

THE ETHICS OF DISTRIBUTION

INTRODUCTION

The present chapter should be a book. The problems are complex, and even basic concepts such as need, contribution, disease, health, and health care are ambiguous. In addition, many if not most of the ethical problems of distribution involve the whole society and its common good. In this chapter, then, we attempt first to clarify these key concepts and then to provide a brief introduction to the problems of allocation of health care. Although we will attempt to establish principles for the distribution of goods and services, often we can only point out the complexity of the facts that society must consider in attempting to distribute goods in such a way that the dignity of the individual person is preserved.

Disease: any deficit in the physical form or physiological or psychological functioning of the individual in terms of what society wants or expects from that individual or in terms of what the individual wants or expects for himself or herself.

FOCUS QUESTION: *Should all human beings have community supported access to reasonable life-sustaining health care?*

THE GOALS OF HEALTH CARE

The initial step in this evaluation involves understanding the psychosocial nature of health and disease. This requires, first, a definition of terms and, second, an indication of how variations in this definition can affect what is expected from the health care system. We are not attempting here to define any particular condition, but we wish to show how social expectations and habits influence what we perceive to be good or bad. This evaluation lies at the heart of particular health conditions and so ultimately determines society's recognition of a need for health care.

Health and disease can be understood only in terms of what is perceived to be significant because to talk of health and disease is to assume a privileged

position. From a global biological perspective, there is no health or disease; there are only different organisms competing for survival in the ways available to them. For example, a bacterium is simply a living organism with its own structure and evolutionary strategy for survival. That it causes pneumonia in a human being is the result of a coincidence of location and the biological response of the human being. Further, age, physical condition, and stress can strongly influence the person's biological response. Thus, like justice, although perhaps more surprisingly, health and disease can be fully understood only in their social context.

In noting the social context of definitions of health and disease, we do not mean to deny the scientific nature of much of what contributes to health care. We simply mean that health and disease are not exclusively biological or physiological. On the contrary, health and disease are loaded with social and subjective concerns, as well as objective scientific criteria. Indeed, most scientific considerations are nested within larger and controlling social and subjective issues (Ehrenreich and English, 1979; Rosenberg, 1979; Oppl and von Kardorff, 1990).

These social and subjective considerations take several forms. Social conditions influence and may control the recognition of a problem and, once recognized, its determined degree of seriousness. In other words, people may suffer the symptoms of a disease without ever considering themselves to be ill. The point at which a collection of symptoms is admitted to be an illness varies greatly with social background (Spector, 1985; Starr, 1982). For example, some people will not admit that they are ill until they cannot continue to work. Others consider themselves ill if they feel any discomfort or pain. Even the type of symptoms counted varies with social background. Social conditions may also encourage the perception of a behavior, once accepted, as a disease. For example, the dramatic growth in the diagnosis of hyperactivity or attention deficit hyperactivity disorder is a study in the effect of changing cultural expectations regarding the behavior of children (Diller, 1996). Also, back pain in the United States is a common "disease" and not often found in other countries.

Because of the influence of social concerns on the recognition of disease, we define a disease as *any deficit in the physical form or physiological or psychological functioning of the individual in terms of what society wants or expects from that individual or in terms of what the individual wants or expects for himself or herself*. As defined, disease involves a reference to the desires of the society and those of the individual and not merely to physiological functioning (see Callahan, 1991). Even "symptoms" vary with regard to society, as for example in hypertension where there are no symptoms experienced by the patient, only the results of a test.

This definition of disease emphasizes the role of the society and the individual in defining disease. Certainly, the biological and physiological

elements are included. If a tumor causes such pain that the individual cannot get out of bed or even think, then it meets the criteria of a disease. On the other hand, an individual with arthritis may not consider himself or herself as having a disease as long as he or she can function effectively. Similarly, society may consider arthritis a disease only when it makes the individual unable to contribute anything to society. Thus, by recognizing or emphasizing (or by denying and de-emphasizing) particular physiological conditions, social and individual expectations and history influence the presence or absence of disease.

Although individuals and the society at large are the major actors in deciding what is a disease, the health care professions, acting as agents of society, have an important role to play. As we mentioned in chapter 1, health care professionals possess special knowledge and are thus responsible for mediating between the needs of the patient and the social resources available to care for that patient. Furthermore, the professions' social responsibility includes direct participation in the decisions about what constitutes a disease and its appropriate treatment. The health care professions have not always been helpful to society and may on occasion be self-serving. Despite these reservations, the health care professions are needed to help society and individuals to make informed judgments about what should be considered a disease and how to marshal our resources against it.

Given our definition of disease, health is easily understood as the *lack* of any deficit in the physical form or psychological functioning in terms of what the society wants or expects from that individual or in terms of what the individual wants or expects for himself or herself. If you can do what you want or expect to do or what society wants or expects, then you are healthy.

Disagreement in Defining Disease

The conceptions of health and disease held by individuals and society may vary widely enough to allow two people to look at the same condition and evaluate it very differently. There are health authorities who argue that the low body fat levels, the enlarged heart, and the stress on muscles and ligaments characteristic of athletes indicate an actual decrease in their health, while many others argue that athletes who "suffer" from all these conditions represent the genuinely healthy individuals in our society. Not only is it necessary to understand the social circumstances and personal expectations of the individual in order to be able to understand their "health" or "disease," but it must be further recognized that one will bring to that analysis presuppositions, or prejudices, that will strongly influence the analysis. When a disease has its own lobbying group, the disease gets disproportionate attention. If the presuppositions and prejudices enlarge the scope of disease, they will create a demand for health care that makes it even more difficult to distribute scarce resources for the service of all members of the society.

Not only may there be differences among individuals in their understanding of disease, but there may be differences between the individual and society as well. As we have seen, both have different concerns, interests, and responsibilities, which may lead to conflicting evaluations. A father caring for his desperately ill son may not accept society's (i.e., the health care system's) judgment that his son should not receive the organ transplant that he needs. Although society sees a boy too ill to be likely to survive treatment and thus an inappropriate risk of scarce resources, the father sees only his son. Both are correct. Yet when it comes to the distribution of health care, the society's judgment will prevail when the individual cannot afford to pay for treatment or when resources are apportioned.

The tragic dimension of this conflict results from the irreconcilability of the two perspectives under current historical and material conditions. Only so much can be done and, given differences in perspective, the judgment of what should be done will be contested. Deciding against the desires of the individual and her or his definition of disease is not an attack on the dignity of the individual if there are socially significant reasons for doing so. This irreconcilability between the views and concerns of the society and those of the individual is not simple ambiguity: it is a genuine difference in interest and perspective that will remain in any system.

This conflict between individual and social definitions of disease can be a danger to a fair system of distribution in that the society's power can be used to silence the anguish of the individual. Fair distribution and even political stability require a continuing dialogue between the society and the individual on what counts. To maintain this dialogue, the potentially tragic dimensions of distribution must always be acknowledged, and the society must restrain itself and hear the individual (another way of explaining the need for autonomy). It is only by an honest attempt to mediate both concerns that there will be growth in the understanding of what fair distribution is all about.

The Goals of Health Care

As we discussed in chapter 1, there is some ambiguity about the purpose of health care. It is usually assumed, as part of our "common sense," that health care is a good. It is, however, an instrumental good; that is, it is not a good for its own sake, but a means that helps us to attain some other good. In the next paragraphs, we attempt to remove some of the ambiguity so that the choices and their implications for distribution become clearer.

One possible goal of health care is the prolongation of life. Modern medicine has been developed over the last 300 years in light of the hope that all human dysfunction can be eliminated, thus putting death off indefinitely. In other words, in our culture we expect medicine to help us to avoid or indefinitely postpone death. Yet every living, natural organism dies. Thus, the hope that health care may forestall death indefinitely is not based on any

scientific evidence. This hope is a social intention that overlays the scientific investigation of life and disease. This hope creates in many individuals a socially induced need for medical care that may go far beyond what medicine can accomplish.

This hope, based on impossible roots, can have a devastating effect on human dignity and on a society's resources. There is now a wide variety of technical means to extend life: respirators, mechanical hearts, dialysis machines, and many other devices. But what kind of life is maintained under such conditions? The increasing number of well-publicized cases of mercy killing indicates a growing uneasiness with the vision of life hooked up to such devices. (We will return to this question in chapter 7.) It is also the case that such life-prolonging efforts are tremendously expensive. For example, one-quarter of all Medicare funds are spent during the last year of a person's life, and most of that is spent during the last month. Much of this money is spent prolonging dying and represents scarce resources that could be used to maintain and improve health. This purpose does not appear to serve any inherent need since we do not seem built to last forever. Furthermore, the socially induced need must be reduced if society is to distribute its scarce resources most effectively.

A second possible goal of health care is to alleviate suffering. Most of us will agree that people should live their lives as free as reasonably possible from pain. But what is pain or suffering? Pain is a personal or private experience, and it is very difficult to accurately comprehend the pain another individual is suffering. Also, what is the purpose of alleviating suffering? If we alleviate suffering without dealing with the cause of that suffering, we are simply masking the pain. Is it better to mask pain, or should we be left suffering so as to be forced to act to change the conditions that caused the suffering?

For example, painkillers are certainly useful and appropriate in many cases. A woman suffering from incurable cancer is aided by morphine in a way that many see as totally consistent with her dignity. But another woman, suffering from disorientation and loneliness, is kept sedated in an understaffed nursing home against all understanding of human dignity. Human beings ought to be spared senseless suffering, but ought not be warehoused like used machinery.

There are less dramatic examples of how the alleviation of suffering can be abused. Some drugs on the market, for example, are highly effective in treating ulcers by stopping acid production in the stomach and thus preventing pain. In most cases, such treatment does not deal with the underlying cause of the ulcer, such as stress or excessive use of alcohol or the presence of a bacterium. Thus, the drug effectively masks the true problem, allowing it to continue and perhaps cause greater problems elsewhere in the body.

These considerations make it clear that prolonging life and alleviating suffering are not always goods; that is, they do not always fulfill a need so as to protect the dignity of the person. As we will see in chapter 7 in our discussion of death and dying, there is a wide variation of estimates of what counts as too much suffering. If health care takes on the task of alleviating suffering, it is going to have to confront that variety and be responsible for judging private emotional as well as physical conditions.

The third possible goal is to optimize the patient's chance for a happy and productive life as defined by the patient. One problem with this suggestion, as we have already seen, is that society has a decisive role in defining health and disease. This is a role that society cannot abrogate because of its own need for survival. In the context of socially financed or socially delivered health care, the debate on the meaning of optimum health care would be endless and would probably lead to no improvement in government-sponsored health care.

The consequences of optimization for fair distribution are also quite significant. Enormous amounts of resources will be affected by even small gradients of change in the meaning of optimum. Take as an example mental health. Should we be free of only those anxieties that prevent us from functioning at all, should we be free of all but minor anxieties, or should we be free of all anxieties? An attempt to free the members of a society of all but minor anxieties would not only be fantastically expensive but probably impossible.

Optimizing the happy and productive life of a person is certainly a possible goal of health care. Unfortunately, the insistence on such optimization will cause grave problems in distribution. As we will point out shortly, it is probably safer and more realistic to speak of adequate measures of happiness and productivity.

Because of the social influence on ideas of happiness and productivity, it should be clear that the definitions of the individual must be reconciled with the ideas of the society. As already noted with regard to the mere prolongation of life, society may have to change the induced need in order to better address the problem of distribution.

We should also note a further problem in identifying the goal of health care. Not only may health care have an obvious, or generally intended, purpose but, in its instrumental capacity, health care can be used to serve several less obvious ends. In our economic and social systems, health care delivery not only takes care of patients, but it also pays the salaries of and provides social status and psychic satisfaction for health care providers. Any understanding of the purpose of health care is going to be influenced by the economic, social, and psychic concerns of health care providers. Such concerns are not the goal of the health care system, but can easily be treated as if they were.

For the present, we will proceed as if health care is generally a good, but with an indeterminate goal. Thus, we must recognize the possibility that there are cases in which it is not a good, and we will recall the potentially self-serving aspects of the role of health care providers in defining health and providing health care.

Health Care Has Its Own Limit

In light of these concerns, there is also a limit intrinsic to health care based on the limits of medical and health care knowledge. The knowledge or skill of a health care professional is a combination of science, experience, and compassion. Much importance has been placed on health care as a science, but questions have been raised recently about what it means to say that health care is based on scientific knowledge.

According to Bursztajn et al. (1981), Americans have exaggerated ideas of the power of health care and medical knowledge because they have a dubious concept of science in general and of medical knowledge in particular. Many people believe that health care is simply a matter of scientifically and certainly identifying the cause of a problem and treating it with a scientifically validated drug or procedure. They expect that this cause can be identified by a diagnostic procedure that will give a clear and unambiguous answer. They further expect that the treatment will be equally precise and straightforward. It is as though medicine, in particular, is a kind of magic that offers cures and restoration beyond the frustrations and limits we find in other areas of human life.

Medical advances and reports in the popular press seem to validate this attitude. The advances made during the twentieth century stem from identifying the causes of diseases such as influenza, polio, smallpox, whooping cough, and many others. Once identified, these diseases were treated with recently developed miracle drugs or vaccines, which drastically limited their destructive effects, leading to an increase in life expectancy and to a decrease in infant mortality.

But whatever their impact on the daily lives of people, these successes have created an impression about health care that obscures the nature of many health problems. For example, hypertension, a clinical problem that figures in many diseases, is apparently the result of several different factors: genetic history, health habits, and stress. Identifying the contribution of each of these factors, and even how they influence one another, is a much more complex problem than identifying the virus that causes smallpox. Health care for these problems must settle for diagnoses that are probable, rather than certain, because the diagnosis reflects the recognition that a disease may have many interrelated causes. Indeed, some causes of a disease may be beyond the reach of any health care.

The limits of medical diagnosis and of all forms of health care need to be acknowledged if we are to have a realistic view of the extent to which they

can satisfy needs and should be supported by society. Indeed, the removal of exaggerated views about the magic of modern health care can do much to mitigate the demand for health care and so decrease the costs. Such realism should result in making it possible to serve more people with fewer scarce resources. This point needs to be stressed, since even the wealthy American society has long since arrived at a point where the cost of health care can no longer be disregarded and is likely looking at a future where this level of spending cannot be sustained.

Humane Health Care

Society will be working toward a distribution of basic health care that is adequate for the restoration and preservation of health as society defines it. This basic and adequate health care may be called humane insofar as it protects the dignity of the individual person.

When the absence of a certain type of health care leads to early death, disfigurement, or loss of the functions necessary to take one's place in society, we have certainly fallen below the basic minimum of health care for American society. In other words, the absent care is part of the basic and adequate minimum. It is basic because, in our society at our stage of ethical, scientific, and technological development, the dignity of the individual demands that we employ reliable and ordinary means to maintain a certain minimum level of treatment. This minimum level requires that

- the individual gain relief from debilitating pain;
- the individual be restored at least the minimum ability to function valued by society;
- the individual be spared a death that is the result of trivial or avoidable circumstances;
- the individual be spared disfigurement that will make him or her repugnant to society and himself or herself; and
- the individual be spared a loss of function that will make him or her unable to share the actions, burdens, and accomplishments that membership in society demands.

In this area, the society has limited freedom to specify what basic needs are and how they will be met. What limits the freedom of society in specifying these needs are the demands of human dignity and the extent of the society's resources. Both concerns are limits, for the society must not only protect its members by protecting their dignity, but it must also protect itself by protecting its resources. Thus, the society must refer to considerations broader than those viewed by the individual, considerations such as the individual's contribution to society and the cost-benefit ratio of any treatment. It will not be obligated to treat a private in the army in the same way as the president,

nor will it have the obligation to provide the most expensive false teeth if a cheaper pair will do the job. Granted a superabundance of resources, society might specify a right to all these things, but we can see no general right that would call for such specifications.

In these decisions, the functioning desired by the individual cannot control the definition of adequate care, since we know that resources would not permit satisfying all those desires. The distribution, then, will undoubtedly leave some individual sick in his or her own estimation; that is, below his or her desired level of functioning. As noted earlier, there is a genuine and irreconcilable difference in concerns and perspective between the individual and society. We cannot argue that a person who demands social payment for health care has a right to establish the level and type of treatment that will be received. Only the reasonable desires of the individual for health care need to be satisfied and everyone must understand that the reasonableness of the desire for restored function depends on the judgment of society as well as of the individual.

THEORIES AND THEIR LIMITS

Many theories have been proposed for solving the problem of distribution. Most of these theories fail because they disregard one or more of the reality factors that we mentioned at the beginning of the chapter.¹ In practice, however, need and contribution are the main factors in the just distribution of all goods. We have already developed the place of need in the process; after a brief consideration of the more likely—but still defective—theories, we will return to develop the importance of contribution as the second great norm of distribution.

The Basic Concerns: Need

A need is a deficit or a lack of something considered requisite (i.e., necessary). Many needs, if unsatisfied, will lead to the destruction of the human person. This brief explanation of the concept of need can be made a little clearer, albeit more complicated, by making the following distinctions.

Needs can be inherent, subjective, or socially induced. An inherent need exists no matter what the individual person may think about the matter. Thus, everyone has an inherent need for a certain minimal amount of nourishment. If food is not taken for a long time, the person will grow feeble, will be unable to function, and may even die. The amount needed may vary with the body size of the person, but it is rooted in the reality of living beings in general.

Subjective needs, on the other hand, grow out of the ideas and desires of the individual. These needs may be peculiar to the individual, as when someone in love claims that they “need” the other. Or they may be socially induced, as when anyone over the age of 16 who lives in a suburban area “needs” a car. Often, when these subjective needs are socially induced, they mimic inherent needs and must be addressed, as when adults say that they “need” a job.

Socially induced needs are a result of a historical development of material and social conditions coupled with a social consensus that some things are necessary for happiness, social life, or some other goal. In our society, indoor plumbing and running water are considered necessities. Most Americans would agree with this, although it is clear that societies survived and often flourished without these necessary goods. Even today, many societies lack the wealth and infrastructure to supply these goods to the majority of their people. Yet, Americans experience these and hundreds of other items as necessary because their society both produces these goods and teaches their necessity. Examples include television sets, microwave ovens, showers in the bathroom, air conditioning, and a private phone line. The cellular phone and the personal computer with connection to the Internet are becoming socially induced necessities.

It is clear that socially induced needs grow historically and so create ever-increasing demands on individuals and society. The restless human being is forever discovering new and better ways to satisfy the need for shelter, food, education, defense, and health care. Each new invention creates a demand or a need for itself, and full participation in society often requires access to these new inventions. The existence of these socially induced needs and their relationship to human dignity can be adequately understood only in the actual circumstances of a given society. In short, what is necessary in one society is not always necessary in all societies. In view of this, there cannot be a definitive list of things that are needed. Indeed, the list keeps changing, creating ever-new demands for the goods in question.

It should be noted carefully that because individuals vary enormously in their natural endowments, desires, and social situations and sensitivity to social pressure, all needs are not equal in practice. Some need more food and health care than others. Others need less elaborate shelter and clothing. Very much to the point, a healthy population needs less health care than a sickly one. So, too, older people generally need more health care than young adults. These differences in need eliminate the possibility of a simple egalitarian solution to the problem of distribution.

Need will be one, but not the only, basis for the distribution of health care. Contribution to society will also enter into the distribution.

The Basic Concerns: Contribution

If there are no contributions to society, there is nothing to distribute; that is, no society produces anything without the effort of its people. For this obvious reason, all societies have found it necessary to base at least part of the distribution of goods, health care included, on the contribution of groups and individuals. This acknowledgment of contribution motivates contribution and so is essential to the functioning of society.

It should be noted that economic contribution is not the only form of contribution and payment not the only form of reward. Individuals create

a variety of political and social goods that enrich society. The father and mother who raise good children, for example, may make the biggest contribution of all: the good citizen. Teachers make enormous contributions by training students for the key positions in society. The U.S. Department of Veterans Affairs, with its educational benefits, home mortgages, hospitals, insurance plans, and other programs, is designed to reward those who served in the military. These benefits are intended to be rewards for service and inducements to continued service. The political and social health of a society depends directly on continued contributions in key areas of the society. All these contributions should be weighed in a fair and prudent theory of distribution.

Distributive Justice: Needs and Contribution

The nuanced concepts of need, contribution, and health developed earlier in this chapter must be kept in mind in considering the ethical applications of these concepts. Our earlier treatment may even be considered as additional criticism of any theory that neglects one or more aspects of the problem.

A system of justice based on need alone holds that a just system provides goods to its members simply on the basis of their demonstrated need and their inability to satisfy it on their own.² The individual is the exclusive focus of this theory of distribution, and the individual is understood in his or her uniqueness; that is, in terms of his or her particular problems and possibilities. For example, an individual with allergies has a need for specialized medical treatment. Simply because the person has this need, this theory entitles her or him to receive treatment for it.

If the individual cannot get the treatment on her or his own, the individual has a claim for treatment against the larger society. A society that does not strive to supply what a person really needs attacks the dignity of the person. Thus, denying food to a starving person is an attack on his or her health and life and so on the dignity of that person. In line with our insistence on the dignity of the person, we may say that a person has a right to the satisfaction of needs connected with his or her dignity. Insofar as health care can satisfy such a need, a person can claim a right to it. When the individual cannot satisfy the need on his or her own, the right is a claim against society.

Two things must be stressed. First, the right to health care does not specify for whom or how the right is to be honored. Second, even when there is a claim against society for the health care, this does not specify how the society shall fulfill the claim. The fulfillment does not necessarily or always involve government intervention. Indeed, such government intervention may be a last resort to be used only after society has failed to set other mechanisms in place.

A theory of distribution based on need alone has an intuitive attractiveness, but it ignores not only contribution, but the power of society in defining and creating needs as it defines disease and health care. In short, it refuses

to face the real world as outlined earlier in this chapter. Finally, it neither considers the scarcity of resources nor the importance of a differential in distribution in order to motivate contributions. Need, however, remains one of the principal factors in any just theory of distribution.

Contribution

The contributions of individuals to society must be acknowledged in practice. Failure to do so undermines a powerful motive for producing goods and leaves the society with less to distribute. Nowhere is this clearer than under communism, which believed “to each according to his need, from each according to his ability.” The communists failed to recognize that contribution, when added to other factors, leads to the economic problems that ultimately forced the collapse of many communist societies. The need to protect society and increase production of goods in short supply demands that contribution as well as need must be considered.

The provision of a return for contribution also helps to avoid paternalism and foster a respect for the right of the individual to make her or his own decisions; that is, it provides the consumer some freedom of choice. Although it is always tempting to say that everyone should eat certain foods or be sheltered in a certain manner and even to dictate how much medical care a person should consume, the fact is that people have different needs and tastes. This is a result not only of differences in biological and social needs, but also of differences in subgroup membership and individual choices. As long as individual choice, subgroup autonomy, and individual differences are valued in American society (and it is our position that on moral grounds they should be in any society), they should be respected in the distribution of the basic goods.

Practical Wisdom and Just Distribution

In short, a just distribution must consider both need and contribution. How is each to be judged and the distribution accomplished? It is the authors' contention that justice as distribution is accomplished through the application of practical wisdom to meet the demands (needs) of human dignity in the social and economic circumstances of the time. Justice thus involves respecting human dignity, satisfying human needs, and recognizing human contributions within the system and in ways that are characteristic of the system.

The specific definition of human dignity and the specific demands that flow from it fluctuate according to a number of factors: the traditions and goals of the particular society, the available economic and social resources, the current understanding of the meaning of appropriate social ideals, the power and persuasiveness of political authority, the consensus of the society in the distribution, and the preferences of individuals.

In attempting to promote human dignity, the traditions and goals of a particular society must take into consideration both the strengths and weaknesses

of individuals. For example, in the United States the economic system tries to encourage industriousness and efficiency as socially beneficial ideals. It does this by rewarding the pursuit of selfish interests in the belief that such selfishness can be turned to the advantage of the common good by increasing productivity. Unfortunately, without the moderating influence of other social values, the system can isolate many individuals who do not fit the model well; their strengths might not be in industriousness or efficiency, but in artistic conception and expression or tender care for the sick and dying. As a result, these individuals who do not flourish under capitalist competition may not receive their share of health care when looked at from the perspective of other social values. This, in turn, raises questions about the adequacy of a pure capitalist market distribution of health care resources. For all that, most of the distribution should take place because people are able to purchase what they want and need. Where that is not possible, society as a whole must intervene directly or indirectly.

These questions illustrate how our understanding of the demands of human dignity evolves and why the actual practical principles of justice can be specified only through the historical circumstances of a society. Both the identification of general principles and the specification of these principles take place in a social tradition. There is a rough form of practical wisdom at work as the community faces the tasks of surviving through changing circumstances. This practical wisdom works through the history and language of this tradition; concepts are informed and understood in terms of the tradition, and social consciousness exists as its derivation. From the original doubts of the country's founding fathers about the institution of slavery, through the Civil War, to the civil rights movement of the 1950s and 1960s, American culture has evolved both an intellectual understanding and an emotional awareness regarding the practical issues of civil rights. This understanding is fragmented among different factors of the society and is changing (one hopes improving) as new issues are raised, such as hiring quotas and reverse discrimination. In short, justice in practice is not the result of the application of a few simple principles, but also a question of politics and social consensus. It is a ragged sort of justice, but all we have in the face of the reality of human existence.

In deciding difficult cases, the factor of contribution or potential contribution becomes important, even critical. When the basic needs for health care as previously defined have been met, society has discretion in the use of its funds for health care or any of the other essential goods, whichever promotes the public good. Here the utilitarian principle of the greatest good for the greatest number seems justified, within the general limits of human dignity.

Social Priorities

Political and economic realities force us to acknowledge that costs of basic goods, including health care, must be considered when dealing with scarce

resources. One cannot simply say that cost should not be considered just because it is unpleasant to consider it. Here, as elsewhere, the basic dilemma of guns or butter remains prominent. No society can provide everything that everyone needs, let alone what everyone wants. Just as political considerations must be acknowledged to avert the danger of revolution, economic considerations must be acknowledged to prevent destroying the economy.

There can be no general right to the best a society can offer because in an era of scarce resources (which will most likely be our permanent condition) a society would destroy itself if it tried to provide all of its members with the best of every material advantage.

Ethical distribution, then, must provide for priorities and a system of allocating resources that at least regularizes expectations in the light of what is politically and economically possible. Appeals to such norms as equality or equality of opportunity as a principle of distribution are useless if there is not and never will be enough to go around or if such appeals define their terms in ways alien to the society.

For these reasons, we emphasize the centrality of practical wisdom in ethical decision making. As our ability to recognize and tackle social problems, including health problems, develops, as our political understanding of such issues improves, and as our economic ability to satisfy human needs changes, we will be called on time and again to rethink our ethical decisions and commitments. Our practical wisdom must balance the shifting demands and possibilities that our changing circumstances present.

Health Care versus Public Health

Granted that health care is generally the focus of discussions of distribution, health care alone is not enough to promote health, long life, and reduced suffering. Health education and public health measures, such as sewage treatment, water purification, smog control, safety inspections at work sites, and school lunch programs, are equally if not more important. It is increasingly clear that a person's lifestyle and genetic endowment are key determinants of health. Thus, alcohol and tobacco use, secondhand smoke, asbestos in buildings, and illegal drugs, as well as nutrition and sleep habits, all affect health. The Environmental Protection Agency, the Occupational Safety and Health Agency, and school lunch programs are health programs that should not be neglected in the name of health care.

This distinction between health care and public health will pose a problem in the ethics of distribution. Society must decide how much it wants to dedicate to public health and health education, which will prevent disease in the future, and how much to health care, which seeks to cure or rehabilitate here and now. It is not obvious that one should always take precedence over the other. One major difficulty in making this decision is found in the fact that education and public health measures save statistical lives, rather than

identified lives.³ No one ever knows that she or he was saved from a disease by public health measures, even if the incidence of that disease has dropped significantly. On the other hand, anyone sick who is cured by a physician or nurse fully appreciates the influence of health care on her or his situation. The emotional difference between the influence of public health and that of health care must be recognized in forming a policy on public health. Once again, the actual situation, the resources available, and the definitions of a given society will have to be weighed and balanced to allocate efforts in a manner consonant with human dignity.

A Very Current Example: The Patient Protection and Affordable Care Act

In March 2010, President Barack Obama signed the Patient Protection and Affordable Care Act. This is a sprawling legislative act which complexity makes it difficult to summarize. However, the purpose of this act is three fold: limit increases in health care spending, to insure access to health care, and to improve and control the quality of health care delivered. Both the nature and scope of the act reflect the complexity of concerns we have discussed in establishing ethical distribution of health care, notably the conflict between the ideals of acknowledging the demands of human dignity and humane health care, and the financial concerns that grow out of a particular society's traditions and economic system. To use one central issue as an example, there is a mandate that all individuals must purchase health insurance either from private insurers or the government. The idea that all people have health insurance and thus access to health care is an important recognition of the dignity of all people and their need of health care (and for that matter, a significant contribution to public health). It is also an effort to control insurance costs by requiring young and healthy people to have insurance, thus spreading more widely the risk pool from which insurers draw their funds. But the government mandate that individuals must purchase such health insurance runs afoul of the individual's autonomy and, in capitalism, the individual's right to make their own decisions to enter or not to enter into contracts. The Supreme Court of the United States upheld the legality of this mandate because it is enforced as a tax, thus side-stepping any direct legal decision on the impact of this mandate on the right of the individual to make decisions regarding entering into contracts.

MICROALLOCATION: INDIVIDUAL AND INSTITUTIONAL RATIONING

A balanced distribution is not the result of society's efforts alone. The individual, as well as health care professions and institutions, must be present in the dialogue. That is, the distribution of health care is influenced not only by political and social decisions, but also by microallocation.

Although society can control macroallocation, individuals, both lay and professional, as well as institutions such as nursing homes and hospitals, are deeply involved in microallocation on a daily basis. Both the patient and the health care professional are engaged in triage or at least the allocation of their time and energies. Hospitals and health care institutions are faced with rationing decisions on the basis of their resources and the ability of the patient to pay. All these groups have a great impact on what health care is offered to an individual, but their influence is limited by the macroallocation of the society.

Triage and the Health Care Provider

The term *triage* originated in military medicine, in which it refers to the process of sorting sick and wounded soldiers on the basis of urgency and type of problem so that they can be sent to the proper treatment facility. The triage rules for emergency surgery in war call for giving first preference to the slightly injured who can be quickly returned to battle, with second place being given to the more seriously injured who need immediate treatment. The hopelessly wounded are treated last.

By extension, triage can be used for the prioritizing of treatment in catastrophes and emergency rooms. In a disaster, for examples, rules like the following apply: give first preference to those who need treatment to survive. Give second place to those who will survive without treatment, and give last place to those who will not survive even with treatment. Emergency room triage may introduce additional distinctions. First place might go to those who have life-threatening conditions that, if not treated immediately, will cause serious physical injury. Emergency rooms may well put the third-priority military group in this first position, even though they will not recover with treatment. Second come those who will require treatment within thirty minutes to two hours before being threatened with serious physical injury. Finally, there are those who at the time of examination are not critical and do not require treatment to survive.

Military triage and any other triage that is not based on individual need but on social concerns might be quite different. In military triage, the good of the group is given precedence over the good of the individual, so the contribution made by an individual to the group, rather than the need of the individual, is made the primary criterion of judgment. Jonsen, Siegler, and Winslade (1986) note that, when penicillin was scarce during World War II, it was given first to soldiers with venereal diseases, rather than to the wounded. Those with venereal disease could be returned to the battle much more quickly than the wounded.

Because most triage is done in emergency or crisis situations, it generally and correctly disregards everything but the medical indications and the good of the individual patient. Although emergency room triage sometimes disregards medical indications when it treats a hopeless patient, this is a reflection

of a social belief in the magic of medicine, which suggests that no one is beyond help and that everything possible ought to be done.

We can expect current triage practices in emergency situations to change as cost factors make society aware that we cannot afford to use resources when no good can be accomplished. Cost factors and other considerations involving a recognition of the limits of health care are currently eroding the belief that no one is beyond help and that everything possible ought to be done (see chapter 7).

More importantly, this interaction between costs and hopes in the emergency room is paralleled by the system-wide discussion we have been outlining in this chapter. Efforts found in managed care corporations or in government, such as the Oregon plan for distributing Medicare and Medicaid funds, are essentially triage on a larger scale. Not only are we now seeing a more close social evaluation of the benefits expected from treatments, but we may also see a lowered priority assigned to those who have a life-threatening condition but little or no contribution to make to society. For example, should dialysis be withheld from diabetics who are also alcoholics and homeless? This is a shocking thought because it involves judging the value of human life in terms of social utility; that is, it is a matter of making social investments that will reap the best returns. Yet this type of judgment may become a fact of life as society is forced to give more consideration to efficiency under the constraints of scarcity. The dangers of this shift in attitude demand continued public debate about the tragic ethical conflicts involved.

Dangers of Social Power

The importance we have assigned to the social debate and social consensus is not without its dangers. As society assesses the extent of its own social needs and the limits of its obligations, there is a tendency to overlook the dignity of the person. This is especially true when resources are scarce. The society might stop listening to the needs and expectations of the individual, in particular powerless persons. But the dignity of each person requires that society listen to those who are potential patients. The dialogue must continue despite the conflict between social and individual definitions of disease.

Society may also diminish the dignity of the individual by labeling a person "diseased" without some clear and overriding social justification. Such a process is acceptable only when, all things considered, it is necessary to protect the dignity of other members of the society. Thus, quarantining an individual might be acceptable if he or she has a highly communicable disease. On the other hand, such labeling is not acceptable if it is done because the individual does not have the proper political ideas or does have a limitedly communicable disease associated with socially unacceptable behavior. Even though social concerns are legitimate factors in a decision, the needs of a society are not trump cards that simply override personal dignity.

In labeling or categorizing people for the public good, practical wisdom cannot avoid issues regarding the quality of life. These issues are beyond the scope of medical competence, as, for example, when contribution is included as a factor in awarding care. This opens up the possibility of abusing the dignity of individuals who do not fit the expectations or preferences of those making the political decisions. Thus, the practical requirement of establishing a hierarchy of health care needs raises issues that the society must treat very carefully, for they open the door for a potentially strong paternalism, or even political tyranny. At the same time, there appears to be no other even semiprincipled way of approaching the problem in a world where scarcity is a fact and the need to apportion resources is disregarded at the peril of both the individual and society.

Compounding the problem is the fact that the socially accepted concept of human dignity changes over time and reflects the circumstances of society. This changing social ideal of human dignity must be continuously and critically examined. The examination must involve the entire society in dialogue with all social and political authorities. After all, the demands of dignity do place some limits on what society can impose on the individual. At the very least, dignity requires society to listen to the individual in determining what human function and health care mean. This will be difficult and painful because the discussion must always face the tragic dimensions of human life. If, however, the society fails to hear the individual, it has not merely neglected but destroyed the dignity of the individual.

The Economic Dimension at the Institutional Level

As noted in chapter 3, health care providers, whether individuals or institutions, are not charitable institutions that can supply all services free of charge. Those institutions that received federal monies for certain purposes, such as construction, are legally obliged to care for a certain number of the poor free of charge. This obligation, however, does not call for free treatment of all indigent patients. The needs of the indigent poor would soon overwhelm the resources of any voluntary health care institution. Economics, then, becomes a central factor in an institutional distribution policy.

Up to the present, the American society has permitted economic considerations to enter into microallocation at the institutional level. To prevent such considerations from dominating admissions decisions, the society permitted differential pricing. For example, hospitals were allowed to charge one class of patients more so that it could subsidize the care of the poor. Changes in how medical bills are paid, such as by third-party payers (for example, Blue Cross and Blue Shield), have made such attempts to shift economic burdens ineffective. The health maintenance organizations (HMOs) have exacerbated the problem. They use their power to contract lower rates with the hospital and so decrease the hospital's income. This also slows down or stops cost shifting.

Indeed, a hospital may have all beds filled by HMO patients and be losing money. Those persons without any form of health insurance or government help are thus more vulnerable than ever. The authors are not wise enough to know the solution to this problem, but clearly new mechanisms must be developed to cover those persons without the means to pay, while protecting the existence of these institutions needed to satisfy the needs for care.

Society is faced with two problems; the first concerns the extent to which society will require health care institutions to care for the poor without recompense. The second involves to what extent the society itself will pay for the care of those who cannot pay. In short, we are back to the problem of macroallocation. In the long run, problems cannot be solved on the institutional level without recourse to the societal level.

Microallocation: The Institutional Sphere

A fundamental distinction at the intersection between the societal level of allocation and the institutional level is between health care institutions that are for-profit groups and those that are not-for-profit groups. The not-for-profit groups can be further subdivided into those that are run by the government and those that are controlled by voluntary associations. These, in turn, can be classified as general community hospitals or specialized facilities devoted to only one illness or even to a single class of patients. Because each stands in a different relationship to society, the distributive ethics vary.

The for-profit institutions clearly operate under an entitlement theory and, at the present stage of history, this is correct insofar as they pretend to do no more. To put it another way, inside a socially approved market economy, they are as institutions ethical, if not admirable, when they take those who can pay and reject those who cannot.

Government-owned and -operated general hospitals should be open to all, with priority granted to the economically disadvantaged on the basis of medical need. These hospitals are paid for out of general funds and should be for the good of all citizens, but priority is to be given to the economically disadvantaged on the assumption that those with health insurance or sufficient wealth can obtain services elsewhere. Government hospitals for specialized populations, such as those run by the U.S. Department of Veterans Affairs, should distribute within the limits of their purposes. All this assumes that society has reached some consensus on the levels of need and how they will be satisfied.

Private, voluntary, not-for-profit groups are a more complicated matter. They do not derive their funds from the general funds of society, but they do have special privileges, such as tax-exempt status. In short, voluntary, not-for-profit hospitals are burdened with the public interest because they receive support and income from both the government and their communities. They also derive much of their income from government programs such as Medicare and from other tax-exempt institutions, such as Blue Cross

and Blue Shield. These hospitals are, moreover, so much a part of the local community that they have special relations with and possibly obligations to that community.

Some specialized voluntary hospitals, such as those in academic medical centers, often give preference to interesting cases that are particularly important for teaching health practitioners and increasing knowledge in the field. This is allocation on the basis of potential contribution to society, rather than on the basis of patient need alone.

A Microallocation Problem: Institutional Allocation

No matter what manner of macroallocation is developed by society, the need for a principled method of allocation also exists on an institutional level. Some advocate institutionally fair allocation by the use of procedural rules that either eliminate bias or minimize its effects. Although these rules do not come to grips with the basic economic problem, they should be considered.

One set of procedural rules proposes selection by lottery or by some form of the first-come, first-served rule. Behind these rules is the belief that a strict equality should be the governing principle in allocation decisions. We reject these procedures for the same reason that we rejected the egalitarian view. The rules disregard the differences in need and the fact that the differences must be acknowledged because they are relevant to the dignity of the individual person. If all things were equal, which they never are, then the lottery or first-come, first-served principles might be applicable. In the real world of scarce resources and unequal needs, they merely dodge the issues. Fortunately, these rules are generally not used in practice.

A better proposal is that there be some sort of due process in the allocation of resources. Thus, the allocation might be done by a committee that represents a cross-section of the community. Such a method, it is argued, should prevent any one person from having too much power and so unduly influencing the decision in favor of his or her biases. This proposal has great merit precisely because it looks to the incorporation of a community judgment. The judgment of the local community, however, may not be enough in the face of the economic problem, which seems to call for decisions on the national level. In any event, it should be recognized that committee decisions can lead to trading and back-scratching as well as to balanced judgments. Thus, due process is a step forward, but not a final solution.

In the long run, only some sort of a national policy that represents the broadest possible community judgment will prove reasonably, although never completely, satisfactory. At every step of the way, there must be a dialogue between the society and its members about the nature and meaning of human dignity and how its demands may be met, given the abilities of the society.

Rationing

At the very beginning of this chapter, we noted that the distribution of any scarce resource involves rationing. This means that not everyone can have everything she or he wants. In short, it means limiting consumption and parceling out the goods that can be consumed.

In a society that assumes that everyone can have everything, such rationing is impossible except in times of extreme emergency. To change such a mentality, a society must both face the scarcity and evolve rules for the distribution; that is, the application of the concepts of need and contribution. We suggest the following controversial rules for discussion. Such discussion will illustrate the difficulty of the task of changing social evaluations of health and life itself.

In health care, basic needs such as the preservation of meaningful life must take precedence over mere wants and desires and acquired needs. Thus saving the leg of an otherwise functional diabetic woman has precedence over a treatment that might or might not prolong her life, and might or might not improve the comfort of a functioning individual who already has a fatal condition.

Priority should be given to the needs of individuals who have a chance to resume functioning over the needs of individuals who are never going to be functional in any way or who are already terminal. The dignity of the person demands that comfort care should be administered to this second group, but prolonged treatment merely to keep them minimally alive wastes not only money and energy but is often an affront to the dignity of the person. We shall return to this in chapter 7.

Managed Care and the Common Good

In the early 1990s, the HMO, the most common form of managed care, was proposed as a solution to the problem of scarce resources. Typically a for-profit corporation, an HMO requires its members to enter the system of health care delivery through a gatekeeper—that is, a care manager (a physician-employee) of the HMO who provides basic care and controls access to other forms of care, such as testing and specialists. Thus, the patient's choices are limited so that he or she has little or no role in choosing or rationing health care. By stressing preventive medicine, the gatekeeper is, in theory, supposed to minimize the appearance of serious diseases and in the long run have healthier and less expensive patients.

In many cases, the gatekeeper-physician is rated as an employee, or even rewarded, on the basis of his or her ability to control costs. This creates a tension between the concern to treat the patient properly and to control health care costs adequately. In light of this manner of evaluation, HMOs have been criticized for substituting the goal of controlling costs for that of improving health care. In short, the task of rationing social resources has been put squarely on the shoulders of primary care physicians, who are not necessarily the people best suited for the task (Angell, 1993).

There have been several legislative efforts to limit how far HMOs may go in cutting care. For example, in response to concerns about significant decreases in the length of maternal hospital stays, federal legislation now mandates that a woman and her newborn child may not be forced to leave the hospital earlier than 48 hours after delivery. Beyond such specific interventions, it has proven difficult to seriously restructure the entire health care system, as evidenced by a ten year effort by the U.S. Congress to define and pass a "Patients' Bill of Rights," not to mention the dominance of the discussion of health care reform in American politics for at least two decades.

In the meantime, the changes accompanying HMOs have become the standard of practice for all health care institutions, public and private, profit and non-profit. The economic competition facing these institutions has become sufficiently intense that no institution can avoid being as economically aggressive as possible. All now embrace the principles of managed care.

Some Concerns

While all this was intended to cause a decrease in health care costs for the insurer, it has not done so. The principles of managed care, by themselves, do not lead to a better distribution of health care and so do not necessarily serve society as a whole. Those who are uninsured are still uninsured. The basic health care needs of these people are not met by the system in a significantly better or more complete way than twenty years ago. Indeed, even those who currently receive Medicaid (for the poor) or Medicare (for those over age 65) may find themselves with reduced benefits under state or federally mandated managed care. Some poor people who currently qualify for Medicaid may even find themselves excluded from the revised HMO plans. The Patient Protection and Affordable Care Act has gone a long way to address some of these issues, but it remains untested in terms of the final cost. The government-run "public" health insurance option to provide low-cost, affordable health insurance for everybody is designed to spur competition. Such competition will only occur if the provider will recognize a profit.

The Mechanisms of Distribution and Ideology

The furious debates about managed care and other mechanisms of health care distribution rest on an underlying set of ideologies rooted in the economic concerns of contribution and need. Conservatives wanted to use the market as the main mechanism of allocation. This neglects the fact that the market disregards needs and supplies only those who have the money to purchase the service. At base, it is an overemphasis on contribution. Liberals, on the other hand, incline toward a system that, while it does not completely eliminate the market, tends to make the government the organizer if not the financier of health care distribution. In general, the liberal approach disregards or downplays the scarcity of resources and the necessity of rationing in

favor of meeting needs. In so doing, the liberal position often overlooks the importance of contribution.

To avoid the worst effects of these ideologies, which tend to oversimplify the reality, it is necessary to return constantly to the principles and factors outlined in the previous pages. These principles may not solve the problem of what distribution mechanisms are to be used, but will alert us to the dangers to human dignity that result from the naive acceptance of one or the other abstract simplification.

Finally: Allocation of Resources by the Patient

The patient must make decisions about the allocation of his or her resources among all needs, including those of the family. For example, a parent under age 65 with no medical insurance and no claim to Medicaid will have to decide whether to take a child to the doctor or hospital while taking into consideration not only the medical condition of the child, but also the potential economic damage to the family that might be incurred by the resulting bills. Patients are already constrained by the economic and social organization of health care and make decisions on allocation in terms of careful calculations of results and costs. In other words, the parent must ask if the child is sick enough to justify paying the doctor or going to the trouble of getting medical assistance. The uncertainties and trade-offs in this decision are so intractable that there appear to be no clear ethical guidelines for the individual except that all relevant factors must be considered within the context of the society's macroallocation of resources.

SUMMARY

A just society seeks to protect the dignity of its members and to satisfy their basic needs. Ordinarily, a society accomplishes these two tasks by giving its members the opportunity of satisfying their own needs in their own way. When members cannot satisfy their own needs, the just society specifies how it will attempt to satisfy these needs directly and humanely. In short, society must decide what constitutes a minimum level of satisfaction consistent with human dignity and the resources available. In making this specification and setting this minimum, the society is limited and influenced not only by the needs of members and the resources available, but also by the need to keep itself functioning. These concerns must be weighed and balanced within its own culture, values, and history. Because resources are always scarce, this direct distribution involves a judgment evaluating various sorts of basic needs and various ways of satisfying them directly. In particular, this judgment must recognize the need for rewards for those whose contributions keep society going or produce the surplus from which direct distributions can be made. The ideology of both liberals and conservatives, which would specify the mechanism of overall distribution, must be examined critically in this context.

Directly provided adequate humane health care should include the care necessary for the individual to avoid premature death as measured statistically, to function in society as a productive member, and, when such functioning is no longer possible, to be free of unnecessary physical pain in life and death. Society may decide that it has the resources to do much more than this minimum. That would be a desirable situation. It is not, however, a situation necessary for every society.

There are no easy answers to the question of what is the minimum in a given society and how it is to be attained. As we have suggested, human dignity is maintained only by consistent attempts to be consciously aware of its demands.

CASES FOR ANALYSIS

1. Clozapine (Clozaril) is a drug manufactured by Sandoz for the treatment of severe chronic schizophrenics who are unresponsive to regular treatments. One study indicates that after a year of treatment 68 percent of the treatment-resistant patients were improved. In another study, 55 percent of those improved were able to work or go to school, and readmissions to the mental hospital were reduced by 88 percent (Meltze et al., 1990, p. 892). A third study (Eichelman and Hartwig, 1990) in a state mental hospital showed that over two years the new treatment saved the state \$20,000 a year per patient. In addition, clozapine has a low incidence of side effects, such as tardive dyskinesia, associated with other drugs for schizophrenics. It can, however, produce seizures and tachycardia, which can cause individuals to refuse further treatment. Unfortunately, unless constantly monitored, the drug often produces damage to the bone marrow, reducing immunity and exposing patients to all sorts of infection and even death. The proper use of the drug demands weekly blood tests of peripheral white cell counts. As a result, in the United States the combination of drug and tests costs \$8,944 per person per year for the remainder of the patient's life. One study estimates that it would cost \$1.2 billion a year to treat the 133,000 patients defined as *eligible* for the drug (Terkelsen and Grosser, 1990, p. 866).

If the use of the drug is extended to groups other than the *eligible* group, Terkelsen and Grosser (1990, p. 867) estimate that 186,000 patients could benefit. Under these assumptions, the treatment could cost \$1.7 billion a year. The fact that most eligible patients are indigent makes these figures all the more significant.

Part of the cost seems to be explained by the fact that the manufacturers have insisted that the drug and tests be bought as a package, with the tests being administered by a for-profit home health company, Caremark, Inc. Many professionals feel that the price of the package or system is excessive and that

there is good evidence both here and in England that the testing can be done by other laboratories (Reid, 1990). Sandoz later agreed to sell the drug aside from the whole package.

Do ethics demand that clozapine be authorized for all patients on medical assistance and all patients in state mental institutions? Are additional studies on cost savings necessary? Which principles are to be used here? Why? In answering the questions that follow, it will be well to ask what additional information would be useful or necessary to be more confident of the answer and then push for a decision on the basis of what is known.

Is this drug part of basic adequate care or is it, because of cost, a non-basic treatment? In answering this question, weigh the monetary costs, the side effects, and the fact that much of the drug will be wasted since a fairly high percentage will abandon the treatment. If it is basic, should the law stop Sandoz from increasing costs by insisting on its Patient Management System? Will the decrease in readmissions to mental hospitals and the return to the work force of a significant number of patients offset the costs of the treatment? If there must be a rationing scheme because the resources are limited, what should be the basis of that rationing since we do not know ahead of time who will benefit from the treatment? Can you think of other areas where the same expenditure would help more people and give a greater return to society? Discuss prenatal care, breast cancer prevention, free inoculations for children on medical assistance, alcohol and drug rehabilitation, and antismoking campaigns.

2. Dr. Harried is at work for another typical day. He is seeing 26 patients today. A few years ago a typical day would have been 22 patients but the rising costs of his practice including the electronic medical record system he has put in place and the benefits package for his employees have forced him to see more patients. One year ago he stopped taking patients with one type of insurance because it was paying less than the others.

M., the first patient of the day, presents with a sore knee. He is not sure what caused it. He is aged 38 and well. The exam is not helpful. An X-ray is ordered because his insurance does not cover an MRI. A return visit is ordered to discuss the X-ray results. A medication for inflammation is ordered. P., age 40, presents later in the day with a similar story. An MRI is ordered since it is covered by P's insurance (see Brody, 2010).

Is Dr. Harried ordering based upon what the insurance will cover ethical? Does Dr. Harried have a responsibility to decrease national health care spending or is his role only to treat his patients?

3. A debate erupts when Community Hospital announces that as a cost-saving measure it will close its emergency room from 10:00 P.M. until 6:00 A.M. The hospital explains that it is in danger of going bankrupt, and its emergency room is a very expensive hospital department. Patients will

still be able to receive emergency treatment at the State Hospital 7 miles away. Opponents argue that this will severely restrict indigent patients' access to care.

Granted that Community Hospital is in danger of going bankrupt, is its decision ethical? Is Community Hospital guilty of what is really a form of indirect "dumping" that is not covered by the law? How will the access of indigent patients to health care at State Hospital be limited? Will the poor be unable to get there because they do not have cars and there is no public transportation? Will State Hospital's emergency room be too small to handle the increased patient load? Assuming that the answers to the last two questions are yes, what should the health care community have done to make the general community solve the problem? Do health care professionals have any obligation to mobilize the community to remedy maldistribution? What are the limits of that obligation?

4. When, in the summer of 1996, reports were released on the success of protease inhibitors in treating AIDS, both the government and clinical directors were faced with new problems of distribution. Protease inhibitors were used as part of a drug cocktail that can drive the HIV virus below the level of detection and lead to a great increase in disease-fighting immune cells. But no one knew if the drugs could wipe out HIV lurking in the lymph nodes. Indeed, little had been published. Attention had been focused on dramatic turnabouts, but less attention had been paid to failures, or resurgences of the virus. Since that time many more effective and costly drugs have been produced that are prescribed usually in combination. To date, these treatments have never been proven curative.

Treatments developed would cost between \$10,000 and \$20,000 year at retail. The exact price would depend on the other drugs used in the cocktail. Although most private health insurance and managed care programs cover the treatment, some are restricting its use to the advanced stages of the disease. The decision to treat is usually based upon laboratory tests that show the depression in the immune system (CD₄) and the amount of virus present (viral load). Indeed, there is debate as to when it is best to begin treatment with the newer cocktails. Early treatment might make HIV cells drug-resistant and leave the patient with no drugs when the virus re-emerges. Waiting for even the first symptoms to appear might take five to ten years, making clinical trials difficult.

Even today many infected individuals have no insurance or are underinsured. Clinical directors estimated that they would have to double their income in order to meet the demand for the new treatments. National estimates put the total cost of treating HIV in the billions, with the average total cost of HIV care being near \$20,000 per patient per year. There are, moreover, problems with the treatment. The patient must many per day on

a very tight schedule along with dietary restrictions. In most cases the treatment will last for the rest of the patient's life. There is serious doubt about the ability of drug users, alcohol abusers, and many rootless people to maintain such a regime. This fear is reinforced by the side effects of some of the cocktails: nausea and headaches at the start of treatment. These effects cause some to stop treatment. If the patient starts and then stops, there may be serious social consequences. Specifically, a new drug-resistant form of HIV may develop and spread through the population. Already there are cases of patients who have sold their protease inhibitors in order to purchase street drugs. Newer, once-daily regimens offer a greater likelihood of compliance, but the issue remains. Even aside from the discipline required for the treatment, should the government increase payment for these new antivirals? What health care services or general public services should be reduced to provide this extra money? This is a political and social question that involves the opinion of the whole society.

Should clinic directors refuse to treat those who do not appear to have the discipline to carry through with treatment? If they do treat them, how can they justify the risk of producing new drug-resistant strains of HIV? How are the answers to these questions affected if the clinics receive no new funding?

Notes

1. The utilitarian theory would call for distributing so that the greatest good for the greatest number results. Unfortunately, this tends to subordinate the individual person to some abstract aggregate. The egalitarian theory aims at an equal distribution of goods or at least the opportunity for goods. Unfortunately, needs are not equal, so this would actually lead to a waste of resources. Justice as fairness (Rawls, 1971) is an attempt to balance the basic equality of people with the inequality of their needs and abilities. The inequalities result from a sort of natural lottery and may be tolerated so long as any pattern of inequality is evaluated by effects on the least advantaged members of society. Unfortunately, so many schemes of distribution can be justified by this theory that there is nothing to prevent the fox from ruling the hen house. The fairness theory also disregards the natural selfishness of some people who would forever produce new inequalities for their own profit. Justice as entitlement holds that goods ought to be distributed according to a system of contracts. Without such a contract, a person would have no right to health care or any other good. Most find this offensive, since it would deny basic goods such as food, shelter, and health care to those who do not have a contract or cannot afford one.
2. The communists advocated such a single principle when they preached, "To each according to his needs, from each according to his abilities." They failed for a variety of reasons, not the least of which was the failure to reward contribution properly.

3. In the previous pages we have insisted that in most encounters the primary purpose of medicine and the other health care professions is to treat *the particular patient*. Once having entered into a relationship with this specific and identifiable patient, the health care professional has an obligation to that patient. In the vast majority of cases, then, there is a moral claim of an identified life; that is, a specific person.

The health care professional, however, has obligations to others as well. As just noted, health care professionals, generally through their professional organizations, have obligations to society; that is, a duty to prevent disease, to maintain the health of the populace, and to oversee the delivery of health care. Such work in public health saves *statistical lives*. The people who do not get sick because of public health measures cannot be specified individually. But, in a sense, we know of them through the statistics that show that interventions had a good effect. Individual practitioners can satisfy this obligation to save statistical lives through their professional organizations or through their own actions.