health-care plan for the needy would also have the possibility of eliminating some of the public assistance clinics, hospitals, and "Medicaid mills" as woefully inadequate primary care providers. (In this respect, an idealization of Enthoven's scheme would closely parallel my own scheme--presented for providing just access to the health-care delivery system.)

Geographical barriers do present a problem to Enthoven's scheme, however.

> The kind of competition between large conglomerate providers that Enthoven envisions makes little sense in rural Alaska, but it is a possibility for the 80 per cent of Americans who live in urban areas. (Neuhauser, 1980:1116)

There could be geographical barriers in urban areas as well in Enthoven's scheme if the HMOs and other health-care alternatives are not within the transportation means of the low-income recipients. Problems like these would have to be resolved in the implementation stage if Enthoven's plan is able to continue to satisfy the criteria of justice demanded by the difference principle considerations.

In terms of the provision of adequate health care to the least advantaged, and in terms of the satisfaction of its aspects of chain-connectedness, the difference principle is generally satisfied (with the possible exception of continuing geographical barriers) by Enthoven's scheme by ensuring just access to the least advantaged members of the community. Close-knittedness is also achieved in that the gain in advantages for the least advantaged is also reflected in a gain of advantages by those somewhat better off.

The question of the impact of Enthoven's plan on the middle class might seem to deny this, however. Health

care could be more costly to this group of people--not only in direct payments but also in loss in tax benefits as well as possible increases in taxes. There are two responses to this objection that may mitigate it. First of all, there would still be a direct subsidy for the people in the middle-class. They are to receive adequate health-care. Direct payments may increase at the time of providing for health-care needs with deductibles and co-payments--but these increases would only take a bigger bite out of the pocket book if the person chooses a more expensive health-care plan. Secondly, although taxes may increase in order to provide the resources for this scheme, Enthoven hopes that the competitive nature of this plan will ultimately result in generally lower health care costs for this society. If that is the case, then the demands of the difference principle are still met in providing just access to the health-care delivery system.

Thus Enthoven's proposal for a health-care delivery system generally satisfies the constraints of the difference principle. With the possible exception of continued geographical barriers for the least advantaged members of society, his scheme can be considered a relatively just one (as opposed to an idealized just scheme for a well-ordered society) with regard to the criterion of satisfaction of difference principle conditions.

The second criterion being used in evaluating the justice of existing and proposed health-care delivery system involves Rawls' legislative stage constraints which do not allow for special interests and one's own particular desires to be involved in the deliberations. The problem of special interests being involved leads to the following formulation of this criterion: Are the claims of justice given priority over considerations of efficiency and conflicting claims when making institutional policies concerning the health-care delivery system? In answering this question, I will not only focus on Enthoven's proposal, but also on the difficulties involved in implementing it as a new kind of health-care delivery system for the United States. This seems only fair because of the enormous range of opposition that this proposal has engendered--and because attempts to even implement part of this proposal have met opposition by powerful lobbies in Congress.

In terms of Enthoven's proposal as it stands, the appeals of special interest groups have certainly not been given priority. The medical establishment opposes the implementation of Enthoven's plan in that traditional single-physician offices would be at a disadvantage in the competitive market. Radical changes in the structure of the health-care delivery system would also force changes

in hospital policies and cost-structures--which leads to opposition from this branch of the health-care delivery system. On the other side of the political spectrum, there is opposition from both business and labor. Businesses would no longer get the tax-breaks they presently enjoy in providing health-care benefits. Unions see Enthoven's plan as chipping away at traditional bargaining points. Political liberals oppose this plan because, in part, it does not go far enough, and, in part, because of party politics. Enthoven, while admitting that adoption and implementation of his proposal should be an incremental process, continues to defend his proposal as it stands. He does not bow to special interests.

The more important question, however, is this: Does Enthoven give priority to justice over efficiency? This question is more difficult to answer. In the sense that the use of the difference principle generally leads also to an efficient scheme, Enthoven's use of cost analyses, actuarial tables, and so forth (while still arguing for a just minimum of health-care), seems to be consistent with difference principle considerations. In this sense, Enthoven can be said to give justice priority over efficiency.

However, in his (begrudging) willingness to abandon his criterion of need as defined by the HMO Act, and, for

the sake of cost considerations, adopt a definition of "all the care one needs" (Enthoven, 1981:110)--without further elaboration--Enthoven may, in fact, relegate concerns of justice to a secondary consideration. The problem here lies with what Enthoven would accept as a just minimum of health care--and whether he would abandon that just minimum for the sake of cost considerations. If he would abandon the just minimum, his proposal is less than just in this respect, for then justice would not be given priority over efficiency.

As to the adoption and implementation of Enthoven's plan, special interests abound. This list includes the AMA, The Health Insurance Association of America, Blue Cross and Blue Shield, the AFL-CIO, and even The Group Health Association of America (the national lobby for HMOs) as groups that oppose or have reservations about the adoption and implementation of a voluntary version of Enthoven's proposal (Iglehart, 1981:295-296). If each special interest group were to have its way in protecting its own domains, the resulting plan would not even be recognizable. Add to this the problem of federal budget priorities and the concomitant constraints on spending for social programs in these conservative economic times and the proposal would probably drop many of the provisions of health-care for the needy that Enthoven perceives

as necessary. The resulting health-care program would probably be much less just than Enthovan's proposal in terms of the problems of special interests and giving efficiency priority over the concerns of justice.

Thus Enthoven's proposal for a new health-care delivery system generally is consistent with the legislative stage constraints on special interests and, for the most part, can be perceived as giving justice priority over efficiency (with the one possible exception noted). In this respect, the CCHP satisfies, relatively well, the second criterion being used for evaluating the justice of existing and proposed health-care delivery systems. Although there are obvious problems in adoption and implementation in this area given our political and economic model, fairness to Enthoven's plan demands that only his proposal be considered here.

The third criterion can now be considered in evaluating Enthoven's proposal for a health-care delivery system. The question here is this: How closely does Enthoven's proposal for a health-care delivery system come to achieving efficiency, coordination and stability by determining a just minimum of health-care for all citizens and by limiting the great disparities of both the quality and the quantity of health-care that can occur in a capitalistic scheme such as this? In determining the answer

to this question, I will first consider the second half of this question, thus enabling me to effectively address the questions of efficiency, coordination and stability.

Enthoven's proposal for a health-care delivery system certainly attempts to set a just minimum. Although there are concerns about his willingness to lower the minimum (to some ambiguous degree), for the sake of argument, I will accept the fact that the minimum of health-care that will ultimately be considered is a just minimum. His subsidy plan is also geared to all individuals. The just minimum is thus provided for everyone. In this respect, then, his proposal fulfills part of the third criterion.

The proposal is interesting in that it also seems to limit the disparities in both the quantity and quality of care provided for its citizens. The implementation of the HMO as an alternative for Medicare and Medicaid recipients certainly will have a positive effect on the quality of care, while the quantity of care is positively affected by the acceptance of the list of services mandated by the HMO Act of 1973. Not only does Enthoven upgrade the quality and quantity of care for the least advantaged, he makes it more difficult--more costly--for those who are better off to have a better quantity (and maybe, quality) of care. After setting the just minimum due all citizens, and after implementing that just minimum by a subsidy for all,

Enthoven essentially says, "If you want top-dollar health care, you have to pay for it out of your own pocket!" In that this plan limits the amount of available health care to those who are better off by requiring greater proportions of co-payments, it also minimizes the disparities in health care between those who are better off and the least-advantaged--disparities that are so obvious in our existing system of health-care delivery. In these respects, then, Enthoven fulfills the second half of the third criterion.

Before moving on to the first half of this criterion of evaluation, however, I would like to point out some other features of Enthoven's plan that are also consistent with the demands of this criterion. In dealing with Rawlsian health-care delivery systems, I specifically looked into the roles of the background institutions. Now the above discussion is indicative of the functions of the transfer branch in Rawls' theory. There are also three other background institutions involved in Rawls' theory. Because Enthoven's proposal has proven to be relatively just, I would like to take the time to point out the functions of the other branches and see how closely Enthoven's theory actually parallels those functions.

Rawls' allocation branch has the function of limiting the free market place in a capitalistic society.

Enthoven's proposal can be seen to contain that function by limiting the nearly monopolistic freedom of the medical establishment. His competitive structure for physicians embodies those limitations in that, in order to compete, physicians and other health-care providers will have to be cost-effective. Although Enthoven's plan offers alternatives in types of health-care provision, it is biased against the "free choice of doctor." Furthermore, Enthoven's plan limits the choices of third-party health-cost providers and provides rules they must follow.

> Such a system would prevent preferred-risk selection, excessive costs for high-risk persons, and deceptive or inadequate coverage. (Enthoven, 1981:109)

These kinds of restrictions on the market place of the health-care delivery system, although controversial, certainly adjust the market-place in a manner that may ultimately be seen as more just--even if capitalistic. In this sense, Enthoven's plan embodies the functions of the allocation branch.

Enthoven does not obviously address the concerns of the stabilization branch. His plan is primarily concerned with health-care delivery and the implementation of a scheme for it. His remarks about the deployment of Medicare and Medicaid subsidies in such a way that services can be rendered by HMOs and paid by those subsidies as well as his remarks about the deployment of other

subsidies for the choice of health-care plans are the closest Enthoven comes to dealing with the functions of this branch. Indeed, according to Ginzberg ("Competition and Cost Containment," New England Journal of Medicine, 1980, 303:1112-1115), one of the concerns of teaching hospitals is the fact that the redeployment of Medicare and Medicaid funds to other, more competitive providers of health-care would have a devastating effect on their ability to continue to function. In this respect, then, Enthoven's plan is less than just.

Regarding the two-fold functions of the distribution branch, Enthoven's proposal certainly addresses its concerns. For example, his taxation scheme tends to redistribute the wealth in that business no longer can charge off benefit plans. The additional taxes would help to generate the funding needed to provide the subsidies for a just minimum. This also limits the disparities in the possession of social primary goods like power and wealth in society. Thus, from the standpoint of this background institution, Enthoven's scheme fulfills the common sense precepts of justice.

Now Rawls' scheme also has background assumptions in relation to these institutions--that the system of liberties is worked out and that the worth of liberty is assured by the principle of fair equality of opportunity.

These are issues that are not approached in Enthoven's scheme. He proposes a health-care delivery system. Only in terms of the proposal itself can his scheme even begin to address these issues. My only response here is that if Enthoven's scheme were properly implemented, the worth of liberty would be enhanced by the limitations of the disparities of health-care between those who are better off and those who are the least advantaged. (That is why I have avoided using these assumptions as criteria in and of themselves. The assumptions that the system of liberties has been worked out and that the worth of liberty is assured by the principle of fair equality of opportunity automatically and correctly--in Rawlsian terms--skew any existing or proposed form of health-care delivery as being less than just. In fact, this is one of the hallmarks of a well-ordered society which distinguish it from an existing society. Thus even a Rawlsian type of proposal that attempts to account for these issues, would be relatively unjust once it becomes part of the real world with all of its contingencies.) The brief examination of Enthoven's proposal in terms of Rawls' background institutions themselves has, however, shown that it is a fairly just proposal.

It is now time to address the issues of efficiency, coordination and stability into this discussion of the

third criterion of evaluation. Enthoven's proposal, in my opinion, has some deficiencies here. Although Medicare and Medicaid programs assist in determining those who need additional assistance beyond the basic subsidy in order to provide for the health-care needs of the least advantaged members of this society, they are also costly and inefficient bureaucracies which tend to overlap the basic functions of his proposal. Determination of who is eligible for additional assistance does not need two major bureaucracies to complete the task. The criteria they use is certainly useful, but the bureaucracies themselves could be streamlined into one health-service agency--whose task it is to implement and supplement the subsidy program for those who need additional financial assistance. In this way, efficiency could be enhanced while still meeting the demands of justice. Coordination of the particular program would also be enhanced when there are no longer a number of bureaucracies competing for their share of privileges and funds.

Enthoven's plan does enhance stability, however. Since it is a fairly just proposal in most respects, and since it improves the health-care of the least advantaged members of society (thus lessening the disparities in the existing health-care delivery system), the society is itself more just--even from Rawls' point of view.

In conclusion, Enthoven's plan, when the criteria for the evaluation of the justness of a health-care delivery system are applied, is fairly just. In contrast to our existing health-care delivery system, it is a much more just system. Enthoven's proposal fulfills each of the criteria in most respects, thus, although there may be elements of injustices in the proposal, the system as a whole is relatively just. If I were to apply a scale of one to ten in evaluating Enthoven's plan for its justness (with one being considered unjust and ten being considered as perfectly just in Rawls' sense of the term), I would probably rate it at a level eight.

III. CONCLUSION

This tasks set for this chapter have now been completed. Four health-care delivery systems have been depicted and evaluated to see how just they are using the criteria I have developed as a result of my modifications of Rawls' theory of justice. Both of the Rawlsian systems of health-care delivery have been shown to be just. In the case of our existing health-care delivery system, it was found that it is only minimally just. Enthoven's proposal, one that is particularly controversial and rejected by liberals as being too capitalistic and not

providing enough health-care, has been found to be relatively just.

I admit that I have bent over backward to present Enthoven's proposal in its strongest--and, perhaps, idealized--form. If it were to be adopted as it stands, it would be a fairly just health-care delivery system. On the other hand, the two Rawlsian systems are just systems. The problem for all three, however, lies not in their present structure--or in their justness in their idealized forms--it lies in their implementation in an unRawlsian, existing society. Given special interest groups, and existing legislators (as opposed to ideal legislators), the resulting structure--if any of these systems were chosen above our present health-care delivery system--would be considerably less just than it presently stands.

The three criteria for the evaluation of the justness of existing and proposed health-care delivery systems have been put to a practical test in this chapter. They have been relatively easy to apply to issues of access in health-care delivery. In other words, they are workable tools. The evaluation of the criteria themselves will be the subject for the next chapter. Furthermore, the modified Rawlsian theory itself will be analyzed to see if it is, indeed, a workable tool for evaluating the justness of health-care delivery systems.

CHAPTER IX

THE MODIFIED RAWLSIAN THEORY OF JUSTICE AS A TOOL FOR EVALUATING THE JUSTNESS OF HEALTH-CARE DELIVERY SYSTEMS

I. INTRODUCTION

In this chapter, the modified Rawlsian theory will be analyzed to see if it is an adequate tool for evaluating the justness of existing and proposed health-care delivery systems. In particular, the criteria which I developed for the purposes of that evaluation will be analyzed for their soundness. After completing that task, the modified Rawlsian theory as a whole will be discussed in relation to its applicability for use in social issues in medicine.

II. THE CRITERIA FOR EVALUATION OF THE JUSTNESS OF HEALTH-CARE DELIVERY SYSTEMS: AN ANALYSIS

The three criteria that I have developed for use as a tool to evaluate the justness of existing and proposed health-care delivery systems have been applied to four different systems. Two of them are proposed Rawlsian health-care delivery systems; the other two are not. One of the latter is our existing health-care delivery system; the other is Enthoven's proposed system (the Consumer Choice Health Plan--CCHP).

Both Rawlsian proposals were found to fulfill the

proposed criteria for evaluating the justness of health-care delivery systems. Our existing health-care delivery system, however, was found to be only minimally just. In terms of these three health-care delivery systems, the conclusions were consistent with my intuitive judgments. In the case of Enthoven's proposal, which, outside of a purely Rawlsian context, I had intuitively believed to be unjust, I found that the application of my Rawlsian criteria showed that Enthoven's proposed CCHP was a fairly just system. By working through the CCHP my Rawlsian "considered judgments" have certainly changed my initial reaction.

There is the possibility, however, that my criteria are inadequate for the task set out for them. Or it may be that, when dealing with second-principle concerns, Rawls' theory is much more conservative than many philosophers would believe. The first possibility is the subject of this section, while the second possiblility remains a topic for the last section.

Before entering into an analysis of the three criteria used as evaluation tools, it would be appropriate to present them in both of their forms since it is possible that the change of form has had an impact on their usefulness as criteria. I will first list these criteria in their original form; then list their modified

form. (I am presenting these criteria in their most general form in that any second-principle social primary good could possibly be used in evaluating the justice of its relevant social issue.)

1. Satisfaction of the difference principle subject to the constraints of equal liberty and fair equality of opportunity. This criterion demands that the standpoint of the least advantaged representative citizen is used. Rawls' conditions of chain-connectedness and close-knittedness must also be in effect at least to some extent.
2. Satisfaction of the constraints on the ideal legislators. This criterion demands that no particular information or personal desires be included in policy-making and that the constraints of the first two stages of the four-stage sequence are in force.
3. Satisfaction of the specific roles of the background institutions. This criterion demands that the just minimum must be determined; it further demands that disparities in the possession of the social primary goods be limited. Satisfaction of this criterion especially enhances the efficiency, coordination and stability of the institutions of a society.

The following modifications of these criteria were made at the point at which we were no longer working with Rawlsian proposals for health-care delivery systems. In dealing with non-Rawlsian proposals, we were, at best, working in fourth-stage, partial compliance theory, and perhaps not even in partial compliance. As a result, I argued that these criteria were too strong in their demands for evaluation of health-care delivery systems that were not Rawlsian. The format of the criteria was only modified slightly, however. The question to be applied in evaluation has now been approached with the additional preliminary phrase: "How closely does this health-care delivery system satisfy X? This then is the modified list of criteria as they have been used for evaluating non-Rawlsian health-care delivery systems. (Again, the general form rather than the specific form attuned to health as a social primary good is being used.)

1. How closely does X satisfy the difference principle subject to the constraints of equal liberty and fair equality of opportunity? This requirement includes judging X from the standpoint of the representative equal citizen subject to the constraints of the difference principle and, further, satisfying to some extent Rawls' conditions of chain-connectedness and close-knittedness.

2. How closely does X satisfy the constraints on the ideal legislators that particular information and desires not be included in policy-making and that the constraints of the first two stages of the four-stage sequence are in force. The second part of this criterion is modified to the simple form: Are the claims of justice given priority over considerations of efficiency and other conflicting claims when developing institutional policies?
3. How closely does X provide for the specific roles of Rawls' background institutions? In other words, how closely does X promote efficiency, coordination and stability in a society by determining the just minimum and limiting great disparities in the possession of the second-principle social primary goods?

In effect, this modified list--when applied to distributional issues in health-care--seems to acknowledge that no non-Rawlsian health-care delivery system will have at its heart a shared conception of justice, or work from the standpoint of an original contract that is derived through a four-stage sequence of moral deliberations. In other words, no non-Rawlsian system will fulfill these criteria and be considered perfectly just from the standpoint of Rawls' theory. (Some proposed and existing

health-care delivery systems will, however, go beyond Rawls' conception of justice--e.g., socialized medicine, for one.)

In some respects, these modified criteria are somewhat weaker than the original criteria since they do acknowledge that no existing or (non-Rawlsian) proposed health-care delivery system can approximate the conditions of Rawls' theory of justice which is hypothetical and ideal. Yet, even Rawls distinguishes between ideal theory and nonideal theory--between a well-ordered society and an existing society. Part of that distinction rests on the fact that a well-ordered society is a just society, while any existing counterpart can only be relatively just. So the fact that the modified criteria are somewhat weaker is only a reflection of that distinction. In this sense, the application of the weaker criteria to non-Rawlsian systems is acceptable, then.

The more fundamental question, then, is: are these criteria acceptable for use as a tool to evaluate existing and proposed health-care delivery systems? I am afraid that the only way to find an answer to this question is to test these criteria until a counter-example can be found to show that they are inadequate for their task. What this counter-example must do is show that "X" is just, when all evidence of our considered judgments shows that

it is unjust in its structure. Another possible way for these criteria to be shown as inadequate is to find a distributional issue concerned with Rawlsian second-principle social primary goods which cannot be evaluated using these criteria. These problems, however, go beyond the scope of this project (which is to evaluate some existing and proposed health-care delivery systems using the criteria developed in this study as tools).

In this study, the only health-care delivery system that seemed intuitively unjust and has been shown to be relatively just is the Enthoven proposal. Because the CCHP is a health-care delivery system designed to replace our own existing system, its analysis was done in a particularly careful manner. Criterion number three was extensively applied, for example. The same questions that were asked of Rawlsian proposals were asked of the Enthoven proposal. Except for the fact that in this existing society, the two principles of justice do not underlie a constitution which is based on liberty (with an additional provision for the principle of fair equality of opportunity)--a fact that Enthoven cannot control--his proposal fulfills all of the second principle considerations relatively well.

In fact, there are a number of obvious similarities between the CCHP proposal and HMO proposal (which is

particularly Rawlsian)--i.e., the CCHP preference for HMOs as an alternative program for the Medicare and Medicaid subsidies, whereas in the HMO model, subsidized HMOs are chosen as the basic tier of a multi-tiered health-care delivery system (which includes the list of HMO health-care services that Enthoven also supports as his definition of health-care needs). With such similarities, it really is not all that curious that Enthoven's proposal generally fulfills the criteria of evaluation as I have used them. In other words, Enthoven's proposal is not really a counter-example.

There is at least one other aspect of these criteria worth mentioning. They should be applicable in evaluating other distributional issues in the health-care delivery system. In this study, I focused on the issue of access to the health-care delivery system, hence other distributional issues like scarce health-care resources have not been addressed. Perhaps, if there are defects in these criteria, they will be found in attempts to apply them to other distributional issues in health-care. That, however, is a project for another study.

There is a final note concerning these criteria that is interesting. When they are presented in their general form by eliminating any references to health as a social primary good, and thus to the health-care delivery system

as well, they should serve as criteria in evaluating the distribution of other social primary goods as well. Thus, if they continue to prove to be workable tools in other studies, evaluations of other social problems can be done from a Rawlsian viewpoint as well.

Thus the first task of this section has been completed. Although no conclusive proof has been given that these criteria are adequate tools in evaluating the justice of health-care delivery systems, the Enthoven analysis (which I found troubling initially) has been shown not to be a counter-example--which would otherwise prove that they are inadequate tools. The discussion does point to the conclusion that these criteria are workable tools, however.

III. THE MODIFIED RAWLSIAN THEORY OF JUSTICE AS AN EFFECTIVE TOOL IN EVALUATING SOCIAL ISSUES IN MEDICINE

The process of modifying Rawls' theory of justice so that it is applicable in analysing social issues in medicine has been illuminating. Very early in the process of modification, the analysis of Rawls' theory pointed to the fact that it is not as liberal in dealing with second-principle issues as one would expect from his analysis of first principle claims.

Rawls' theory of justice is what I would call a

"minimalist" theory of justice--only in dealing with issues that are the concerns of the second principle of justice. As a result, it does not mandate socialized medicine, for example. In its unmodified form, Rawls' theory suggests that health as a natural primary good is not directly a concern of the principles of justice. Here health care can only be accomodated through the use of the principle of the common interest. Socialized medicine as a form of health-care delivery can be derived from this stance, however--but it is not part of the principles of justice. In other words, it is not part of Rawls' moral theory. When Rawls' theory is modified so as to include health among the social primary goods--hence as a proper consideration of Rawls' moral theory--it is found to be a second principle primary good. This is where Rawls' minimalist tendencies are manifested.

In dealing with second-principle issues, one must always try to derive the just minimum of the second-principle social primary goods. These considerations must be further limited by the fact that all of the second principle social primary goods must be balanced among one another. Furthermore, even in the first stage of deliberations--second principle considerations belonging to the third stage, the legislative stage--Rawls allows as acceptable information behind the veil of ignorance the fact of

moderately scarce resources, cf., Hume on scarcity as a condition of justice. Thus, scarcity of resources is another consideration in determining a just minimum. The just minimum is not, then, very much at all.

Rawls mitigates this minimalist account by demanding that the disparities between those who are better off and those who are the least advantaged be limited. Thus the enormous disparities in the possession of the second principle social primary goods that occur in existing societies cannot occur in his well-ordered society.

Having a minimalist theory of justice in relation to issues like wealth, power, income, and even health has some positive aspects, however. In acknowledging facts like scarcity of resources, Rawls' theory--even though it presents a hypothetical ideal--is grounded in the realities of existence. It also distinguishes between what we want and what we need--or to use Rawls' terminology--what we rationally desire and prefer more of rather than less. By using the standpoint of the least advantaged citizen, and by using a realistic account of the facts of life (yet remaining behind the veil of ignorance), these rational desires can be narrowly focused so that a just minimum can be derived. As a result, his theory reflects existing problems for justice. How much is enough? Is that amount also a just minimum? Applications of Rawls' theory thus

can result in realistic appraisals of the social issues that we must face--even if the conclusions lead us to accept as just much less than we would want. (My analysis of Enthoven's proposal certainly showed this to me.)

Critics of Rawls would tend to point to my analysis of Enthoven's proposal and claim that his theory does not do enough to solve the social issues facing us in this society. In other words, Rawls' theory is not just enough in the sense that they define the concept of justice. That may be true, yet that is not the issue at hand. The point is that Rawls' theory is a useful tool in evaluating the justice of the social issues that face us. It certainly sharpen's one's considered judgments about these issues even if it does not engender agreement about the definition of justice.

Finally, Rawls' theory of justice has two parts in that he has two principles of justice. The first principle of justice (which is lexically prior to the second principle) pertains to liberty--or in our existing society, the issues of civil liberties. In elaborating his theory here, Rawls can be considered as radically liberal--i.e., far to the left of center of the political spectrum that we have in our society. In the case of second principle issues (social and economic issues of justice not directly pertaining to liberty), however, the

conclusion must remain that his theory is much more conservative. The demands of justice are met in Rawls' theory--the just minimum is determined and disparities in the possession of the second-principle social primary goods are mitigated--but it is still a minimalistic account of economic and social justice.

In conclusion, the tasks set forth for this chapter have been completed. The criteria that I have developed as tools for evaluating the justness of existing and proposed health-care delivery systems, even when slightly modified, were found to be adequate in fulfilling their tasks. Finally Rawls' theory as a tool for evaluating social issues in medicine has been examined, and found to be a minimalist account of justice when second principle social primary goods (like health) are the issue under consideration. Although this fact may not be acceptable to some people, it does present a somewhat realistic basis for our considered judgments. As such, it has been found to be a workable tool for evaluating social issues in medicine in its modified form.

CHAPTER X

CONCLUSION: A REVIEW

The substantive part of this study is now completed. Before closing this study, however, it will be useful to review the deliberations that have developed. This will be done in a brief chapter-by-chapter review.

In Chapter I, a brief delineation of the issues to be covered in this study is undertaken. Terms are defined and cases have been presented so that a clearer picture of the scope of this study could be drawn. The chapter ends with a discussion of the reasons why access to the health-care delivery system is a moral issue, thus applicable to Rawls' theory of justice.

In Chapter II, an analytical review of Rawls' theory is begun. This chapter focuses primarily on the derivation of the two principles of justice and the four-stage sequence which makes Rawls' account both coherent and workable for application to social issues. No attention is given to issues in health care in this chapter since Rawls' theory does not include health as an integral part of the basic structure of society. For Rawls, health is a natural primary good, not a social primary good--and only social primary goods are considered as part of the basic structure of society. Since Rawls' theory is presented in

highly technical terminology, much of that terminology is explained in this chapter as well.

Chapter III presents a focus on Rawls' principle of the common interest, which governs those primary goods that are not included in the basic structure. The role that this principle plays in Rawls' complete theory is analyzed in this chapter as well. The chapter ends with an analysis of the treatment of health-care issues as governed by the principle of the common interest. The analysis in this chapter results in the conclusion that a Rawlsian well-ordered society could choose a form of socialized medicine or, alternatively, it might have no mandated form of health-care delivery at all. In other words, if health is not a social primary good, health-care issues are not a concern of justice, hence the form of the health-care delivery system is optional, but not mandated. This chapter concludes my work in unmodified Rawlsian theory in this study.

In Chapter IV, the focus turns to some previous attempts to modify Rawls' theory so that it can be used to evaluate the justice of existing health-care delivery system. This analysis centers on the work of Norman Daniels and Ronald Green since their work is among the most notable attempts at Rawlsian modifications for purposes of application in issues relating to the health-care

delivery system. Each modification is found to be riddled with both conceptual and methodological inconsistencies with Rawls' theory. Thus it is found that yet another modification of Rawls' theory is needed if it is to be used as a tool in evaluating existing and proposed health-care delivery systems.

The beginning of this modification is undertaken in Chapter V. In this chapter, the specific issue of health as a social--as opposed to natural--primary good is demonstrated. If health can be shown to be a social primary good, then health care issues would be a direct concern of Rawls' theory of justice. Special care is taken to provide conceptual and methodological consistency to Rawls' theory in developing these modifications. The conclusion derived in this chapter is that health--defined as the ability to function--can indeed be included as a social primary good.

The modifications continue in Chapter VI. In this chapter, health care is shown to be a second principle right. Again special care is taken to maintain methodological and conceptual consistency with Rawls' theory. As a result, attention is again turned to Rawls' four stage sequence and the constraints involved in each stage. The inclusion of health as a social primary good is shown to result in a modification in the first stage of Rawls'

four-stage sequence--the original position in which the principles of justice are derived. Further modification takes place in the legislative stage--the third stage--of the four stage sequence since health care is a second principle right. The role of Rawls' background institutions in legislative stage deliberations about health care is also developed in this chapter.

As a result of the modifications to Rawls' theory of justice undertaken in Chapters V and VI, Chapter VII begins developing the structure of a well-ordered society that is the counterpart of our existing society. Further analysis of the first principle of justice is undertaken since this is a series of deliberations at the constitutional stage (the second stage) and it (as well as the first stage) imposes constraints on the legislative stage considerations. As a result of these analyses, the work of constructing a framework of a just health-care delivery system is begun. Rather than develop a just health-care delivery system and use it as the model for evaluation of existing forms, it is determined that it would be more consistent with Rawls to develop criteria to employ in the evaluation process. These criteria are developed as the last task of this chapter.

Chapter VIII begins with a brief discussion of the last stage of Rawls' four-stage sequence. It is shown

that this stage is the appropriate one in which to evaluate the justness of existing and proposed health-care delivery systems. Four health-care delivery systems are evaluated in this chapter--two Rawlsian and two non-Rawlsian types. At the same time, the criteria for evaluation of the justness of health-care delivery systems are tested to see if they are indeed workable. The criteria work quite well with the Rawlsian proposals. However, they must be modified somewhat during the process of evaluating both our existing and Enthoven's proposed forms of health-care delivery systems (the two non-Rawlsian systems). These two health-care delivery systems are chosen because both have generally been depicted by critics as not fulfilling the demands of justice. This is found to be the case with our existing health-care delivery system. Enthoven's proposed health-care delivery system, on the other hand, is found to be relatively--even quite--just to the degree that any real-world theory can be just in terms of Rawls' theory.

Chapter IX is begun with an analysis of the criteria used as tools for evaluating the justness of existing and proposed health-care delivery systems. Discussion focuses on the Enthoven analysis since it might initially appear to present a counter-example to the adequacy of their use as evaluative tools. The Enthoven evaluation is shown

not to be a counter-example. Thus the evaluative criteria are found to be adequate in the face of the tests imposed in Chapter VIII. Finally Rawls' theory (as modified in this study) is examined in light of the results of this study to see if it is truly an evaluative tool. Although Rawls' theory is minimalistic in that it determines the just minimum of the distribution of second principle social primary goods, it is also found to reflect the realities of existence. Hence it is a useful tool in evaluating the justice of social issues in medicine. Since the answer to this question has been the primary goal of this study, its aims have been satisfactorily accomplished.

REFERENCES

REFERENCES

Abram, Morris B.
1983a "Letter of Transmittal." Cover letters to President Reagan and Congress in Securing Access to Health Care, Vol. I: Report. Washington, DC: U. S. Government Printing Office.

Beauchamp, Tom L. and Walters, LeRoy (Eds.)
1978 Contemporary Issues in Bioethics. Encino, CA: Dickenson Publishing Company, Inc.

Boylan, Brian and Weller, Charles
1976 The New Way to Live with Diabetes. Garden City, New York: Doubleday and Company.

Brock, Dan W.
1983b "Distribution of health care and individual liberty." Pp. 239-263 in Securing Access to Health Care, Vol. II: Appendices Sociocultural and Philosophical Studies. Washington, DC: U. S. Government Printing Office.

Cable News Network
1982 "Healthwatch." Television News Program. Atlanta, GA: Turner Broadcasting System.

Callahan, Daniel
1973 "The WHO definition of 'health'." Pp. 77-87 in The Hastings Center Studies, Vol. 1, No. 3.

Daniels, Norman
1981 "Health-care needs and distributive justice." Pp. 146-179 in Philosophy and Public Affairs, Vol. 10, No. 2 (Spring, 1981). Princeton: Princeton University Press.

Dennett, Daniel C.
1978 Brainstorms. Montgomery, VT: Bradford Books.

Dubos, Rene
1959 Mirage of Health: Utopias, Progress, and Biological Change. New York: Harper & Row.

Dubos, Rene
1965 Man Adapting. New Haven, CT: Yale University Press. Cited here as "Health as ability to function," pp. 96-99 in Beauchamp and Walters (eds.), Contemporary Issues in Bioethics.

Engelhardt, H. Tristam Jr.
1976 "Human well-being and medicine: Some basic value-judgments in the biomedical sciences." Science, Ethics and Medicine, ed. by Engelhardt and Callahan. Hastings-on-Hudson, NY: Institute of Society, Ethics and the Life Sciences. Cited here from Mappes and Zembaty (eds.), pp. 213-222 in Biomedical Ethics.

Enthoven, Alain C.
1980 Health Plan: The Only Practical Solution to the Soaring Cost of Mecidal Care. Reading, MA: Addison-Wesley.

1981 "The competition strategy." Pp. 109-112 in The New England Journal of Medicine, Vol. 304, No. 2. Boston: N Engl J Med.

Ginzberg, Eli
1980 "Competition and cost containment." Pp. 1112-1115 in The New England Journal of Medicine, Vol. 303, No. 19. Boston: N Engl J Med.

Green, Ronald M.
1976 "Health care and justice in contract theory perspective." Pp. 111-125 in Ethics and Health Policy, ed. by R. M. Veatch and R. Branson. Cambridge, MA: Ballinger.

Iglehart, John K.
1981 "Drawing the lines for the debate on competition." Pp. 291-296 in The New England Journal of Medicine, Vol. 305, No. 5. Boston: N Engl J Med.

Institute of Society, Ethics and the Life Sciences
1973 The Hastings Center Studies, Vol. 1, No. 3. Special Issue. Hastings-On-Hudson, NY: The Hastings Center.

Luft, Harold S.
1983c "Health maintenance organizations and the rationing of medical care." Pp. 313-346 in Securing Access to Health Care, Vol. III: Appendices, Empirical, Legal, and Conceptual Studies. Washington, DC: U. S. Government Printing Office.

Mappes, Thomas A. and Zembaty, Jane S. (Eds.)
1981 Biomedical Ethics. New York: McGraw-Hill Book Company.

Maslow, Abraham H.
1968 Toward a Psychology of Being, 2nd Edition. New York: D. Van Nostrand Company.

Neuhauser, Duncan
1980 "Enthoven's 'health plan.'" Pp. 1115-1117 in The New England Journal of Medicine, Vol. 303, No. 19. Boston: N Engl J Med.

Office of Research and Demonstrations, Health Care Financing Administration
1982 The Medicare and Medicaid Data Book. Department of Health and Human Services. Washington DC: U. S. Government Printing Office.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research
1983a Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services, Vol. I: Report. Washington, DC: U. S. Government Printing Office.

1983b Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services, Vol. II: Appendices, Sociocultural and Philosophical Studies. Washington, DC: U. S. Government Printing Office.

1983c Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services, Vol. III: Appendices, Empirical, Legal, and Conceptual Studies. Washington, DC: U. S. Government Printing Office.

Rawls, John.
1971 A Theory of Justice. Cambridge, MA: Harvard University Press.

Rogers, David E.
1980 "Statement before subcomm. on health and scientific research, comm. on labor and human resources, U. S. Senate" (September 24 at 3-4). In Securing Access to Health Care, Vol. I: Report, 1983a. Washington, DC: U. S. Government Printing Office.

Siegler, Miriam and Osmond, Humphry
1973 "The 'sick role' revisited." Hastings Center Studies Vol. I, No. 3. Cited by Engelhardt in Mappes and Zembaty (Eds.), Biomedical Ethics.

Starr, Paul
1982 The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry. New York: Basic Books, Inc., Publishers.

1983b "Medical care and the pursuit of equality in America." Pp. 3-22 in Securing Access to Health Care, Vol. II: Appendices, Socio-cultural and Philosophical Studies. Washington, DC: U. S. Government Printing Office.

Szasz, Thomas S.
1961 The Myth of Mental Illness. New York: Harper & Row.

Taber, Clarence W.
1965 Taber's Cyclopedic Medical Dictionary, 10th Edition. Philadelphia: F. A. Davis Company.

Veatch, Robert M.
1981 A Theory of Medical Ethics. New York: Basic Books, Inc., Publishers.

Veatch, Robert M. and Branson (Eds.)
1976 Ethics and Health Policy. Cambridge, MA: Ballinger.

World Health Organization
1946 "Preamble to the constitution of the world health organization." Cited here as "A definition of health," p. 89 in Beauchamp and Walters (Eds.), Contemporary Issues in Bioethics.

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