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Glenn C. Graber
Glenn C. Graber, Major Professor

We have read this thesis
and recommend its acceptance:

John Edwards
Ron B. Edwards

Accepted for the Council:

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Michael J. John

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MACROALLOCATION OF HEALTH CARE RESOURCES
AS DISTRIBUTIVE JUSTICE

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ABSTRACT

There are many ways in which and by which a society might choose to distribute health care goods and services, from laissez-faire "pay as you go" medical delivery to highly structured resource distribution. What sort of distributional system, however, is truly just? This thesis seeks to examine the question of justice in the way in which a society allocates health care. The approach to this problem is one of applied medical ethics. The justice theories of such writers as John Rawls, Karl Marx, and John Stuart Mills is contrasted with the actual history of health care distribution in the United States since its colonial period. These provide a background of varying concepts, both theoretical and actual, of what justice in health care distribution actually is.

The problem is put in the language of desert-claims, which is to ask, "By virtue of what may a person be said to be deserving of health care?". Some writers have suggested that a person merits health care merely by virtue of being in need of health care. This position is rejected as being unsubstantiable; needing health care is a necessary, but not sufficient, factor for receiving health care goods and services. It is shown that some other consideration, such as a commitment to provide health care, is necessary to establish a claim of desert for the provision of health care. This understanding of distributive justice is derived from a basic ethical commitment to the sovereignty of the individual.

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I. INTRODUCTION

One man benefits from the wizardry of a multi-million dollar diagnostic scanner, while another perishes for want of an ampule of antibiotics. An industrious and decent worker finds her family's savings ravaged by the costs of a catastrophic illness. A man must endure a lifetime of suffering because the illness which he suffers from, though curable, affects so few people that no funds are available for the research required to develop the needed cure. A gifted medical student of modest means must place herself \$210,000 in debt in order to become a medical specialist (Wohl, The Medical Industrial Complex, p. 54).

Such facts may be expressed calmly and described neutrally in the language of medical economics. There are peculiarities and inequalities in the way that each country creates and distributes health care resources. These may be catalogued along with other data about a country without regard for whether or not things ought to be as they are. But among other things, man is a moral creature, making judgments about right and wrong, good and evil, as he observes and contemplates his world. Humankind also makes judgments about what is right and what is fair, asking, "does each person receive what is his or her due?".

Medical resources are, for a number of reasons, considered to be of a special sort in society, a sort which is of particular concern in matters of resource distribution. Great importance is attached to the way a society distributes medical resources, and an unjust distribution of health care is considered to be a greater wrong than injustice

in the distribution of other kinds of goods. Why this is so will be discussed in later sections of this thesis. The central concern of this thesis will be attempting to understand just what it is which constitutes a just distribution of health care. A number of approaches will be taken in this effort. The first will be an investigation of justice theory itself, particularly those aspects of justice theory which pertain to distributive justice. Ideally, an examination of such theories will help to allow for an examination of our presuppositions about justice. Much of what may be considered to be "obvious" about distributive justice may simply be our own cultural norms and expectations, rather than an understanding of justice which would transcend particular times, places, and social orders.

This will also be a study in applied philosophy. Pure theory of justice will be contrasted with how the United States has de facto chosen to distribute health care during its history. In part, this will be intended as a critical examination of how distribution of health care has been and is done in this country. It is, however, also hoped that in examining an actual state, rather than ideal one, we will better be able to focus on actual issues in the distribution of health care. Applied philosophy is an interactive enterprise. Theory may show us the failings (and strengths) of our world; the world shows us the failings (and strengths) of our theory.

A word must be said about the choice of the U.S. health care system as the focus of this thesis. The U.S. currently devotes 10.7% of its Gross National Product, \$387.4 billion (according to Grady, "The Cruel Price of Cutting Medical Expenses", Discover, p. 26), to health

care. With such a resource pool, the U.S. is as well-equipped as any country to justly meet the health care needs of its peoples. It ought not be presupposed, though, that justice in distribution excludes the possibility of rationing resources. Some manifestation of rationing of goods is necessary unless resources are so abundant to meet all possible use to which they might constructively be put. Justice merely demands that rationing be done in a just manner.

The peoples and government of the U.S. have also declared a commitment to the just distribution of health care. The strongest statement was uttered by President Carter, who spoke of "adequate health services as a right" (Alpert and Tsuno, "Health Care: Your Money or Your Life"). More recently, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Securing Access to Health Care, vol. 1, p. 33) has indicated that there is no "...constitutional right to health or to health care," though it affirms the more recent public mandate to provide adequate health care to those who need it. "The Commission concludes that society has an ethical obligation to ensure equitable access to health care for all" (Securing Access to Health Care, p. 4). The exact language of these commitments to just health care will not necessarily be adhered to in this thesis, but they have been cited in order to establish a concern, public and official, about how the U.S. distributes its health care resources. This concern will be taken as an invitation to scrutinize and to learn from the ways in which health care is distributed in this country.

II. THE CONCEPT OF MEDICAL NEED

When does a person need medical care? Why, when they are sick. Sick from what? Cancer, the flu, paranoia, obesity, alcoholism, bad breath, social inappropriateness? All of these have been defined as illnesses, but it is not clear that each represents a medical need. The business of medicine, it has often been stated, is to promote, to preserve, and to restore health. But health can be as hard to define as illness. Take the following definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (taken from the Constitution of the World Health Organization, cited in Beauchamp and Childress, Principles of Biomedical Ethics, p. 335). If it is accurate, then it is doubtful that any of us are truly healthy. To most of us, however, this sounds more like a perversion of the notion of health than a definition.

By health we generally mean bodily well-being or harmony. We can be healthy without experiencing optimal bodily fitness, and we can be healthy even if our bodies are not able to service every fancy of our imaginations (like flying). There is, however, a range of activities which a human body may be expected to perform at maturity, and a person is healthy if he or she has the physical capacity for those functions. Most critical are those biological functions which are required to sustain life (blood flow, breathing, digestion, and so on). There are also functions like being able to see, being able to walk, and being able to hear which, while not absolutely required for life, may be necessary in a secondary way in order to procure life's necessities.

A third class of biological functions are those which are useful but not essential to the survival of the individual. This would include the ability to reproduce, the ability to see colors, the ability to carry a tune, and the ability to dance. These physical abilities add to the pleasure which one may derive from living, though one can, and many do, survive quite well without them.

For each kind of physical ability there are neurological or mental abilities as well. There are fundamental neurological processes required for survival, others secondarily necessary for sustaining life, and those which are useful or desirable. These abilities, physical and mental, are subject to disabling factors of many sorts, some of which may be remedied by current health care resources. When current health care resources may remedy such a disability, we may say that a health care need exists. These needs vary in importance just as disabilities (again, speaking in broad terms) vary in importance. It is easy to identify a disability to a critical physiological system as a medical need, but we are reluctant to identify surgical rhinoplasty the same way. Certainly medical technology may serve to benefit our physical or mental selves and so improve the quality of our lives, but it is useful to constrain the use of the concept of medical need to those cases where a primary or secondary disability is being remedied.

Recent developments in endocrinology have allowed for supplemental injections of growth hormones to be given to those individuals whose bodies fail to produce adequate levels of growth hormone. Such individuals would otherwise suffer serious physical difficulties as a consequence of pituitary insufficiency. There are also individuals who

are genetically disposed to short stature, who would benefit from these injections in being able to attain average height. No life-or-death matter is involved here, but a general increase in life satisfaction would obtain. There are also persons of normal height who would find increased height to be of benefit in athletic competition. While few people would want to be shorter than average, it strains the notion of medical need to say that they need to be taller, though in a weaker sense it would be correct to say that "he or she needs the injections to reach normal height".

Throughout this thesis, considerations of medical need will be intended to deal only with those strong needs. Most considerations of justice assume that the only medical care of concern is that which is strongly needed. It is worth noting that there are two extremes of justice theory which would escape any consideration of medical need. Radical egalitarianism (as suggested by Graber, Beasley, and Eaddy, Ethical Analysis of Clinical Medicine, p. 208) would distribute all medical goods and services equally throughout a population. Not only would all persons have equal shares of antibiotics, they would all have equal appendectomies and equal caesarian sections as well. Medical care allotted without consideration for need would be allotted without consideration for benefit as well. This pure ethical theory has never, to the best of my knowledge, been seriously advocated, though the language of "equal health care" has on occasion been so imprecisely stated that it might be taken to mean such a policy.

A more plausible manner of distribution which would avoid considerations of medical need would be radical libertarianism (see Rescher,

Distributive Justice, p. 80). In this extreme libertarian framework, persons are free to do as they wish concerning health care. The only factor limiting access to medical care would be ability to pay for the goods and services desired. If someone wished to take large doses of antibiotics for a viral infection, the fact that that is not standard medical wisdom would not limit access to the antibiotics. A physician could name any number of reasons why such a regimen would be inappropriate, but the individual would be free to ignore that information at his or her own discretion.

Individual liberty and equality in a society are both valued, and of value; but to isolate either as the true nature of justice, in exclusion of all other values, does not fully capture what is meant by our use of the word "justice". I will now begin to examine what distributive justice is and how theories of distributive justice apply to the problems of allocation of medical resources. Most views hold that medical need is a necessary, though not necessarily sufficient, condition for receiving medical care.

III. THE NATURE OF DISTRIBUTIVE JUSTICE

One of the questions which ethicists have traditionally faced, along with "what is the Good?", has been, "what is the Just?". Aristotle defined the realm of concern of justice as being "complete virtue in relation to our neighbor" (Nicomachean Ethics, 1129b). This is to say that justice operates on a societal, rather than on an individual, level. A single survivor on a desert island need not concern himself or herself with the dictates of justice. But given two persons, there is room for that area of ethics known as justice.

The unifying concern of justice is that each person receive what he or she deserves. Just what constitutes one's "just desert" is the heart of the disputed nature of justice. The ancients suggested numerous candidates for the source of a desert-claim. Plato cited the poet Simonides, who said that justice is "to give what is owed" (The Republic, 332a). Plato himself came to the conclusion that "the having and the doing of what is one's own would be admitted to be justice" (The Republic, 433c). The just man does his job and, literally, minds his own business. What he receives is commensurate to his performance of his duties.

Aristotle's just man observed two kinds of justice. One justice, the universal, was due all men regardless of individual merit. Particular justice, on the other hand, consisted of giving to each man as his merits dictated. Universal justice was likened by Aristotle to "the lawful," though he made it clear that his reference was not to the formal laws of any given state, but to transcendent moral law. Particular justice he linked to the concept of fairness. It is not fair to give

a military decoration to a soldier who was timid in the face of the enemy, whereas it is fair to give an award to a man who fought boldly against superior forces. As a matter of universal justice, however, one would be unjust to steal from the timid man simply because of his moral inferiority to the brave man (Nicomachean Ethics, Book V).

Aristotle's division of justice into universal and particular is important in that it shows that a theory of justice may be heterogeneous, that is, that a single theory of justice may allow for several sources for desert-claims. In the third century Ulpian, a Roman jurist, apparently gave two definitions for justice. In the first he called it, "the constant and perpetual will of giving to each his own right." In the second, he spoke of "to give to each his own." Martin Golding, in Justice and Health Care, questions whether or not the early Roman concept of rights actually can be compared with our current nomenclature of innate human rights. Most likely the reference to rights in Ulpian's writing was to a concept of legal rather than moral rights. If that is indeed the case, then the pair of references parallel Aristotle's understanding of justice quite closely.

Whatever the source or sources of desert-claims, justice has traditionally been divided into two realms: distributive and retributive. Retributive justice deals with the distribution of (artificial) punishments in a society. Theories of retributive justice are commonly merit-based rather than right-based. An individual may only be punished if he or she has done something to merit that punishment. Occasionally, it may be maintained that punishment may be justly allocated to those who are in some way deserving of punishment, even if their acts have not

(yet) manifested those undesirable or immoral traits which merit punishment. At extreme ends of the theoretical scale a few theorists hold that artificial punishments ought never be employed; it may also be claimed that punishment may be exercised against individuals for the higher good of society, even though those individuals have done nothing to merit punishment (for example, if a society had a poet whose work was best when he suffered, he might be placed in prison so that that society would benefit from his superior creations).

It is distributive justice, however, which is the focus of this study. Distributive justice deals with the just allocation of goods in a society ("goods" being used in its sense of commodities, services and physical resources). The allocation of these goods need not be the task of an identifiable agency; allocation may be effected by societal mechanisms or institutions. Distributive justice takes place on two levels: the level of microallocation and the level of macroallocation. The two differ in that microallocation deals with specific ("small") problems of given resources and known competitors for those resources. Decisions of macroallocation are at the "big" level, the level of the society as a whole. The general policies, mechanisms and institutions of distribution are found at this level.

In the literature of Biomedical Ethics, the classic problem of microallocation of resources has been the case of the distribution of kidney dialysis machines during those years not so long ago when that technology was at its infancy. Many ways were used by hospitals which had access to those machines to determine who, of the many persons who could benefit from them, should be allowed time on the dialysis machines. A

charitable hospital in Seattle established committees of medical professionals and lay people to determine who would receive treatment and who would not. The committees chose to use a criterion of social worth to determine who would live and who would die. Of those medically suited for dialysis, the committees attempted to determine which individuals' deaths would mean the least detriment to the society; in that way, it was felt, the machines would be used for the greatest possible good. When Life magazine revealed how the "god squads" in Seattle were going about their decision-making, there was an uproar of national outrage. Public consensus was that the criterion being used by the committees was unjust, and that individual human worth, regardless of individual merit, was far more important than the committees had credited.

Rather than determine how such scarce resources ought to be justly distributed, the microallocation decision was transformed into a macroallocation decision. In 1972, the U.S. Congress extended Medicare benefits to victims of end-stage renal failure. Those who needed kidney dialysis became an oddly blessed group; treatment, at greatly subsidized cost, was available to all who needed it. Further, with that assurance of funding, the availability of kidney dialysis machines blossomed far faster than would have otherwise been the case. The cost of this generosity has vastly exceeded its original projections, but the hundreds of millions of dollars spent each year have bought Americans the peace of mind of knowing that there are no unpleasant choices being made about who will and who will not receive this life-saving therapy.

In this case, a macroallocation decision eliminated the need for for microallocation decisions. But microallocation will always be with

us unless society chooses to evade all microallocation decisions by making all health care services either available to all or totally unavailable; constraints of the resources which a society might be able to direct to health care mean that it is impossible for a society to meet all health care needs. Given finite resources and needs which exceed those resources, there must be rationing of resources.

Many object to the notion of rationing of scarce resources, especially health care resources. Who, it is asked, has the right to make such critical choices for others? The question, however, is misleading. The choices will occur whether or not we consciously make them. Take, for example, a pristine libertarian distribution of health care resources. In such a system, resources (money) are freely exchanged for health care services with those who choose to provide those services and goods. There is no agency, governmental or otherwise, whose task it is to oversee how health care is distributed. Health care transactions take place freely in a free market setting. Even in this setting, de facto rationing takes place. Those who do not have adequate resources (money) to exchange for health care goods and services do not receive them. Health care resources which are not profitable, in some sense, to provide are not available to consumers. The passive societal mechanisms ration health care just as surely as an overt institution would.

There is no question of whether or not rationing will occur--only one of how it will be done. The real question is how to allocate health care justly. A survey of competing models of justice will hopefully shed some light on this problem. They will be examined with several considerations in mind. First, how do the theories of justice relate spec-

ificantly to distributive justice? Secondly, do they have any special place for the distribution of health care, or are all resources distributed in the same manner? Thirdly, how does a given system of distribution affect the production of resources? In the case of kidney dialysis, we have found that when there is a change in the distribution of health care, a change in the production of health care may (unintentionally) result. This is an aspect of justice theory too often overlooked by philosophers in attempting merely to pin down justice in distribution of a group of resources; a group incorrectly assumed to remain stable in differing distributional climates.

IV. THEORIES OF DISTRIBUTIVE JUSTICE

While agreeing that resources should be distributed justly, there is considerable debate among authors on the subject of distributive justice as to the precise nature of a just desert-claim. The bases for desert-claims are here divided into two classes, those which are, to use Biblical terminology, "respecters of persons" and those which are "no respecters of persons." In more conventional language, there are those ethical theories which assert that just distribution of health care resources must take into account individual merit. Rescher (in Distributive Justice) identifies these as "earned claims," as opposed to "unearned claims," which hold that health care should be distributed solely on the basis of its being needed, without concern for individual merit.

Several of the theories being presented will parallel each other along this demarcation, being contrasting interpretations of similar basic concepts. Utilitarianism, for example, will be shown to provide conceptual foundations for both earned and unearned claims to health care.

Earned Claims

- 1) Libertarianism
- 2) Distribution by Lifestyle
- 3) Utilitarian Distribution
- 4) Distribution by Social Utility

Unearned Claims

- 5) Rawlsian Contractarianism
- 6) Marxist Needs Distribution
- 7) Utilitarian Egalitarianism
- 8) Distribution as Social Right

1) Libertarianism

Robert Nozick in Anarchy, State and Utopia deals predominantly with the use of force as the central concern for a theory of justice. Rather than ask how the society, or the state, should distribute resources so that justice would prevail, Nozick asks for justification of any external, forceful redistribution of properties in a society.

Nozick begins with individuals in a Lockean "state of nature". Each individual is a free agent, holding, as his by right, autonomy of action. In order that freedom of action may prevail within an area, individuals freely choose to form a "mutual protection association" which serves to maintain a monopoly on the use of force. This is to the benefit of those who support the mutual protection society because it protects them from the use of force to curtail their liberties. As an institution, this becomes a minimalist state, the only kind of state which Nozick finds to be ethically justifiable.

In the setting of the minimalist state, economic transactions are wholly and totally free. I may freely give away all that I own, or I may engage in exchange of goods, or I may remain economically isolated, using only what I own or make. Since each individual is entirely free, he or she need never provide goods to others unless that is what is freely chosen, nor need the individual engage in transactions which he or she does not wish to make. In the area of health care, those who wish to go into the business of making health care services available may simply do so, and those who wish to obtain those services find agreeable terms of exchange for those services.

What of those who need medical care but have nothing (agreeable)

to trade for it? They go without, unless someone freely decides to take pity on their wretched state and give them medical care or goods to exchange for same. The core of justice, to Nozick, is the preservation of individual liberty. Anything which interferes with individual liberty is, by definition, unjust. The existence of the minimalist state is just because it serves to preserve individual freedoms. A program which would, by force of taxation, take goods from free individuals in order that the poor might be able to receive health care would be a blatant violation of individual liberty and thus be unjust.

The libertarian need not deny that it is a tragic thing when a man dies for want of medical care, just as he need not deny that it is tragic when a man starves to death, or dies of exposure. But providing for such needs is a matter for individual charity, if one is so inclined. Failure to help others is not itself unjust. Nozick gives the following example.

A medical researcher who synthesizes a new substance that effectively treats a certain disease and who refuses to sell except on his terms does not worsen the situation of others by depriving them of whatever he has appropriated. (Nozick, Anarchy, State and Utopia, p. 159)

Libertarianism challenges many common intuitions about the scope and nature of justice. It reduces the language of desert-claims to the language of property rights; the only things which I have a claim to are those things which I own (including ownership through gift and inheritance). As was previously indicated, while liberty and individual freedoms have their place in justice theory, other values need also be considered in order to fully describe what is commonly considered to be the Just.

A serious failing in Nozick's theory is that he accepts the Lockean "state of nature" as the basic moral state of the individual (effectively granting that each man is, morally, an island). Nozick recognizes that this is historically counterfactual (Anarchy, State and Utopia, p. 7), but does not consider that to detract from its ethical veracity. I disagree. The historical inaccuracy in the Lockean account is this: we, each and every one of us, enters the world in a state of utter dependence. Without the constant support of those around us during our first ten years or so, we would not survive. It is quite some time before the most resourceful of us could hope to be able to perform all of the tasks necessary for survival, and then only with the cooperation of a fairly friendly environment. To finally emerge from the contributions of so many others and then declare oneself to be utterly free is an affront to one's history. This is not to say that we have a debt to those who cared for us (a doubtful claim, since we had no choice in the matter), but rather to show that our nature is social, rather than individual.

2) Distribution by Lifestyle

One of the chief arguments for an egalitarian distribution of health care resources has been that people are not morally accountable for being in need of medical care. Cancer, like rain, falls on the virtuous as well as on the immoral. Since diseases observe distributional patterns which are "no respecters of persons," justice would seem to require distribution of health care with similar lack of discrimination.

A few authors have mused, with varying degrees of conviction, that a national health care system (socialized medicine) ought to discriminate against those persons who have chosen to engage in health-risking

pastimes (see Beauchamp and Childress, Principles of Biomedical Ethics, p. 198). Smokers who acquire lung cancer, drinkers who acquire cirrhosis of the liver, skate-boarders who break their wrists, and Type-A businessmen who develop stomach ulcers may be said to be accountable for their maladies in ways in which other individuals are not. At the very least, we are likely to be less sympathetic to such a person's condition than to the illness of another person who "did nothing to bring it on himself." We might also take this to be a very just and natural distributional guide for the allocation of health care.

As a principle of distribution, distribution by lifestyle would be phrased, "an undeserved problem merits an undeserved cure. A deserved problem merits no cure." In the context of a national health care system, few authors suggest that no treatment be available to the victim of such a self-imposed illness; treatment would be available, but be paid for out-of-pocket rather than by the national health care system's own funds. Others suggest that medical care for such problems be covered by the system, but that those who insist on unhealthy lifestyles would be required to pay more than others for the upkeep of the fund. "Good" people who do not smoke, drink, or engage in hazardous employment or pastimes would pay the lowest premiums. There might even be a discount for proof of regular exercise and proper diet. Perhaps also one for persons who remained sexually faithful to each other, another means of reducing the likelihood of illness. And there might also be a cash bonus if persons with genetically inheritable diseases agree to be sterilized so as to eliminate yet another risk to the common health of the society.

As the list grows, it becomes clear that there is not a direct relationship between risk-taking and actually being deserving of an illness. Remarks have been made to the effect that men who have had hundreds of homosexual sexual partners "get what they deserve" when they acquire AIDS. Yet it boggles the imagination to propose that sexual promiscuity be made a capital crime, and further that punishment be executed in the form of a slow, lingering death. Such a punishment would easily exceed the magnitude of whatever "crime" was being committed. It would also be grossly objectionable to casually break the wrist of a skateboarder, just because he deserved to have his risky behavior punished.

There is further difficulty in assigning accountability for all sorts of risk-taking activities. A coal miner certainly undertakes risks when he mines coal, and truck drivers knowingly court a higher probability of traffic accidents than the rest of society; such risks, however, are needed in order to secure employment, as well as to provide the society with necessary services. Even day-to-day activities involve factors of risk. It is not always clear which risks are necessary and which are not.

Distribution by lifestyle has a certain appeal as a theory of just distribution, but its application begins to reveal the intrinsic conceptual flaws in its formulation. When I cross the street, I risk being run over. If I do in fact get run over, did I deserve to be run over? No. I was just crossing the street.

Despite its failings as a theory of justice, this theory serves as a basis for insurance rates, at least in part. Those in higher risk

groups pay higher rates for health insurance, in a sense paying out for being in those higher risk factors. The supposed difference between this and the proposed theory is insurance rates are not punishing those in the higher risk categories, they are merely reflecting the greater probability that they will need medical care. Older people are more likely to need medical care than younger people, so their rates are higher even though they are not considered to be somehow culpable for being old.

3) Utilitarian Distribution

The creed which accepts as the foundation of morals "utility" or the "greatest happiness principle" holds that actions are right in proportion as they tend to produce happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure. (Mill, Utilitarianism, as found in Melden, Ethical Theories, p. 395)

Under Mill's utilitarian theory of ethics, who receives happiness is neutral, so that, all other things being equal, the happiness of three people is superior to the same level of happiness in two. The ethical utilitarian must respect this valuation even if it means that he or she would personally miss out on a potential benefit; if act A means that the actor would benefit, and act B means that another person would receive greater benefit, then the utilitarian would desire the latter act to take place.

The upshot of utilitarianism for distributive justice might be interpreted thusly: just distribution would be that which would, in each case, produce the greater happiness for the greatest number. A desert-claim would then be tied to an ability to receive pleasure from the receipt of the goods in question, or to experience a lessening of pain from the goods. This works two ways when we are considering the distribution

of health care. At first consideration, a desert-claim would seem to be based on need, rather than on any sort of individual merit. But utilitarianism, taken to a possible logical extreme, would not treat persons equally. Individuals would be weighed by their ability to experience happiness or release from suffering from the receipt of health care resources. A person with a high tolerance for pain would be at the end of line, metaphorically speaking, after those whose sensitivity to pain is greater. Likewise, those especially capable of experiencing pleasure would be "rewarded" with a larger share of goods under utilitarian distribution. This distribution would be justified by adherence to the maxim, "the greatest good for the greatest number."

Many supposed counterexamples of utilitarianism have been proposed involving cases where one person, or some minority of society, is treated in a manifestly unjust manner in order to produce the maximal benefit to the society. In the area of medical treatment, we might suppose one unfortunate individual being anaesthetized and all of his bodily parts removed. His heart would be given to someone with end-stage heart disease, his liver with a person with liver failure and so on, so that ten lives are saved by the loss of the one. The suffering which that unfortunate would experience would be minimal (we'll get him while he's sleeping--he'll never know what happened), and the goods produced would be vast.

The utilitarian would likely argue that the reason why we find such an example so heinously unjust is because we can see beyond the immediate results of such an action and realize that, in its fuller societal impact, far more pain than happiness would be produced. The utilitarian

is very likely to hold that all of our moral judgments, including our judgments about justice, are based upon the precepts of utility, even though we may not suspect it. Our objections are not to the principle of utility itself, but only to improper or misinformed applications of that principle. We certainly apply utilitarian precepts when we administer analgesics; you don't give a pain-killer to someone who is not in pain. We also make decisions about the necessity of medical procedures based on whether or not the afflicted person experiences pain or inconvenience from his or her condition. Magnitude of pain and suffering are certainly considerations when we speak of degrees of medical need.

4) Distribution by Social Utility

Under Nozick's schema, a desert-claim is equated with a property claim, and the individual is the source of all rights. Under the theory which is now being considered, the state (or society) is taken to be the ultimate source of all rights. Such a view has not been strongly advocated in this century, but is readily found in earlier writings on the subject of justice. Hobbes' Leviathan presents a particularly well-known exposition on this concept of justice. My concern here is not so much with Hobbes per se as with the concept that individual liberties and benefit must be made subservient to the well-being of the greater social order.

Distributive justice, when guided by the dictates of social utility, rewards with distributional favor those whose contributions to the well-being of society are greatest. Further, this distribution is weighted to benefit those who will provide for the future benefit of the society, as opposed to those who have served the society well in the past. This

distribution is highly practical, as it rewards those who are of a certain moral worth--those who strive to be useful to their society.

To illustrate this distribution, let us take two men as example members of our society. Bob, though he isn't very smart, is a hard worker, and contributes to the best of his ability to the betterment of his neighborhood. Carl, his neighbor, is quite smart and well-educated, but he sits around the house all day eating bon-bons and watching the soaps. Carl talks about finding a job, but nothing seems to be good enough for him. The state looks at these two men and determines just distribution of society's goods for each of them. The state judges that Carl, though having potential to contribute to the social good, has chosen not to. The state might choose to give him just enough food to keep him alive, hoping that he may one day get his act together, or it might choose to allot him nothing at all if it is felt that he will never be of use to the society. It is quite another story with Bob. The society wishes both to thank and to encourage his kind of attitude and behavior. His living quarters and his diet will be very good, and he might even be given Carl's TV, so that he can relax when he gets home at night.

The main problem with this system of distributive justice is that people are not fully in control of their social value. A person might be a gifted dancer, but the society might have no use for a ballet company. A person might have the desire to work, but be physically unable to do so. Further, a soldier may be considered worthless during times of peace, though his profession is honored during wartime, something which the individual has no control over. So distribution by social utility does not actually reward moral excellence (the will to be

useful), but only this moral excellence when combined with the means for its actual manifestation.

The practical consequences of this distribution would seem obvious, but they may have little to do with social justice. If a construction worker breaks his leg, he would receive first-rate medical care so that he could return to his job. But if an elderly person broke his leg, there would be little incentive to provide more than the most rudimentary care, since a disabled elderly person would be of only slightly less use to the society than a more able elderly person, even though the difference would seem quite large to the person in question.

As with utilitarianism, however, distribution by social utility may be faulted not so much for its own conceptual failings as for incorrect application of its dictates. It may well be that the society as a whole may be well served by the provision of quality health care for those who for various reasons are unable to be productive. Workers may be that much more diligent if they know that they will be cared for in their later years. If it is for the good of society, then so be it. It may also be in society's best interest to take good care of soldiers during times of peace. If it is good for the society, when the individual will be extended that benefit.

5) Rawlsian Contractarianism

There have been shown to be any number of reasons why distributive justice might have it that medical care not be provided on the basis of need alone. Under libertarianism, the need has to be accompanied by either payment or charity; if you can't afford it, you don't get it. If distribution by lifestyle is correct, then you don't get care if you in

some way have brought your malady upon yourself. Under utilitarianism, your need must outrank other demands on health care as a source of happiness in the world. Finally, if one adheres to distribution by social need, the society must have some benefit in seeing to your medical needs. We will now look at possible claims that need alone be a determining factor in the distribution of health care.

Certainly the most respected name in contemporary justice theory is that of John Rawls, whose book, A Theory of Justice, is considered by many to be the most important work on the subject of justice of this century. Rawls offers both a methodology for properly discerning the dictates of justice, as well as a series of conclusions which he feels may be properly drawn from this correct contemplation of the nature of justice. We can only appreciate justice from what Rawls calls the "original position."

This original position is not, of course, thought of as an actual historical state of affairs, much less as a primitive condition of culture. It is understood as a purely hypothetical situation characterized so as to lead to a certain conception of justice. Among the essential features of this situation is that no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence, strength and the like. I shall even assume that the parties do not know their conceptions of the good or their special psychological propensities. The principles of justice are chosen behind a veil of ignorance. (Rawls, A Theory of Justice, p. 12)

Given such a "veil of ignorance," we would be wisest to order society as if our "place in society is decided by a malevolent opponent" (Rawls, A Theory of Justice, p. 153). Prudence in such state would have us make use of a policy wherein we would create a society such that the lot of the worst-off individual would be as favorable as possible. Rawls calls this policy the maximin principle, which is short for the Latin, maximum minimorum (Rawls, A Theory of Justice, p. 154). Maximin is chosen by

those who are behind the veil of ignorance because they cannot be sure that they will not be born into the least fortunate lives. Rather than choose a sharply skewed social order and hope to be one of the few lucky ones, the rational individual would choose to avoid the risk of an extremely wretched state.

The impact for the distribution of medical care would be that medicine, like all other social institutions, would be set up so as to maximally benefit the worst off. Not knowing whether or not I might be born into the body of a hemophiliac, I would rationally will that those who thus suffered at the hands of the natural lottery be compensated at very least by medications which would allow for some chance of a normal life. A further consequence of the Rawlsian position would be that skilled medical professionals would receive special benefits in the society (salary and other perks) if those benefits in some way beneficial to the worst off. "...the most extreme disparities in wealth and income are allowed provided that the expectations of the least fortunate are raised in the slightest degree" (Rawls, A Theory of Justice, p. 157). The ability to be an M.D., the discipline to complete medical school, and the resources to do so would simply be one's draw from the natural lottery. To award such undeserved good fortune at the expense of the less fortunate would be manifestly unjust.

From the veil of ignorance, Rawls contends that we will agree on three important principles. The first is the principle of greatest equal liberty, which states that all persons be allowed the most extensive individual liberties which do not conflict with others' exercise of those same liberties. The second principle is that of fair equality of

opportunity. Under this principle, all positions and offices are to be available equally to those whose qualifications match the needs of the job, without such unrelated discriminations as gender and race discrimination. The third principle is that institutions are structured and operated so as to maximally benefit the worst off. Each principle is necessarily prior to those which follow (Rawls, A Theory of Justice, p. 302).

The weight of this conception of justice clearly rests on a foundational belief in a highly deterministic universe, and more particularly, a highly deterministic model of human behavior. It is an appealing concept of the just if we consider cases where a person suffers injustice upon injustice through no conceivable personal blame. A person born poor may be chronically malnourished, and thus readily susceptible to disease. Poor health would further prevent that person from improving his or her lot in the world, being caught up in a "cycle of poverty." The Rawlsian model is not nearly so satisfying when we identify what, at least on a gut level, appear to be cases of true moral culpability. Many pairs of individuals can be found who seem to have come from identical backgrounds with identical chances for accomplishment and contribution in life; yet one will be found to have (seemingly) chosen a self-destructive lifestyle, while the other will (seem to) have chosen to "make good and to maximize himself and his contribution to others."

Rawls does make a good point in relation to medical care, though. Since none of us knows for certain what health problems we may confront, we might well will that our common resources be used to care for the ill, on the chance that we may need them. This sounds more like a case

of prudence rather than a striving for justice in such an instance.

6) Marxist Needs Distribution

From the French Socialists of the last century came a description of ideal justice which was later adopted by Karl Marx, "From each according to his ability, to each according to his needs!" (see Feuer, Marx & Engels, p.119). This terse description of distributive justice includes, as previous formulations have not, some mention of the creation of the goods being distributed, as well as the standard for their just distribution. It is also important to note that, for Marx, the production of goods and services was a more critical issue than their distribution.

What we understand by the economic relations, which we regard as the determining basis of the history of society, is the manner and method by which men in a given society produce the means of subsistence and exchange their products among themselves...this technique also determines the manner and method of exchange and, further, of the distribution of products...(Feuer, Marx & Engels, p. 410)

The manner of production of goods and services was held to be causally connected with the manner of their distribution.

Though its phraseology is appealing, this Marxist definition of distributive justice is inadequate due to want of clarity. It is also not an exhaustive description of distributive justice, as a bit of reflection will reveal. The first half of this statement, to give or to produce according to one's ability, gives no guidance as to which of a person's abilities ought to be employed. It is presumably the case that each person has some activity to which he or she is best suited, and that society would make use of a division of labor rather than attempt to have each person be a generalist. But the distribution of natural talents rarely if ever exactly matches the needs of a society (we can only have so many artists,

priests and so forth), and so some people would either be serving in non-productive roles, or more likely, working with one of their lesser talents. This system would, of course, run contrary to our fondness for free choice in career options, but in reality it takes a substantial aptitude in a skill to obtain employment, even in a "free" society.

How much work is then to be expected of people, once their place in the social order is determined? It is possible to put in twelve hours of work per day, albeit with considerable lessening of individual well-being over the long run. But Marx, I am sure, intended for the second half of this statement to modify the first; work must be done until needs are met, and after that point the society has no more claim on the worker's productive capability. As Thomas More observed in the Utopia, when people work diligently and aren't attempting to get rich, or having to feed another's coffers, it doesn't take very long to produce what is needed.

The problem of need returns in the second half of this analysis of distributive justice. The problem of medical need has already been considered in Section II of this thesis. Taken more broadly, on the level of the whole society, it is exceedingly difficult to determine what exactly constitutes the needs of an individual. Clearly each person needs x grams of protein, y calories, and z liters of water. Clothing and shelter appropriate to the climate also readily classify as needs. But there is so much to what it is to be human which does not fall into the category of "necessary for survival" that such a list seems to be a mockery of our true needs.

The core of the appeal of this interpretation of distributive justice is the dual attractiveness of the propositions that those who can

put in a day's work should do so and that regardless of means or resources, no one ought to go without the essentials of human existence. But an important question remains. What of those who do not give according to their ability, but who instead either do no work or who work far below their ability? Marx believed that in the ideal communal state, workers would not feel alienated from their labor, and would in effect be proud enough of their labor to work well. But as many socialist countries have discovered, a worker who will eat regardless of whether or not he works is not a reliable source of labor. Some sort of enforcement, possibly disenfranchisement, seems necessary to make communism workable.

7) Utilitarian Egalitarianism

All utilitarians would have it that a just system would be that which would produce the greatest happiness for the greatest number. Just how that goal is to be obtained is an area of considerable dispute among utilitarians. Some have argued that that objective would be best served by egalitarian distribution. According to John Hospers, Jeremy Bentham and John Stuart Mill, "if they had to choose between a society in which good was equally distributed and one in which there were glaring inequalities, they would choose the first" (from Rescher, Distributive Justice, p. 46).

Why would a utilitarian choose egalitarianism? Because and only because it, as a pattern of society and distribution, would produce greater happiness than haphazard ethical determinations. A utilitarian may follow any law, rule or maxim so long as it itself serves the rule of utility. The rule may produce instances that are less-than-optimal, but because faithful adherence to that rule will serve the greater good,

the utilitarian is justified (again, by utility) in following that rule. Each rule can be judged by its overall utilitarian consequences. As a rule, "let everyone have as much health care as he or she desires" would be disastrous, because such a level of consumption of health care would tax our ability to provide for all other resources, such as food and shelter, and our ability to consume would outstrip our ability to produce consumables. The rule, "let everyone receive only that health care which he can afford" would mean that many would suffer and die for want of health care resources, while society might easily be able to meet at least some of the unmet needs. The rule, "let everyone receive that health care which he or she needs" or some similar formulation may be the rule of distribution which would produce the greatest happiness in the society.

Because of the essential nature of health to a person's life, an adequate level of health care would appear to be an important factor in being able to experience happiness. Further, medical care can be critical to the relief of chronic pain, certainly a factor in the utilitarian formula. The larger question is whether or not the provision of health care to meet all medical needs would take away from other important sources of happiness in a society. For instance, no distinction has yet been made concerning the cost of various needed interventions in the consideration of what constitutes a need-claim. Medically, one may need a liver transplant just as validly as one may need polio vaccine. The concept of medical need may be modified by a stipulation that the least costly remedy be chosen over more costly healing modalities, but this does not alter the fact that for some, the only hope for a cure involves

an intervention on the scale of an implantable artificial heart.

Needed medical care may also involve a small probability of success. At the earliest stages of prematurity, an infant has only about a 10% chance of living to see its first birthday. Should it receive the costly intensive care required for that 10% probability and survive, its chances for a normal life are quite good (from information received while on a practicum at the University of Tennessee at Memphis' neonatal intensive care unit). There is the inescapable fact that health care resource utilization is heavily skewed, unless a society resorts to a distribution based on radical egalitarianism. Further, the upper limits of the amount of health care that a person can medically need can be incredibly expensive without guaranty of success. It is therefore an open question as to whether or not a commitment to meeting all medical needs will consume such a large portion of the society's resources that it would, on the whole, serve to reduce the overall utility of the society.

8) Distribution as a Social Right

The language of human rights has been grossly overused in the popular media in recent years in this country. Rights have as their root concept the concept of a legal right, which is certainly not something innate to a person, but which is rather a social and institutional convention. I do not wish to speak of rights here as divinely endowed (as our Declaration of Independence would have it), but of rights as endowed by other persons.

There are any number of practical reasons for a society extending an artificial right to health care to its citizens. Such a policy

would allow for control of infectious diseases, and help to reduce the number of productive days lost to ill health by the work force. The provision of health care is also an extremely popular function for a government to engage in, because people value their health so highly. A society which furnishes uniform medical care for its people can also have strong hopes for the future, since children would be given optimal prospects from appropriate immunizations and critical care.

There is, however, a reason why this is a theory of justice and not merely a theory of social expediency. A point was made in the section about libertarianism that each of us has come from a position of dependency, and that our nature, because of our origins, is a social nature. It is interesting that so many writers on the subject of justice, with so much talk about indigent care, fail to notice the most common instances of indigent care in any society. Children are, individually and as a group, unable to care for themselves, unable to offer payment for care, and unable to contract for deferred payment. They simply have needs which must be met if they are to survive and flourish. Obviously at least some of these children find adults to care for them. The question is, what is the nature of this relationship? Is it an instance of charity? If the children are not one's own, then that might be the case. But the nature is such that the recipient of charity has no desert-claim to the charity given. If the adults in question are the child's own parents, then we feel there to be a true desert-claim which the child has to the parent's resources.

One traditional explanation of this relationship is that it is one of social contract. The parent contracts to care for the child when young,

and the child contracts to care for the parent when elderly. But there is something quite odd about claiming that a person can be contracted into such an agreement when there is clearly no choice involved. It is also often the case that parents do not bring children into the world as a form of retirement insurance.

I would suggest that the reason why parents care for their children and why children have a desert-claim to that care is because there is a relationship of "common lot" within a family. In a relationship of common lot, members of a group perceive each other as sharing in the same common fate. If one prospers, all prosper; if one suffers, all share in the suffering. A family member recognizes other family members as extensions of his or her self, though this is not likely to be verbalized as such.

Relations of common lot can extend beyond the family unit and into whole societies. At such a level we have terms like "community pride" and "national honor" to describe a basic perceived unity within a group. The language which is used to describe the common lot makes it sound like a strictly emotional affair; what has emotion to do with the dictates of justice? The fact is that these emotions do not constitute the relationship, rather, they sometimes accompany it. Membership in the common lot is not so much a source of desert-claims ("I am your child; feed me.") as a submission to the desert-claims of others, which makes those claims actually possible.

The notion of common lot is hard to express even to those who practice it, and one may simply wish to focus on the expedient aspects of distribution as a social right. In the final section of this thesis, I shall

return to the problem of what constitutes a valid and just desert-claim, and present a basic axiomatic analysis of distributive justice.

V. PATTERNS IN U.S. HEALTH CARE MACROALLOCATION

One may make, quite plausibly, the claim that there is no such thing as macroallocation of health care services and goods in the U.S. Because of the diverse distributional phenomena to be found in this country, there does not seem to be any sort of system of health care distribution; there are a diversity of systems, each working according to its own rules, each subscribing (or perhaps failing to subscribe to) its own concepts of just distribution of health care. As will be seen from the following brief history of U.S. medicine, however, there are in fact only a handful of fundamental principles which guide U.S. health care in its varying manifestations. Further, though the federal government does not dictate the distribution of health care in this country, it nonetheless controls the distribution of health care. Most doctors are not civil servants, but their practice of medicine is highly constrained by the law of the land and by federal social policies.

The purpose in this examination of the history of U.S. health care macroallocation is manifold. First of all, pure justice theory, no matter how sound, may not mesh perfectly with reality. There is a certain naive optimism that a perfect understanding of justice ought to yield a clear answer to a given ethical dilemma. It may well be, unfortunately, that given perfect knowledge of a problem and perfect ethical insight, it would be perfectly clear that there is no "good" solution. Understanding the reality of the problems of health care macroallocation may grant an appreciation of the limits of justice theory. Secondly, seeing how medical resources have been distributed in the past, under real

conditions, may help to point out theoretical considerations not previously addressed. Finally, in seeing where the system of health care allocation has been unjust in the past may point out areas for practical concern and for practical solutions.

I have identified the following ten movements as particularly significant to the history of the way that "medicine is done" in the U.S. The list is not intended to be exhaustive, but rather representative of the factors which have together shaped current medical practice. It will be noticed that little concern is given to health professionals other than to physicians; it is not that other healthcare professionals are not important to the practice of medicine, but that physicians are most likely to be involved in the actual patterning of health care distribution. Some of the events, institutions, and legislations deal directly with health care distribution, others less directly through changing availability of resources.

0) Laissez-Faire and Charity

The base-point of U.S. health care distribution is to be found in the country's colonial past. During the early years of European habitation of the Americas, health care was by and large the concern of the individual, or more precisely, of the family unit. If one became ill, one's family members were usually expected to provide medical care. In the colonies, medicine was a combination of British medicine and whatever practical wisdom could be obtained from the Amerinds. Methodology was not considered to be nearly as important as successful results. The colonists "accepted as healers those who could demonstrate healing skills, whatever their training" (Sidel and Sidel, A Healthy State, p. 245).

If one had goods to trade, or perhaps hard currency, a healer might be employed to cure the sick; otherwise, family members would apply whatever treatments seemed most effective. Given the lack of precision in the healing arts at the time, one might well have been better off in the hands of one's family than in the hands of one who called himself "doctor." With bloodletting, purgings and blisterings fashionable with the better-trained physicians, more pedestrian remedies such as simple herbal cures might well have been a safer choice.

But what of those unfortunates who had neither money nor family to care for them in times of illness? These were known to society as the indigent. The indigent received health care at the mercy and kindness of the better-off. In the colonial period, the attitude was not that such persons deserved medical care, but that medical care was a kindness which a good Christian ought to extend to the less-fortunate. Health care for the poor was a matter of charity, not of justice.

Here we see the two most basic concepts in U.S. health care, that of free medical enterprise (where people are allowed to sell and buy health care as they choose) and "Christian charity," which provides for the poor, though certainly not at a level of care equal to that of the rest of society. The underlying conceptualization of justice is strongly libertarian. It never makes demands on anything other than the goodwill of others, and expects only that which is freely traded for.

1) The Marine Hospital Service

Not long after the Revolutionary War and the birth of the U.S., the new country began to act in shaping the provision of health care.

At first, the federal government took pains not to vary from the practices of the colonial period. However, it made its first attempts to see to it that two groups who were in need of medical care would receive it: the military and the merchant marine. The merchant marine, in particular, did not fit well into the division between the indigent and the non-indigent. Sailors who became ill while away from their home ports could not readily afford medical care, had little to offer in trade, but were clearly deserving of medical care. Their jobs, which were vital to the young country, took them away from their families for extended periods of time. Unlike the indigent, they deserved better than the meager almshouses.

In 1798 the Marine Hospital Service was founded by the federal government to coordinate existing hospitals for the merchant marine, to create new ones where none previously existed, and to support these hospitals with a fee of twenty cents per month per sailor for ships entering U.S. ports. It is important to notice here that the funds to care for the seamen came from the shipping industry itself, not from outside sources. As a conception of justice, this would appear to be an application of common lot for a non-familial unit. Sailors were to be taken care of by their own people.

Soldiers, like sailors, were required by their profession to leave their homes for extended periods. The Continental Army had physicians and a physician-in-chief. Medical care for soldiers was, if nothing else, expedient; a man incapacitated by injury or illness was of no use to his forces. In 1777 General Washington ordered his men inoculated against smallpox, making them the first group in the country to receive compulsory

inoculations (Sidel and Sidel, A Healthy State, p. 247). Caring for soldiers was not a surprising function for the federal government, but the coordination of health care services for the merchant marine was a true exception to the previous pattern of U.S. health care distribution.

2) Licensure of Physicians

In the colonial period, a healer could take and use the title of "doctor" or "physician" as he wished. In Williamsburg in 1730, there is estimated to have been one "doctor" for every 135 people. The U.S. figure for 1978 was 578 people per doctor (President's Commission, Securing Access to Health Care, Vol. I, p. 81). Realizing that a vast number of healers were making a profit from negligible training and skills, the government made attempts to distinguish qualified from unqualified healers. A 1736 Virginia law attempted to draw a distinction between surgeons and apothecaries who had been trained by apprenticeship and those who had been trained at a university; the latter were legally allowed twice the fees of the former (Sidel and Sidel, A Healthy State, p. 250). In 1760 New York City saw the first law passed which forbade new physicians from practicing medicine unless they were first licensed by the city. Unlicensed doctors could be fined, but as it turned out, never were (Starr, The Social Transformation of American Medicine, p. 44).

Similarly ineffective measures for licensure continued until the end of the Nineteenth Century. State licensure and licensure from medical societies were largely meaningless since they had no legal force and only minimal value in the eyes of the populace. Licensing was seen by many Americans as merely an attempt to establish a power-elite, rather than to assure a minimal competence of practice. Physicians and doctors

themselves were only as likely to support licensure as they were certain that they could obtain licensure. Licensure laws only took on force, and hence value, when in 1888 the U.S. Supreme Court upheld, unanimously, a West Virginia licensing law (Starr, The Social Transformation of American Medicine, p. 106). Justice Field based the constitutionality of the state law on the state's duty to protect society from harm.

The impact of licensing laws can be easily underestimated. Licensing not only determined what the standard of education and training was in order to be considered a physician, but what kind of training is accepted as "true" medical training. In the Supreme Court case cited above, the physician was refused a medical license not because of any impropriety in practice, but simply because his education was from the American Medical Eclectic College of Cincinnati. Numerous schools of medical methodology died out when "regular" practitioners gained respect and power in the society, and licensing laws were framed which denied the coveted "M.D." to those with competing philosophies. Licensure defined what was and what was not "real medicine." Licensing laws altered distribution of health care from an almost purely libertarian order by reducing the availability of medical providers.

3) Johns Hopkins University and the Flexner Report

"Modern medicine" has a highly complex and frequently dubious genealogy. In the U.S., the best (which is to say, most extensively) trained doctors had their training in England and on the Continent. These were the "regular" doctors, which licensure accredited with the title of M.D. Yet the medical technology, methodology and technique of this group during the Eighteenth Century and early Nineteenth Century resembles

current medical practice the way a Zeppelin resembles a 747. It must be understood that the current tools of empirical medicine by and large did not exist until the Eighteenth Century, and even then their application was not fully appreciated.

Medical training took on its current form in 1893 when Johns Hopkins University opened its medical school. From its inception, the school strove for a standard of competence far higher than any school of its day. It was the first medical school to require a four-year degree of its students; the first school to combine a two-year period of classroom study with a carefully monitored two-year period of clinical instruction. The University also expected for its instructors to be skilled as researchers.

Several factors worked together to make this medical school more than an academic curiosity. Licensing boards in the various states had begun to raise the requirements expected of new doctors, and medical schools had to either raise their standards or lose their students because they would not be licensed. There was also increasing public expectations of a medical school program. The Carnegie Foundation hired a non-doctor, Abraham Flexner, to investigate the quality of medical schools around the country. The culmination of this investigation was entitled Bulletin Number Four, and its condemnation of a medical school was taken as authoritative. Flexner wished to reform medical schools so that they could transmit the benefits of recent scientific discoveries to medical students. Smaller schools could not afford the laboratory space or the clinical training required to teach these advancements. Under the scrutiny of the Flexner Report, smaller schools either had to find ways

to upgrade their quality, allow themselves to be absorbed by larger local medical schools, or simply close their doors.

As with licensing, the changes in medical education changed the distribution of health care by reducing the number of kinds of healers allowed to practice medicine, and reducing the ways in which "regular" medicine could be practiced. With one blade, entry into the medical profession became more difficult. With the other, the quality of professional training was raised. Increasing the amount of time required for a medical degree and its quality greatly increased the cost of becoming an M.D. Increasing the cost of becoming an M.D. limited the number who could become a doctor; as the class of physicians became elevated, fewer people could hope to become one.

4) The AMA

The American Medical Association was not unusual when it was first founded in New York in 1846. The British had a long history of medical societies, and these had been unsuccessfully imitated on previous occasions in the U.S. Its raison d'etre was straight forward: to increase professional prestige. The AMA was formed at a time when a young doctor had a particularly difficult time starting his own practice; licensing laws were either ineffective or nonexistent, training was not standardized, and non-"regulars" had large followings. Belonging to a strong medical society could grant a young physician something which he needed quite desperately: credibility. During its early years, however, the AMA had almost no impact on either physicians or on the larger population.

In 1901 the AMA was reorganized under a federalist constitution, which made membership in county and state medical associations a

prerequisite to membership in the national organization. By all accounts, it was at that time that the professional power of the physician finally coalesced. M.D.s began to cooperate to achieve goals which had been long sought. The AMA worked for control of the medical schools in order to remedy what it saw as a critical oversupply of doctors. It took advantage of court rulings which limited liability in malpractice suits to "community medical standards"--an M.D. who belonged to his local medical society did not have to worry about colleagues testifying against him in court. The AMA formed a powerful lobbying arm to shape legislation pertinent to medical practice. Indeed, the AMA proved that there is safety in numbers.

In recent years the AMA has become a popular "whipping boy" for those critical of the power held by M.D.s and the medical-industrial complex as a whole. It is first of all worth noting that the AMA did not come to power in a social vacuum. Other professional groups were gaining standing around the turn of the century. And "regular" doctors in large part had to earn the new authority given to them; their curative methodology and modality had to show its worth in a competitively pluralistic setting. It was patently not the case that doctors could just band together and hold the healing arts hostage. If it were, it certainly would have been done much earlier.

The AMA has had mixed implications for justice in the distribution of health care in this country. Much of the criticism leveled against it in recent years has been deserved. When given a choice between improved delivery of health care with a loss in prestige and the status quo, the AMA has shown no proclivity for self-sacrifice. It has specifically

opted to serve the interests of health care providers rather than the interests of health care consumers (such as in the case of common protection in malpractice suits). On the positive side of the ledger, the AMA has long supported ethical physician practice (with the contents of those ethics differing over the years), and has done much to improve the quality of medical care over the past century. It is true that the AMA has taken advantage of every opportunity to give doctors greater authority and power in the society; but then again, authority can be a therapeutic tool.

5) Regulation of Pharmaceuticals

From the strongly libertarian justice of the colonial period, the federal government has been moving towards a system of negative protection of health care. Except for the cases of the military and of the merchant marine, health care has been a matter of individual resourcefulness and private charity. The federal government, though, has been identifying some forms of health care as injurious to the populace, and using force of law to limit their availability. Desert-claims have not been substantially altered, but the production of health care has been substantially changed.

The initiative for reform of the pharmaceutical industry came not from doctors, but from the press. What Abraham Flexner was to medical school reform, Samuel Adams, writing for Collier's Weekly, was to pharmaceutical reform. In 1905 two series were published in that publication which laid bare the lucrative business of selling worthless or even dangerous "patent medicines" and "home remedies." Adams allied himself with doctors in his articles, suggesting that potent therapeutic agents

(such as opium) be taken only at their professional judgment (Starr, The Social Transformation of American Medicine, p. 130).

The AMA had the prudent sense not to allow such an opportunity for social reform slip past, and pushed for federal reform of the drug industry. The first legislation dealing with this area came in 1906, the Pure Food and Drug Act. It proved to be inadequate and ineffective. Within the AMA, a Council on Pharmacy and Chemistry was set up to begin the task of evaluating the myriad of available medications. The Council's results were then published by the AMA and made available to member doctors. The AMA used its newfound strength to its advantage, and forced drug manufacturers to choose their markets. If the drug was to be found acceptable by the AMA, it could not make any erroneous advertising claims, was required to reveal its contents, and was not permitted to list the diseases for which the drug was to be used. The final clause was most significant for physician control of the use of pharmaceuticals. A drug company had to choose then, either to have its products in the hands of doctors, or to shun the growing power of physicians and sell directly to the public. Thus our present distinction between prescription and over-the-counter medications has its roots in the AMA, not in federal regulation.

The Pure Food and Drug Act was amended in 1912 and 1920 and thus finally given the teeth which it needed to push back the patent medicine industry. This reform of the drug industry caused a shift in attitudes concerning pharmaceuticals. Under a truly free market (libertarian) system, products are purchased and produced at the volition of the individuals directly involved; the consumer is to be his own judge of what is and is not to be purchased. Now the federal government was calling

into question the capacities of the individual consumer (albeit, with good reason), and taking upon itself the role of overseer of commerce in this realm. At the same time, doctors were more than willing to withhold the liberty of self-medication "for the good of the patient." The spirit of the original Pure Food and Drug Act had been to disclose the contents of products so that the consumer could make rational choices about the purchase and use of medicines. The AMA, in turn, wanted to take decision-making out of the hands of the consumer entirely, and turn it over to those with medical school educations (a point made by Starr, The Social Transformation of American Medicine, p. 133).

This change in distribution changed the power in medical decision-making, and had its repercussions for justice as well. Placing more power into the hands of the professional meant that the medical professional was in a position to alter distribution of resources to as to better benefit his or her position. Physicians would argue, by and large, that they were due this greater share of power, while many consumers suspected that the next medical power structure would mean that they would be less likely to receive the health care due them.

6) Blue Cross and Third Party Payment

Previous movements in health care have only indirectly been related to macroallocation for the population as a whole. Now, with the Great Depression, the traditional methods of distribution of health care began to falter. It was not just that liquid personal income suffered during that period of economic upheaval. Medical care was shifting from what economists identify as a labor-intensive to a capital-intensive activity. With physicians able to do more for the ill, there came the potential for

greater medical expenses. But in the 1930's, bed occupancy in hospitals dropped, visits to physicians dropped, and voluntary contributions to non-profit health care institutions dropped. Some government relief was forthcoming, but many physicians feared that if the government took over the provision of health care for the troubled nation, it would take over the practice of the individual physician as well. With professional autonomy at stake, a payment plan was sought after which would allow doctors to retain their control over their own practice of medicine. Again, in the U.S. system it is assumed that any professional group is to have control over its own operations; taking control away from a professional can only be justified if there is some overriding interest which the state has in that activity.

The American Hospital Association in 1933 approved plans enacted in Sacramento, California and Essex County, New Jersey, which allowed for a program of hospital pre-payment for employed persons. This idea caught on quickly across the country and was called the Blue Cross program. Each state had its own non-profit Blue Cross, incorporated under local state laws. Though the individual worker might be devastated by a long hospital for a family member, he could easily afford the monthly payments to his state's Blue Cross. The hospitals enjoyed a higher occupancy because of the program, and so they were pleased with its operation. The success of the program encouraged for-profit insurance companies to offer coverage against hospitalization in 1934.

The original Blue Cross plan had intentionally avoided providing coverage for doctor's bills, because that might have been taken as a siege against the medical community. Into the next decade, however, with serious

consideration being given to the possibility of compulsory, state-controlled medical insurance, the Blue Shield program was begun. The first state to offer a program of this type was California, with the California Physicians Service offering coverage to workers with incomes under \$3,000 a year, in 1939. The AMA began to coordinate such programs in 1943. Private indemnity insurance moved cautiously into the area of physician-bill coverage. The early Blue Shield programs ran into serious utilization problems; since the programs were physician-controlled, there was little incentive not to maximize the profitability of the programs (see Starr, The Social Transformation of American Medicine, p. 309).

Shared-liability programs have since become one of the most important third-party payment systems in this country. In the abstract, such payment systems would serve to evenly distribute health-care costs among a large population. The cost to each subscriber would be tolerable, even in the event of catastrophic illness. In practice, shared-liability, especially when physician-controlled, equates with a considerable increase in health care utilization. Previously, inability to pay large medical bills would limit health care consumption. Physicians did not have the attitude that they would be compensated for all work done, and patients did not necessarily feel entitled to everything that medical science had to offer. Shared-liability programs have become at least as important to the production of health care as to its distribution.

7) Kaiser-Permanente and the HMOs

Shared-liability programs need not take on the form of the Blue Cross and Blue Shield programs, which are under the control of health care providers themselves. Henry J. Kaiser founded a group health care program

under business control, the Permanente Foundations, in 1942. At first these programs were open only to Kaiser's own employees, but after WWII, they were opened to the public. The Permanente Foundations did not merely pay doctors and hospital bills. They opened their own hospitals and clinics, and employed their own medical staff, including physicians. The structure of the Permanente plans was expressly condemned by the AMA; according to the AMA, an M.D. is supposed to be his own boss, and it did violence to his professional status to make his practice subservient to a corporation or to a prepayment plan. But the AMA has never held a monopoly on the medical profession, and the stability of the salaried position offered by the Permanente Foundation has attracted enough physicians to serve its subscribers' needs.

There was nothing original about the prepayment plan offered by the Kaiser Health Plan. Large businesses had used prepayment plans to placate their employees; starting physicians had offered their own prepayment plans in cities where they wished to establish a practice. Kaiser has been unique mostly because of its success and its growth. It has inspired a number of other similar health care plans which are usually called Health Maintenance Organizations (HMOs).

The philosophy of the HMO is simple: You pay us, we take care of you. Unlike most insurance programs, there are few exceptions to the care offered by an HMO. However, if total user consumption goes up, subscription rates must likewise rise. The HMO needs therefore to limit the ways in which its services get used without losing consumer confidence in the quality of care. If the care is too poor, or the rates too high, it will lose subscribers. Cost-containment is therefore taught to every doctor

who works for an HMO, and some have even tried systems of financial incentives to reinforce that concept. One benefit does come to the consumer from such a system, however. The HMO benefits from encouraging preventative medicine and "healthy lifestyles." Catching an illness, such as heart disease, at an early stage can greatly reduce the damage (and hence the cost) produced by such a condition. It is presumably the case that other health care programs know this as well, but none are so well situated to take advantage of preventative screening and early management of progressive illnesses.

8) Medicare and Medicaid

The Social Security Act was amended in 1965 to include by far the most important shift in the provision of health care in U.S. history, that of the introduction of Medicare and Medicaid. The programs were a compromise between two conflicting attitudes towards the provision of health care (see Sidel and Sidel, A Healthy State, p. 268). Since the turn of the century, there had been a pressure to follow the lead of many European nations and establish a program of compulsory national health insurance. The U.S. also had its older tradition of believing that help of any kind, including medical help, should be merited; even need could be made subject to tests of appropriateness. Medicare was the first attempt to create a system of national health insurance, though constrained to a limited population. The jargon of Medicare is that its benefits are merely that due its recipients; many elderly people refuse its benefits because they consider it to be a kind of charity. Medicaid, on the other hand, is meant to insure that charity is available to those who actually need it (an odd charity, to be sure, one supported through involuntary taxation). Previous

federal programs of this sort had been instigated under various federal provisions enacted during the Great Depression to ease the suffering which had been brought on by record unemployment.

What has Medicare meant for the state of the justice of distribution of health care in the U.S.? Medicare targets for care primarily the elderly and, since 1972, those with chronic renal disease. In its first full year of operation (1967), medicare cost \$4.5 billion; in 1980, its expenditures ran \$33.6 billion (President's Commission, Securing Access to Health Care, vol. 1, p. 147). In its creation, it was intended not to interfere with "the practice of medicine and the private health care delivery system" (same source). It was intended to provide security, both practical and emotional, to the elderly by insuring that devastating medical costs would not wipe out a hard-earned life's savings. By not having any ceiling on financial resources (to qualify for entitlement), it has served to make the well-off elderly even better-off. Not everyone who receives Medicare needs it. This was anticipated by the framers of Medicare, who regarded it as a necessary evil in order to retain the dignity of the program.

In 1968, Medicaid cost both federal and state governments \$3.45 billion; that same figure for 1980 was \$23.3 billion (President's Commission, Securing Access to Health Care, vol. 1, p. 155). Unlike Medicare payments, Medicaid payments must be accepted by physicians as payment-in-full for services; hence, many physicians turn away Medicaid patients. The reimbursement system allows for the existence of "Medicaid mills," specifically structured to maximize financial gain from the program, generally at the expense of the quality of care to the patient. The structure of payments has also meant that many low-income patients use emergency rooms as their

chief avenue of medical care and services. There is no doubt that Medicare and Medicaid have meant that many persons have received medical care who would otherwise be without it. There is also no debating that the programs have fallen far short of their initial expectations. As anecdotal evidence reveals, the elderly can still have their life's savings wiped out from medical costs in spite of the existence of Medicare (see Grady, "The Cruel Price of Cutting Medical Expenses"). There is also failure with Medicaid's supposed duty of seeing to it that the most needy receive the medical services that they need.

9) Corporate Medicine

The advent of Medicare and Medicaid sent a great many economic forces into motion. Money for services being assured, businesses sought to make the most of the newly available monies. The most dramatic shift here has been corporate control of hospitals. Hospitals had their roots in almshouses, and through the first half of this century were generally run in conjunction with religious or charitable operations. Businesses began to experiment with the acquisition of hospitals, linking them into chains and applying standard business techniques in order to limit waste and to maximize profitability.

The most successful (which is to say, the largest) such hospital chain is the Hospital Corporation of America, which, as of 1984, owned or operated 319 acute care hospitals in this country, sixteen outside of it, and twenty-five psychiatric hospitals. Medicare and Medicaid have played importantly in the growth of this hospital chain; 43% of its income (as of 1981) was derived from these programs (according to Wohl, The Medical Industrial Complex, p. 115). While more traditionally-managed hospitals

were sustaining financial losses during the last decade, large chains like HCA, Humana and American Medical International were showing a profit. Much consideration has been given as to why the large for-profit chains have been able to do so well.

Running a profitable hospital is a complicated task, and the chains have a number of mechanisms for attaining this end. The chains would like to give most of the credit to "superior management" and "less waste", and there is a certain validity to that claim; many hospitals lose money because of inefficiency and poor management, especially those not run with profit in mind. But there are other considerations as well. The large chains are able to buy basic goods and services with a degree of buying power which a local 300-bed hospital cannot compete with. The chains can also use public stock offerings to gain investment capital with which to expand or maintain facilities. They can also keep less-profitable hospitals in operation by taking advantage of the income from the more profitable hospitals in the chain.

There are also less-than-noble ways in which a large chain can increase its profitability. Investments can be made selectively, into areas which are most profitable, both geographically and in type of services being offered. In the choicest areas, incentives are used to attract the physicians and health care workers, while advertising is used to draw paying patients away from other health care providers. For-profit hospitals can also maximize profitability by "dumping" indigent patients. Since caring for too many non-paying patients is obviously not good for the hospital's bottom line, and since the law only requires treatment in emergency cases, all other cases may be sent to other hospitals which do not

have the option of turning such patients away. This is not to say that for-profit hospitals never provide indigent care, only to say that it is provided very selectively. Humana, for example, has made headlines by paying for experimental artificial heart research, something which neither insurance nor the government would cover. Large-ticket, high-visibility cases are good publicity for a hospital or chain.

Stanley Wohl (The Medical Industrial Complex) and others also accuse the for-profit chains of increasing profitability by overcharging third-party payers. A patient may be billed excessively for a treatment, may be given more tests than are medically indicated, or simply charged for services not rendered. Since third-party payers are reluctant to tell a doctor how to treat his patient, they are often lax in seeing to it that they are not being taken advantage of.

Corporate medicine is not limited to hospital chains. Conglomerates have grown in the provision of nursing home care, pharmaceuticals and medical equipment. Recent years have also seen the advent of small, free-standing clinics run much like fast-food chains. They provide care for minor medical problems, and operate at hours much like those of other businesses. The target again is that of providing facilities to meet the most profitable medical needs.

10) DRGs

With dollars being so efficiently milked from third-party payers, the government in particular, something eventually had to give. The federal government in March of 1983 implemented a program of cost containment called DRGs, which stands for diagnosis-related groups, for government payment of Medicare costs. The concept has since been adopted

by some states' Medicaid programs, and incorporated into some insurance programs. Under a DRG payment system, a hospital is reimbursed based upon the illness (and possibly for a secondary illness) for which the patient received treatment. Various diagnoses are grouped together and their average treatment cost becomes the basis for payment. This is called a prospective payment system, because the reimbursement for a patient is fixed at the day of admission.

The introduction of the DRG has meant, in many quarters, draconian cost-cutting measures. Premature discharges have become more common under the fixed payments of the DRGs. When introduced, the legislation enacting the DRGs also called for the creation of Peer Review Organizations at the state level, which supposedly would review discharge records to catch doctors and institutions which misused the system. At Senate hearings, however, it was shown that the PROs are more concerned with cost containment than with quality of care (see Grady, "The Cruel Price of Cutting Medical Expenses," p. 33). Some hospitals have even begun to encourage dumping patients whose DRG payments are likely to be insufficient to cover the cost of their care. From the hospital's perspective, such a patient goes from being a paying patient to being an indigent patient. Since the DRGs have no factor for the severity of an illness, more seriously ill patients who will likely require long hospital stays are sent "somewhere else."

As E. Haavi Morreim has also pointed out (see "The MD and the DRG"), DRGs and prospective payment are threatening to abolish whatever role the M.D. once had as a patient advocate. It was expected before this time, she says, that an ethical M.D. would see to it that his or her patient receive the best possible care under the system. The M.D. was not to

violate the rules of the health care system, but he or she was expected to maximize its benefit to the patient. It was the task of the legislatures, for example, to shape whatever cost containment measures were needed into the system of health care distribution. Now, doctors are expected to make critical care decisions with a bias against care which the third-party payer will not cover. Perhaps this discourages needless lab tests, but it may discourage needed testing as well. Once a patient sees his doctor as an adversary, then patient confidence is compromised.

The DRGs have not meant uniformly hard times for health care providers. As with all systems, there are dollars to be made by seeing where the structural weaknesses are. Patients can be admitted multiple times for multiple DRG dollars. Marginally ill patients may be admitted because their brief hospital stay will be profitable. There is also the obvious possibility of admitting a patient under the wrong DRG code. But all in all, the DRGs have been a violent sort of cost containment for which some patients will doubtless suffer.

VI. IMPLICATIONS AND CONCLUSIONS

Having looked at theories dealing with distributive justice, and at ways in which this society has gone about distributing health care, the task yet remains to identify just what constitutes just distribution of health care. I will begin here with an axiomatic principle for just desert, and expand its application into the area of health care.

In the Nicomachean Ethics, Aristotle begins an examination of justice by asking about injustice. Let us find an example of unjust distribution. One frequently and almost automatically cited is the example of theft (Nicomachean Ethics, 1131a, for example). To understand the notion of theft, we must understand another notion, that of (rightful) ownership. Rightful ownership is not synonymous with a just desert-claim, since one may have a desert-claim to something which one does not in fact own.

Rightful ownership is a sufficient condition for there being a just desert-claim. What may we take to be an example of rightful ownership? Rightful ownership is most obviously instantiated in the ownership of goods which one has produced by one's own effort. The strongest claim I could have to an apple would be, "I tilled the soil, planted the apple seed, cared for the growing apple tree, and finally picked the apple myself."

(J1): A person has a prima facie desert-claim to those goods and services which he or she has produced.

In the case of the apple, there are several possible considerations which would override my owning it, but they do not challenge the basic validity of the axiom. The first is that I might not own the apple

because I did not own the land on which it was grown, or the seed from which it was grown. But this consideration only serves to return us to the initial problem of rightful ownership, which may again be answered by the axiomatic definition.

I might not own the apple because I gave it to Oswald, or because I traded it with Oscar for a peach. My desert-claim ceased to exist when either transaction took place. This is not a problem with the desert-claim, but merely one of its characteristics, that of transferability. Because the desert-claim may be transferred, I might wish to modify the axiom of distributive justice to read as follows.

(J2): A person has a prima facie desert-claim to those goods and services which he or she has produced, or which he or she has been given, or which he or she has traded for.

There are still other possible reasons why I may not own the apple. It may be the case that I am the property of a slave-owner or lord or king, and because of that all of my productive effort is likewise the property of that sovereign. There are two ways to look at this situation. One way is to consider my relationship with the sovereign to be an odd form of voluntary exchange, wherein I trade my productive effort for whatever goods the sovereign provides for me (I may not like the situation, but still agree to it). The situation may also be seen as a form of institutionalized theft, wherein what is mine by right is systematically taken from me ("mine by right" simply means that to which I have a just desert-claim). Neither of these compromises the validity of the initial axiom.

There would be a genuine objection to the axiom if one could establish,

as per Hobbes, that property as such is only possible because of the existence of the state (see the Leviathan, p. 113), or if one could establish that individuals are not sovereign. As to the first objection, I am not convinced by Hobbes' insistence that without the "commonwealth", everyone has a right to everything. He may have been considering such things as natural resources (which I have not yet considered), but his argument is certainly invalid when applied to the productive power of a person, especially considering Hobbes' own claim that each man has the "right of nature" to do as he will to preserve his own life (Leviathan, p. 103). Even without the existence of the state, I have a desert-claim to the apple which I have produced.

The question of the sovereignty of the individual is so fundamental to ethical discourse that it is difficult to seriously entertain the contention that one might ethically own another person. This is certainly a topic meriting a great deal of analysis, but I will accept axiomatically that persons are sovereign, and that it is prima facie wrong to violate a person's autonomy.

This basic analysis of distributive justice is quite broadly accepted by writers on the subject of justice. Nozick accepts a form of (J2) as the whole of distributive justice (Anarchy, State and Utopia, p. 150). Other authors usually accept or assume (J2), but find reasons why it does not constitute an exhaustive description of distributive justice. Even Marx and Engels seemed to accept the spirit of (J2).

In this sense, the theory of the communists may be summed up in the single sentence: Abolition of private property.

.....
 Hard-won, self-acquired, self-earned property! Do you mean the property of the petty artisan and of the small peasant, a form of

property that preceded the bourgeois form? There is no need to abolish that; the development of industry has to a great extent already destroyed it, and is still destroying it daily. (Marx, Manifesto of the Communist Party, as found in Feuer, Marx and Engels, p. 21)

Applied to problems in the allocation of medical resources, (J2) would provide persons with desert-claims to those health care resources which he or she produced, those which he or she had traded for, and to those which he or she had been freely given. As was previously noted, this basic definition does not allow for a person to have a desert-claim to a resource which he or she does not in fact have, unless we choose to count pre-paid medical plans (I give the apothecary a bagfull of apples in exchange for the promise that he will give me medications the next time that I fall ill).

The challenge which many writers find is a desire to justify a just distribution which would see to the needs of those who cannot produce the means for their own health care. Clearly (J2) allows for individual acts of charity for the unfortunate ill, but charity is an unreliable type of behavior. The desire is to justify some sort of universal right to health care, a right not merely based on social convention, but one which is ethically justified. In this country, as well as in many others, if a starving man comes to a food market, the merchant is not expected to feed him; but if a critically ill person comes to a hospital, the medical staff is required to provide at least emergency care. Medical care has a fairly strong bearing on a person's health, and health is to varying degrees required in order for a person to realize autonomy. Medical care is therefore an important need for most of us, and further, it is a need such that needing it can easily entail not being able to procure it.

Our axiom of distributive justice, in either of its forms, does not

provide a desert-claim for such cases. There is no desert-claim to charity, no matter how great the need. Dan Beauchamp ("Public Health as Social Justice" in Mappes and Zembaty, Biomedical Ethics, pp. 551-559), Kenneth Arrow ("Government Decision Making and the Preciousness of Life" in Tancredi, Ethics of Health Care, pp. 33-55) and David Gauthier ("Unequal Need: A Problem of Equity in Access to Health Care" in Securing Access to Health Care, pp. 179-205) each accept the essential definition of distributive justice found in (J2). They see the roots of (J2) as lying in a libertarian framework, which sets out individual liberty as being the value being promoted by just distribution. However, if (J2) is allowed to stand unamended, it fails to adequately serve the interests of liberty. Liberty requires not merely a lack of constraint, in this view; it requires certain basic capacities. It is meaningless to say that I am free to vote in the next election if I cannot read the ballot or if I have no means to travel to the polls. To be free to vote there must not only be an absence of hindrance (such as large men with clubs keeping me away from the voting booth), there needs must also be positive factors such as an ability to understand the ballots and transportation.

In order to actualize maximal individual liberty and thus achieve justice in distribution, a new definition of distributional justice is required, building on (J2), since the elements of (J2) are essentially libertarian in character.

(J3): A person has a prima facie desert-claim to those goods and services which he or she has produced, or which he or she has been given, or which he or she has traded for. A person also has a prima facie desert-claim to those goods and services which are required in order to sustain

life and to allow for the exercise of individual liberty.

Different writers suggest different levels of individual liberty when considering just distribution of goods. The higher the level of liberty, however, the more self-defeating this standard of distributional justice becomes. My individual exercise of liberty is infringed upon more and more as the goods which I produce become more and more subject to the demands of others. Even if (J3) is restricted so that a desert-claims cannot be made "to allow for the exercise of liberty," it is still the case that if I have more food than I need to live on, any person may lay claim to the food that "I don't need" in order to meet his or her needs. None of the authors of this libertarian framework, though, speaks in such terms. A person with unmet needs does not have a claim against any particular ("well off") individual, but rather a desert-claim against society. It is society, in turn, which has a desert-claim against the individuals who have the greater share of natural benefits.

There is an innate contradiction, then, in this libertarian standard of distributive justice. The principle of libertarianism is usually expressed as follows: Each person is allowed the greatest possible degree of individual liberty, so long as the exercise of that liberty does not infringe upon the liberty of others. In attempting to expand each person's liberty by insuring adequate food, health care, education and so forth, (J3) interferes with the liberties of others. Nature does not give each person an equal opportunity to take advantage of simple laissez-faire libertarianism. Correcting these inequalities is certainly promoting egalitarian ideals, but promoting libertarian ideals only by violating them.

At present, it may be germane to consider an egalitarian formulation of distributive justice. Though an egalitarian distribution would, in its own way, serve the ends of libertarianism, it cannot be justified on purely libertarian grounds. In levelling out natural inequalities, egalitarian distribution would allow basic freedoms to those who could not otherwise enjoy them, but in order to do so the mechanism of distribution would have to be extremely restrictive. Dan Beauchamp (in Mappes and Zembaty, Bio-medical Ethics, p. 552) says that, "In the broadest sense, justice means that each person in society ought to receive his due and that the burdens and benefits of society should be equitably distributed." I take this to mean that after basic needs are equalized, a person may then be entitled to benefit according to his or her merit (receiving what is his or her "due"). This would produce a standard of distributive justice which would place the axiomatic principle from (J2) into a secondary position.

(J4): A person has a prima facie desert-claim to an equal share of the basic goods of the society. A person also has a prima facie desert-claim to those goods and services which he or she has produced, or which he or she has been given, or which he or she has traded for, after all have received an equal share of the basic goods of the society.

There would thus be a basic "decent minimum" of food, clothing, shelter, health care and so forth which all the members of the society would partake of, and after those needs were met, individual luxuries could be pursued. (J4), like (J3), involves a relationship of person to society to person, and so becomes contingent upon the existence of a society. It is a distributional model particularly favored by analyses of just allocation of medical care. Medical resources would first go to meet basic

needs, needs like threats to life and limb. Only after those needs are met is it considered just to allow medical resources (even if privately paid for) to be used for cosmetic rhinoplasty and the like.

The most significant problem with this formulation of distributive justice is that it can't be done. Many of the basic goods of society, its burdens and benefits, are simply not transferable. Take an extreme case to illustrate this point, the case of a child born anencephalic. It would be of no benefit to gather brain cells from the rest of the society and give them to that child. The only way to equalize the situation would be to remove the brains from everyone in society in order to have them at the same level as the child--certainly an absurd proposition. Let us take then a lesser case, the case of a child born (incurably) blind. We might pretend that joining together to buy that child a seeing eye dog and Braille reading material in some way evens out the burdens of that blindness, but in the final analysis, that child, and only that child, is the one who is blind.

If (J4) captures the essence of distributive justice, then distributive justice cannot be actualized as an end-state. True equality can only be actualized as everyone having absolutely nothing. The equality being sought must then be some less perfect sort of equality. I take it that what is being sought is a conceptualization of the Good rather than a conceptualization of the Just. The claim which (J4) establishes to health care is far too weak to be a desert-claim. It is contingent first of all on the existence of an identifiable society, secondly on there being medical resources to be distributed, thirdly on there being medical resources efficacious for the society's needs, and fourthly on there being

an adequate resource base to meet the particular need at hand.

It is nonetheless a good thing for a society to meet the needs, in particular the medical needs, of its less fortunate members. A needy person, though, does not have an innate claim against others that his or her needs be met. A claim might exist, but such a desert-claim would not be innate. Under (J2), recall that a person could make a desert-claim against the apothecary for medical services if those services had been promised in an agreement of pre-paid medical services. By virtue of a bag of apples and a prior agreement, there would be a perfectly valid desert-claim against the goods and services of the apothecary. One might be tempted to try to use weaker language here and say that it would merely be a good thing for the apothecary to live up to his end of the agreement. But in agreeing to this health care transaction, the apothecary has exercised his right over his goods and services and transferred his desert-claim to them to me. That my bag of apples is given to the apothecary at t_1 and that I will need his goods and services at t_2 does allow for instances of deception and dishonesty which a face-to-face exchange would not allow does not alter the validity of the desert-claim.

If I may make exchange agreements prior to the actual fact of the exchange, there is no reason why I may not make charity agreements prior to the actual fact of their delivery. Once the agreement has been made, then the recipient of the charity has an actual desert-claim to that charity, whereas none existed before the promise was made. By "promise" is here meant an agreement as binding as that of payment before delivery of goods; it is recognized that promises at charity are normally not considered to be as strong as payment agreements. The point is that when a strong

commitment to charity is made, then it becomes an issue of justice, and not simply one of virtue or goodness. With this in mind, (J2) will be re-phrased.

(J5): A person has a prima facie desert-claim to those goods and services which he or she has produced, or which he or she has been given, or which he or she has traded for, or which have been promised to him or her either as gift or exchange.

The function of this definition in situations of private transaction has already been explained. How then does it apply to situations on a societal level? Let us imagine a society (say, our own), which has made a strong commitment to providing a "decent minimum of health care" or to "access for all to an adequate level of care" (taken from the Introduction to Securing Access to Health Care, written by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research). The members of such a society become party to two sorts of desert-claims. They become able to make desert-claims against the greater society under the terms of the commitment. They also become subject to supporting and providing for such claims to such a degree as the commitment dictates. In practical terms, as a worker I am subject to Medicare deductions from my paycheck, and as a retiree I am subject to receiving Medicare benefits. The existence of Medicare is not a question of justice, but once the society has enacted such a program, its members become bound by justice to support it, and entitled by justice to benefit from it.

What then do we make of the following objection? Some would find support of a program such as Medicare to be an unjust demand because they themselves never made a commitment to its existence. The government could

create any sort of ghastly redistributive arrangement without the support of the individual member of society. Why should the individual be bound to such an arrangement? The theory of distributive justice answers this question itself. Given the sovereignty of the individual, the only just exchanges are those made by mutual agreement, and the only just giving is that chosen by the individual. The relationship between society member and society is a complicated exchange (for the purposes of distributive justice). The society may ask for certain forms of behavior, payment of taxes, participation in the military, and other goods and services from its members; in exchange, the society provides goods and services such as education, military protection, law enforcement, and emergency aid. An individual may agree to these terms of exchange, or he or she may find them unacceptable. If they are found to be unacceptable, the individual should ideally be able to opt out of both the costs and the benefits of being a member of a society; in practice, this normally involves leaving a geographic area and joining another society.

By justice there are two wrongs which might be committed in this exchange with society. One would be for one party to hold true to the terms of the agreement while the other refuses to live up to his or her end of it. A society might derive benefit from a member during his or her productive years and then unexpectedly abandon him or her in his or her old age; a member of society might benefit from education, mutual protection, good roads and so forth and then refuse to pay taxes. The other wrong would be for the parties to enter the agreement with one party (usually the member of society) under duress so that he or she has no choice about whether or not to participate in the exchange. Both of these are

classed as unjust under this understanding of distributive justice.

This final analysis of distributive justice, if correct, explains much of the confusion which there has been throughout American history concerning just distribution of health care. Section V has shown how the very nature of health care has changed in the past two hundred years, and further, how the expectations of health care have changed in that time. We expect more of an M.D. now that we did during colonial times, and we therefore consider medical care to be more of a necessity to life than we did then. Each time health care becomes more important to us, we are more inclined to see it as necessary for others, even for those who cannot obtain it by their own means. We also become more sensitive to the tendency which illness has to reduce our ability to provide for ourselves. With those considerations in mind, it becomes reasonable and quite ethical to devise mechanisms so that basic medical needs are met regardless of individual means. But there is nothing constant about the category which we label, "basic medical needs"; it has changed enormously in the past, and is likely to continue to do so.

So each year we have a new understanding of what medicine is, and our concepts of decent medical care likewise change. Each time this happens, we become less sure about our previous methods of distributing health care, wondering if our society is benefitting as much as it could from our new technological expertise. It is not that just distribution changes each time medicine changes. What changes is what sort of social arrangements for health care a rational individual would agree to.

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VITA

Michael James Booker was born in Augsburg, the Federal Republic of Germany, on December 26, 1961. He graduated from Mankato East High School in June 1979. The following September he entered Mankato State University in Mankato, Minnesota, and in 1982 he received a Bachelor of Arts degree in International Relations with minors in French and Philosophy. The next year he served as a Short-Term Missionary with the Evangelical Covenant Church in the city of Chung Ho, Taiwan R.O.C. In the fall of 1983 he returned to the United States to begin graduate study in Philosophy with a concentration in Medical Ethics at the University of Tennessee, Knoxville. As a graduate student, he worked both as a Graduate Assistant and as a Graduate Teaching Assistant. He received a Master of Arts degree in Philosophy in March of 1987.

The author is a Specialist Four in the Tennessee Army National Guard and a member of Phi Kappa Phi.