

AN ABSTRACT OF THE THESIS OF

Victoria L. Wetle for the degree of Master of Arts in
Interdisciplinary Studies in the co-departments of Philosophy,
Health and Women Studies presented on December 12, 1986

Title: The Application of John Rawls' Principles of Justice
to Health Care Distribution in the United States

Redacted for Privacy

Abstract approved: _____
Peter List

The principles of justice developed by John Rawls and articulated in his work A Theory of Justice, published in 1971, were used as the evaluative tool in assessing health care distribution in the United States. A model for using Rawls' theory was developed emphasizing the role of the 'least advantaged' as the focal point for evaluating the fairness of the health care distribution system. In the United States the classes of least advantaged were found to be unfairly treated using Rawls' second principle of justice.

The implication for social policy of applying Rawls' principles of justice to the health care delivery system in the United States is that a different means of distribution needs to be instituted, as the present distributive model is unable to guarantee just minimums of care for those in society who are least advantaged. To clarify this conclusion, the United States model of health care delivery was

compared to the socialist model of Sweden and the mixed model of Canada.

Application of Rawls' principles to the health care distribution system demonstrates that these principles can be used in a concrete manner to measure the justice of social policies.

The Application of John Rawls' Principles of Justice
to Health Care Distribution in the United States

by

Victoria L. Wetle

A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Master of Arts
in Interdisciplinary Studies

Completed December 12, 1986

Commencement June 1987

APPROVED:

Redacted for Privacy

Professor of Philosophy in charge of major

Redacted for Privacy

Professor of ~~Women Studies~~ in charge of co-field

Redacted for Privacy

Professor of Health in charge of co-field

Redacted for Privacy

Chairman of Department of Philosophy

Redacted for Privacy

Dean of Graduate School

Date thesis is presented _____ December 12, 1986

Typed by Harvey McCloud for _____ Victoria L. Wetle

ACKNOWLEDGEMENTS

This thesis benefited greatly from the help of several people whom I would like to thank individually. I would first like to express my sincere gratitude to Dr. Peter List, Ph.D., Chairperson of the Philosophy Department, who gave tremendous support and encouragement to the project, as well as much valuable assistance in the actual preparation of the manuscript. The McMinnville Hospital Volunteer Guild which awarded me a scholarship that allowed me to devote a complete term to the writing of this manuscript also deserves many thanks. I appreciate greatly the assistance of Virginia Buchanan RN, Assistant Administrator of Patient Affairs at McMinnville Community Hospital, who not only allowed me a work schedule that made the return to school possible, but also gave me much valuable advice and personal encouragement. A special thanks goes to my friends, especially Marjie and Chereyl, who understood the commitment of time and the postponement of our time together in order to complete this project, and, finally, to Myron, whose coffee and toast made each day better.

TABLE OF CONTENTS

I. INTRODUCTION	1
II. JOHN RAWLS' THEORY OF JUSTICE	9
Introduction	9
Contract Theory in the Original Position	12
The Original Position	14
The First Principle of Justice	27
The Second Principle of Justice -- The Difference Principle	29
III. CRITICS OF <u>A THEORY OF JUSTICE</u>	42
IV. APPLICATION OF RAWLS' THEORY TO HEALTH CARE	54
Health Care as a Primary Good	57
Establishing Health Care Rights Using the Fourth Stage	61
The Second Principle and Health Care	64
Summary	74
V. AN ALTERNATIVE APPROACH TO THE APPLICATION OF JOHN RAWLS' PRINCIPLES	75
Conclusion	84
VI. THE HEALTH CARE SYSTEM OF THE UNITED STATES AND THE LEAST ADVANTAGED	86
Women and the Health Care System in the United States	100
VII. THREE MODELS OF HEALTH CARE DISTRIBUTION	113
Market Model -- The United States	113
The Swedish and Canadian Systems	119
VIII. CONCLUSIONS	123
BIBLIOGRAPHY	127
APPENDIX	134

LIST OF FIGURES

Figure	Page
1. National Health Expenditures.	134
2. Median Household Income in Current Dollars.	135
3. Death Rates per 100,000 population for Male/Female and Black/White.	136
4. Infant and Maternal Mortality by Race.	137

The Application of John Rawls' Principles of Justice to Health Care Distribution in the United States

I. INTRODUCTION

The enactment of the "Medicare-Medicaid" bill, PL 89-974, in 1965 and the "End Stage Renal Disease" bill, PL 92-603, changed the distribution of health care in the United States of America dramatically. Health care delivery went from a system which relied on private practitioners and private charity to a system which made the federal government the single largest broker of health care in the United States (Data Watch, 1985). This change in the delivery and distribution of health care in the United States qualified the health care system as a social institution according to the criteria set forth by John Rawls in A Theory of Justice. The enactment of these two bills entitled large specific segments of the population to social benefits and thus obligated the federal government to provide those benefits in a fair and just manner. The purpose of John Rawls' theory of justice was to derive principles which would serve as moral rules to determine the distribution of social benefits. The subject of this thesis will be the use of those principles as tools to evaluate the health care delivery and distribution system in the United States.

Rawls published A Theory of Justice in 1971, and the principles of justice he developed in the book were linked to questions of health care allocation almost immediately. Rawls himself does not explicitly mention health care except briefly.

However, since his theory of justice provides a method of assessing those social institutions charged with the distribution of all social goods, income, wealth and power, and because health care is such an institution, the application of Rawls' principles to health care distribution is appropriate. Social institutions for Rawls are at the very heart of the structure of a society. They consist of systems of distributive rules which tell people what to expect from those who are members of the institutions and those served by them. In Rawls' theory an institution is both (1) abstract, that is, a sort of ideal of how a particular group of practices, rights and duties relates to society as a whole, and (2) concrete, that is, a specific range of actions and persons at specific times and places which make up the institution. The system of jurisprudence with its laws, courts, practitioners and influence over our daily lives is a good example of what Rawls means by an institution. Health care is a branch of what might be called the institution of general welfare. It consists of practitioners, certain socially expected benefits distributed by it, and a system of legislative and informal duties and rights. As an institution it can be examined and judged as just or unjust by applying Rawls' principles of justice to it.

Health care, and thus health care distribution, is perceived as a special social good because it involves questions which are quite often literally questions of "who will live or die." Several other features of health care make it special. First, the ill individual has no control over certain health care needs; an accident or heart attack can precipitate a need where there has been none for fifty

years. Second, the consequences of non-intervention may be severe, leading to death, disability or deformity. Third, the lack of decision-making information for the consumer creates a subsequent high dependency on the health care provider for guidance in making decisions. Fourth, some types of health care may be largely provided by highly skilled professionals clustered in urban areas and using expensive technology, and therefore access may be difficult for many for certain types of treatment. These conditions of uncertainty, dire consequences, dependency and scarcity make the distribution of health care different from that of other social welfare benefits. Simply stated, the lack of health care may invalidate all other life-plans regardless of wealth or position. The issue of justice then is in high relief in the discussion of social policy on health care delivery. Added to questions of justice in distribution of health care benefits are questions of choice and liberty in how consumers are affected by the health care delivery system and what burdens are placed on the individual by choosing to enter the health care system. These latter questions surface because as a country the United States has a long tradition of protection of the individual's right to extensive liberty in choice of life-style. Questions involving a patient's right to refuse treatment and issues of risk-taking are examples of the latter questions.

Health care planners and policy makers must grapple with macro issues which involve the distribution of basic goods and services and the adjudication of competing claims involving liberty and

justice to a society as a whole. Since extrapolations of the moral choices of the individual to the society at large do not work well for these issues, a theory which looks at the basic structures of society is more useful. Such a theory would need to speak to the issues of justice on a societal scale and to the place liberty holds in relationship to both the individual and society. Rawls' theory, I contend, does provide such a vehicle for examining these issues on both levels, macro and individual.

The conceptual tools of justice and liberty have not traditionally been used to deal with inquiries into questions of medical ethics. The intellectual philosophical format more commonly used is one which determines which moral stance or virtue is involved in making a moral judgement about a decision, rather than one which focuses on the concepts of justice and liberty as the basis for decision-making. The literature of biomedical ethics has consisted largely of discussions of moral virtues such as mercy, beneficence and justice, and has been dominated by two types of moral thinking--teleological and deontological. For the most part, these two types of moral thinking have been applied to decisions which are made at the "micro" level, that is, in certain circumstances and with specific outcomes in individual or small class cases. These kinds of thinking are, however, problematic when applied at the macro level. This is because questions about large scale distribution of goods and services and competing claims of justice involved are difficult to resolve when "the principle of

rational choice for one man is adopted for society as a whole," as Rawls puts it (1971, 27).*

That the professional medical and bioethical literatures have not dealt more with the theme of distributive justice is in fact surprising. This is an age where 11.3 percent of the Gross National Product is spent on health care (Aday, 1986), and the crisis in the health care delivery system has reached almost catastrophic proportions. Moreover, health care is a social good, it can be bought for shares of income or wealth, either directly or by transfer, and it is moderately scarce. It should, therefore, fall within the scope of philosophical discussions on distributive justice.

The aim, then, of this paper is to determine whether John Rawls' principles of justice can be used to evaluate the justice of the United States' current social policy regarding distribution of health care. I will first present, in Chapter II, an analytical review of Rawls' theory, focusing on Rawls' derivation of the principles of justice from the vantage point of the social contract, on the two principles themselves, and on a discussion of the concept of the common interest principle and the idea of a well ordered society. Since Rawls' theory is a significant departure from other philosophical conceptual frameworks which have been used to discuss justice, a review of current philosophical criticisms directed at Rawls' theory will be presented in Chapter III. Chapter IV will

*For the sake of simplicity, all future references to John Rawls' A Theory of Justice will cite only the appropriate page(s) from that work.

review the work of several authors who have used Rawls' theory as a base for their own work in distributive justice and health care. I will then, in Chapter V, set forth my own application of Rawls' theory to health care distribution in the United States. In Chapter VI, specific classes of persons will be examined from the perspective of Rawls' theory. Chapter VII will draw comparisons between models of health care distribution used in Canada and Sweden, and the system used in the United States, and will evaluate these alternative systems using Rawls' principles. Conclusions of this study will be drawn in Chapter VIII.

This essay will add to existing literature on distributive justice as applied to health care in several ways. First, the principles of justice as outlined by Rawls will be the philosophical matrix used to discuss the just distribution of health care relative to the broad question of access to differing levels of health care, minimum levels of care appropriate for our level of society, and the role of health care in providing opportunity for personal growth and accomplishment of life plans. Second, actual distribution of health care patterns for the elderly, poor, and women will be examined using criteria derived from Rawls' principles. Third, the impact on present and future health care distribution policies, if Rawls' principles were applied, will be investigated. The result of these three inquiries will lead to some conclusions about the feasibility of using this philosophical system to establish the groundwork for social policy in health care distribution.

There are some obvious limitations to a project such as this, some of which may not be readily identifiable. The concept of health care relates to so many and such a wide range of other concepts that it seems prudent to define and limit my terms. The broad usage of the term "health care" will refer to the three traditional areas of acute care, prevention and public health. I will also confine my application of this concept to the mainstream health care delivery system in the United States, which includes roughly the acute care, long term care and home health care settings staffed by traditional health care personnel, the public health and safety system, and the research community. I am excluding specifically naturopathy, chiropractic, faith healing, home or folklore medicine, and other non-traditional systems which do not rely on the physician as head of a therapeutic team model currently used in mainstream medicine. I do so not to make judgements about alternative methods of health care delivery, but rather as a practical consideration, since the primary data on health care distribution in the United States comes from mainstream sources.

In delineating the patterns of distribution for several special classes of people--the poor, elderly, non-white and women--I do not mean to be exhaustive, but to use the available data to demonstrate how these classes are included in a particular level of society. According to Rawls, the justice of a distribution system is judged by that system's treatment of the least advantaged segments of society affected by the pattern of distribution. I wish to show that the poor, elderly, non-white and women are in fact

disadvantaged by the present system of health care distribution and that they therefore have been treated unjustly using the criteria developed by Rawls. The research data used to demonstrate these patterns will not be original, but rather compiled from published sources as reconstructed evidence of unjust distribution patterns.

In applying Rawls' theory of justice to the three models of health care delivery (fee-for-service in the United States, co-payment and transfer vouchers in Canada, and universal coverage in Sweden), the purpose is to evaluate the theory using the Rawlsian conceptual model--not to critique the actual systems of health care delivery themselves.

These limitations will aid in keeping the discussion focused on the use of Rawls' theory as an evaluative tool in determining the justice of the delivery system as applied to special classes of people, not on the actual advantages and disadvantages of actual delivery systems. By limiting the data to mainstream, traditional health care delivery systems the impact of unjust treatment is more easily identifiable. The strength of this format will be to incorporate the findings of several disciplines in analyzing a particular philosophical viewpoint.

The philosophical viewpoint as articulated by John Rawls is derived from a long line of social philosophers who have used the social contract theory in one way or another. It has some built-in presuppositions which will be explored in the next chapter and in Chapter III, where criticisms of the theory are presented.

II. JOHN RAWLS' THEORY OF JUSTICE

Introduction

The purpose of John Rawls' theory of justice is to derive two principles which will serve as moral rules for society to determine the distribution of five primary social goods: liberty, opportunity, income, wealth, and the bases of self-respect.

The benefits distributed by society in the Rawlsian scheme are of two kinds, primary social goods and primary natural goods. The primary natural goods are health and vigor, intelligence and imagination, and position in society at birth. Natural goods for Rawls are unearned or undeserved, and are therefore morally irrelevant in discussions of merit or desert. Primary social goods are rights and liberties, powers and opportunities, income and wealth, and self-respect. Primary goods are distributed by society through its basic structures and social institutions. A fundamental presupposition of Rawls is that primary social goods are things that every rational person wants more of rather than less (62).

The first principle of justice states:

Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all (302).

The second principle of justice states:

Social and economic inequalities are to be arranged so that they are both:

- (a) to the greatest benefit of the least advantaged, consistent with the just saving principle, and
- (b) attached to offices and positions open to all under conditions of fair equality of opportunity (302).

Justice for Rawls means equal distribution of these primary social values unless inequality will benefit those at the bottom of the social scale--the least advantaged. Inequality is simply unjust distribution of society's benefits. But for Rawls justice is also tied up with the concept of fairness.

"Justice as fairness" is the central theme of Rawls' theory; by this phrase he hopes to express the intuitive idea that fair procedures or rules are at some level necessary to and contained in the concept of justice. The role of justice as the "first virtue of social institutions" is supported by the following four premises, according to Rawls. One, "each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override." Two, "justice denies that the loss of freedom for some is made right by a greater good shared by others." Three, "justice does not allow that the sacrifices imposed on a few are outweighed by the larger sum of advantages enjoyed by many." Four, "being first virtues of human activities, truth and justice are uncompromising" (3-4).

The proper nucleus for the exercise of justice is, in the Rawlsian theory, the basic structure of society, that is, the way in which major institutions carry out the distribution of fundamental rights and duties and determine the advantages or benefits derived from social cooperation. If the basic structure is just, then the theory allows us to adjudicate claims against those institutions or society itself. By major institutions Rawls means the principal economic, social, and political arrangements. Examples would

include marriage and family schemes, the system of laws and customs protecting thought and conscience, the means of production, competitive or regulated markets; or in other words how the society is organized at a macro level. A society is just when these basic arrangements follow the principles of justice.

This is so according to Rawls because it is these basic structures which are at the very heart of any society. They determine to a large extent a person's opportunities and social position because these are the conditions under which one is born (7).

The subject of justice for Rawls is the most important part of assessing any particular arrangement of a society's benefits and duties; the form of society is not as important as how these basic building blocks of society are arranged.

This central concept of justice as the means by which a society divides its resources, benefits and duties needs always to be kept in mind when applying Rawls' views to any particular segment of society such as health care.

This chapter will examine how Rawls derives the two principles of justice. It is not intended to be an exhaustive account of Rawls' theory, but rather to set the stage for using the theory as a basis for examining the social issues surrounding health care in this country.

Contract Theory and the Original Position

Rawls bases his theory of justice on some of the concepts taken from a model of social philosophy known as "the social contract theory."

The conceptual model for the social contract theory both for Rawls and in general is simple. There is a hypothetical period of time prior to the formation of society (state of nature) in which a collection of individuals enter into an agreement, covenant, etc., and there is a variety of characteristics the philosopher ascribes to those entering into the agreement. These usually include provisions for rationality of the parties, for equality of parties, for whether or not the agreement is voluntary on the part of all individuals, for whether they may withdraw and under what circumstances, and for the nature of the relationship which will hold between the newly formed society and the individual. The result of these deliberations is the original state of society or government in some form. From this original or initial position other social structures are derived. This position is a purely hypothetical situation used to construct a line of reasoning to be used in explaining or justifying our ethical principles, or, as in Rawls' case, to derive ethical principles like the principles of justice.

The social contract theory of has a long history in western political theory. The Roman Stoicism of Cicero and Roman law are early examples which have survived into modern political theory. The most well-known modern contractarian is Thomas Hobbes in his Leviathan, but he is joined in political philosophy by Spinoza

in his Tractatus Politicus, John Locke in his Two Treatises of Government, and Rousseau in Du Contrat Social, to mention only the most widely quoted and studied.

John Rawls is understood as a contract theoretician because he uses a hypothetical original position, along with certain limitations on those in the original position, to derive the principles of justice. The contract, then, consists of agreeing to use the principles derived to determine how the benefits of society will be distributed. These principles are subsequently applied to the major social institutions to produce fair distribution of social goods. Rawls wants to justify our moral judgements about what constitutes fair distribution of social values and to explain how it is that we have a sense of justice about what that distribution is. Rawls, himself, notes that "justice as fairness is not a complete contract theory" (17), because he is developing a theory only for the principles of justice and its closely related virtues, not for a specific set of rights and duties which would be involved in a complete social arrangement. An example of the latter is the Leviathan which describes most aspects of the civil and spiritual development of society, including many more virtues, such as beneficence, duty to sovereign, and duty to God.

The use of the contract device for Rawls is important for two reasons. First, the contract sets the stage for an initial situation, called the original position, which can then eliminate some options through stipulations regarding the persons involved in this initial situation. Second, the contract is also a device for

extracting the principles he believes would be agreed to, given the restrictions of the original position.

The Original Position

In the following passage Rawls explains what it is that he wishes to achieve with and how we should understand the original position.

It is clear that the original position is a purely hypothetical situation. Nothing resembling it need ever take place, although we can by deliberately following the constraints it expresses simulate the reflections of the parties. The conception of the original position is not intended to explain human conduct except in so far as it tries to account for our moral judgments and helps to explain our having a sense of justice (120).

Rawls sets up the original position by first determining the general characteristics of the persons involved and their circumstances. The circumstances they find themselves in are ones which would make it advantageous to band together for social cooperation. They follow roughly the same conditions set down by Hobbes. First, there must be a condition of moderate scarcity. This is necessary because if there were a Garden of Eden situation, then there would be no need for cooperation; or if there were severe scarcity, then each person would be on his own and cooperation would not logically benefit anyone because there would not be enough to go around. Individuals in this situation must be at least roughly equal, with no one so superior as to be able to completely dominate others or so weak as to be automatically a ward of another. They are vulnerable to attack or domination from an outside source and are

capable of having their plans disturbed by the united force of others. They have their own plans or ideas of the good and this leads them to have different ends. They have not banded together in a social cooperative with a common good and end, nor are they morally tied to one another. They make conflicting claims on the natural and social resources available to them. And, finally, Rawls makes the interesting stipulation that the parties have no interest in the interest of the others, except it is assumed that each person in the next generation has someone in the present generation who cares about him/her. All parties in the original position know and accept these circumstances (126-128).

Having placed those in the original position in the traditional circumstances used in a contract theory, Rawls then adds constraints. This is done because he is using the original position to account for particular principles of justice, and the circumstances of justice reviewed are not specific enough.

These constraints on the original position are that there be no distinction in the physical or social status of the persons involved in the original position; that the outcome not be to the advantage of any one individual or his forebears or heirs; that the natural inclinations toward particular philosophies or psychological sets not be known; that the individual's conception of the good, i.e. his religious or personal ends, not be known; and that all parties be equal in procedural rights. The first three constraints merely elaborate on the properties and goals of the individuals in the original position. The last constraints are imposed as far as

possible to allow principles to be chosen which are not to the advantage of any specific person or group. Rawls assumes that if one in the original position knew he/she were handicapped in some way, he/she would slant society's benefits to help compensate for that condition; if one knew one were rich, principles would be chosen to protect that wealth; if one believed that one's religious or philosophical view represented the ultimate good, then he/she would stipulate a principle which would protect and enhance that view. Instead Rawls chooses a set of constraints on the person's knowledge about his own position in society and couples that with ignorance of the particular society's conditions, a situation which he calls "a veil of ignorance" (137).

The Veil of Ignorance

One of the most widely recognized features of Rawls' theory is his "veil of ignorance." This is designed to explain how those in the original position are concealed from their specific circumstances. The main concept behind the veil of ignorance is the notion of pure procedural justice, for Rawls wants to eliminate the bargaining power of participants, thus making the outcome of their deliberations fair. The choices they make behind the veil are applicable to everyone because they have no idea of their relative position in society. Rawls believes that this strategy will insure that his principles of justice are chosen. Rawls asserts that:

To say that a certain conception of justice would be chosen in the original position is equivalent to saying that rational deliberation satisfying certain conditions and restrictions would reach a certain conclusion (138).

The conditions referred to are the "circumstances of justice," and the restrictions are the five formal "constraints of right"; the conclusion is of course the two principles of justice. The paramount use of the device of the original position is to set up a fair procedure "so that any principles agreed to will be just" (136). One way to do this very effectively is to make specific facts about the participants' lives and society unavailable to them so that they must make decisions in a condition of uncertainty. They cannot then assess how various alternatives will affect themselves and thereby make unfair decisions. That is, they are behind a veil of ignorance which assures that the parties will not know any of the following: their place in society, class position or social status; their degree of natural assets or abilities, mental or physical; their conception of the good, be it religious or material; their life plan or goals; their particular psychological bent, whether conservative or risk taking, optimistic or pessimistic; or furthermore the particular features of their own society, its wealth, resources or political persuasion.

The parties do know the circumstances of justice and all that implies as well as the "formal constraints" on choice. They also know the general facts about human society and understand political and economic theory. They are acquainted with the general laws of moral psychology and systems of social cooperation. In this respect they resemble the ideal observer of J.S. Mill. There is no limit, according to Rawls, on general information. In other words, they have extensive general knowledge of areas pertaining to conceptions

of justice, but not specific details about themselves or their society.

It is as though two people were deciding how to share a cake. They know that there is a cake, what kind it is, and that there are many alternative ways to share it; what they do not know is whether they will be able to pick the piece they want.

Rawls goes on to argue that given ignorance of their specific positions regarding the distribution of the good (the cake), they would choose an alternative which would protect their interest in an equal piece of cake, whatever position they draw relative to cutting or choosing. This is the "you cut I choose or I cut you choose" theory. Given ignorance of the particular situation, Rawls maintains that a system which insures equality will be chosen. If I cut the cake I will always make the portions equal, so that after the first piece is chosen, I still have just as large a piece as the other person. I cannot therefore bargain from any position of knowledge or strength. I cannot say, "I will give you more ice cream if you give me more cake," because I don't know if I have any ice cream. I also am choosing for everyone else by the choice of equal pieces. Anyone who shares the cake if cut equally will get equal pieces.

This concept is of critical importance for Rawls, for he believes that the restriction on particular information will ensure fair procedures and allow for a definite theory of justice (140). Rawls also adds that he feels that the veil of ignorance allows for a more simple calculation of justice. In general, the simpler

method is preferred when choosing principles of justice; it in fact gives the principles of justice an edge over the principle of utility, which will be covered below under the discussion of the second principle of justice.

The Rationality of the Parties

A rational person is thought to have a coherent set of preferences between the options open to him. He ranks these options according to how well they further his purposes: he follows the plan which will satisfy more of his desires rather than less, and which has the greater chance of being successfully executed. The special assumption I make is that a rational individual does not suffer from envy. He is not ready to accept a loss for himself if only others have less as well (143).

This last condition for the parties in the original position has three functions: to ensure that those entering into the discussion are able to reason about the distribution of benefits and goods without strong ulterior motives; to further reinforce the "mutual disinterestedness" of the parties; and to add to the existing conditions a lack of envy. Rawls indicates that all the conditions for rationality are traditional except for the special condition of lack of envy. This condition is important when the purpose of the original position is reviewed, namely, to set up a situation in which the parties will choose principles of justice as fairness for the "basic structure and fabric of society." These principles will be used to distribute the goods, benefits and duties of the society. Rawls' concept of justice is very general and meant to be applied to the basic structure of society. Envy is a destructive emotion which could allow the parties to choose a

position of lesser good or liberty simply to prevent another from having more. There are three situations in which envy is rational according to Rawls: when the inequities are extremely great and exceed certain undefined limits, when the inequities are founded on injustice, and when they are a result of a chance occurrence which serves no compensating social purpose. In this third category he seems to be talking about the natural lottery of abilities and talents.

The addition of the condition of rationality of the parties serves then to bolster the nature of the persons in the original position. They have enough confidence and self-respect to pursue their own ends without envy and to choose more instead of less of society's goods and benefits.

Rawls then takes one more step prior to actually deriving the two principles of justice. He formulates what he calls "The Formal Constraints of the Concept of the Right." This step is necessary because he is deriving formal ethical principles to be applied to the virtue of justice.

The situation of the persons in the original position reflects certain constraints. The alternatives open to them and their knowledge of their circumstances are limited in various ways. These restrictions I refer to as the constraints of the concept of right since they hold for the choice of all ethical principles and not only for those of justice (130).

Rawls defines five constraints which hold for those in the initial choice or original position.

Generality is the first condition. This requires that the principles chosen must be such that they make use of no proper names

or definite descriptors. The principles formulated must apply to general classes or categories of people rather than specific individuals. One could not formulate a principle guaranteeing the right-to-rule only to those related to the Reagan family, but instead would have to formulate the right-to-rule in terms of general properties and guidelines such as citizenship, age, and share of the electoral mandate (131).

Universality is the second constraint. The principles must apply to all moral persons and the consequences of everyone applying them must be reasonable. He rules out contradictory or self-defeating principles (132).

The third constraint is that of publicity. This assumes that the parties are choosing universal principles which will be known to all moral persons. Further, this knowledge of the principles is to constitute an acceptance of the principles. This constraint integrates the concept of justice into everyday life in a society by making all members aware of all the rules agreed to concerning the basic structures of society (133).

The fourth condition is one which Rawls labels "ordering." This constraint demands that the competing claims of justice be capable of being ranked and that the rank be transitive. The first principle in the concept of justice is ranked more just than the second and so on. This is included according to Rawls so that a person cannot coopt justice by force or excessive coercion. Questions of liberty under this scheme are more important than questions of economic gain or social mobility (134).

The last condition is one of finality. This is the constraint which defines the principles chosen in the original position as the final word on the subject of justice. There is no higher court of appeal. These are the highest standards used in practical reasoning. Rawls explains:

If we think in terms of the fully general theory which has principles for all the virtues, then such a theory specifies the totality of relevant considerations and their appropriate weights, and its requirements are decisive. They override the demands of law and custom, and of social rules generally. We are to arrange and respect social institutions as the principles of right justice direct (135).

This constraint is in harmony with our conception that a moral principle is indeed the final arbiter of moral reasoning.

Why have these five constraints? The purpose of the five constraints is to do two jobs. The first is to rule out a conception of justice based on egoism; the second is to incorporate those traditional conceptions of justice which make a theory "natural and plausible," by which he means "intuitive" or "corresponding to what most moral people feel regarding justice." Rawls summarizes the five constraints by noting that:

Taken together, then, these conditions on conceptions of right come to this: a conception of right is a set of principles, general in form [generality] and universal in application [universality], that is to be publicly recognized [publicity] as a final court of appeal [finality] for ordering the conflicting claims [ordering] of moral persons (135) (words in brackets added).

The above are formal conditions which must hold for any principles which might be chosen by those in the original position.

This completes the description of the original position. Briefly recapped, the characteristics of the parties and circumstances under which the principles of justice are to be chosen are: the entry of rational parties with their own life plans and conceptions of the good into a social contract under the formal constraints of generality, universality, publicity, ordering and finality, and under circumstances of moderate scarcity from behind a veil of ignorance, to define the principles of the basic structures of society with mutual disinterestedness and to accept the outcome.

The formulation of the original position is critical since all other steps in the justification and application of the principles of justice are taken from the standpoint of this "favored interpretation of the initial situation" (118).

The Two Principles of Justice

The two principles of justice are the hallmark of Rawls' theory of justice. They are the yardstick by which to measure the arrangements of society. They speak to the two fundamental areas of society, liberty and distribution of social goods. "They distinguish between those aspects of the social system that define and secure the equal liberties of citizenship and those that specify and establish social and economic inequalities" (61).

Rawls has set up the original position with the veil of ignorance and the formal constraints in order to derive the two principles of justice. But, because of the particular features of the veil of ignorance, those in the original position must make

decisions under heavy uncertainty. So this leads Rawls to borrow the maximin rule from decision theory as a means of justifying the choice of the two principles.

The term "maximin" means literally "maximum minimoru," and refers to a feature of decision theory where decisions are made in light of the worst possible case scenario for any particular course of action. According to this rule, a person calculates the worst possible outcome of the situation which she is asked to judge and always chooses an alternative which eliminates that outcome. The competing principle in decision theory is the principle of expected utility maximization.* According to this utility principle, decisions are based upon a weighing of positive outcome and negative outcome according to likelihood of occurrence and preference for a particular outcome.

According to the expected utility maximization decision rule, it is better to choose a decision in which the best possible outcome is combined with the least risk. Rawls objects to this weighted utility decision rule because of its reliance on subjective utility comparisons; that is, the decision maker makes the comparison rankings. Since the original position is a position of complete uncertainty regarding the decision maker's ultimate place in society, comparison of utility rankings cannot be made in a valid manner. Though Rawls does concede that the maximin rule is not in

* For an excellent discussion of this point see, "Can the Maximin Principle Serve as a Basis for Morality," Jon. C. Harsanyi, The American Political Science Review, June 1975, Vol. LXIX No, 2.

all circumstances the best decision rule, he does not feel that the competing decision rule is applicable under uncertainty because of the following three features of the original position.

- (1) The situation is one in which a knowledge of likelihoods is impossible, or at best extremely insecure. In this case (the original position) it is unreasonable not to be skeptical of probabilistic calculations unless there is no other way out, particularly if the decision is a fundamental one that needs to be justified to others.
- (2) The person choosing has a conception of the good such that he cares very little, if anything, for what he might gain above the minimum stipend that he can, in fact, be sure of by following the maximin rule.
- (3) The rejected alternatives have outcomes that one can hardly accept. The situation involves grave risks.

The paradigm situation for following the maximin rule is when all three features are realized to the highest degree (154-155).

The first of these features is a direct consequence of the special circumstances of the original position; there is not enough particular information in the original position to warrant a probabilistic calculation of risk. The second feature is what Rawls calls the "qualitative anatomy" of the choice problem. It makes basic assumptions about those in the original position, that they will accept as fair an equal share or the minimum share without envy that can be gained by the maximin rule. The third feature is also a part of this qualitative anatomy in that it stipulates that other choice decisions have alternatives which are unacceptable. They have significant risk associated with them. The gravest risk, according to Rawls, is one of not having enough of the primary goods to follow a rational life plan if the decision-makers were to be in

the least advantaged class when the veil is removed. Thus it is these three features of the choice position which Rawls uses to justify the choice of the maximin over most particularly average utility. The three features of the maximin rule, just reviewed, are the components of what Rawls calls the "thin theory of good."

The thin theory of the good Rawls believes is needed to "explain the rational preference for primary goods and to explicate the notion of rationality underlying the choice of principles in the original position" (397). The thin theory of the good says that the parties in the original position are rational persons who will try to secure their own liberty and self-respect. Furthermore, in order to advance their life plans, they will as a general rule want more rights, opportunities, income and wealth rather than less (397).

This thin theory helps Rawls in the derivation of the second principle of justice in two ways. First, it gives the motivation behind the rational self-interest of those in the original position who must choose the principle behind the veil of ignorance. Second, it gives the parties confidence that they will be able to pursue their own life plans, whatever they happen to be when the "veil" is removed, by securing for themselves the primary goods which they would rationally desire in any case. This enables the original parties to choose moral principles despite the limited knowledge shared equally by everyone (155,397,421).

Two principles of justice that Rawls claims would be chosen in his original position are as follows:

First: each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.

Second: social and economic inequalities are to be arranged so that they are both

- (a) reasonably expected to be to everyone's advantage, and
- (b) attached to positions and offices open to all (60).

This is the first formulation of the two principles. The principles are to be understood to be in lexical order, that is, the conditions of the first principle must be met prior to continuing on to the second.

The First Principle of Justice

The first principle of justice, according to Rawls, is concerned with those aspects of the basic structure of society which deal with the definition and security of the liberties of citizenship. As the principle states, these are to be equal to the extent that all may share the same degree of liberty (60-61). The basic liberties of citizenship for Rawls bear a striking resemblance to our Constitution. They are:

... political [the right to vote and to be eligible for public office] together with freedom of speech and assembly; liberty of conscience and freedom of thought; freedom of the person along with the right to hold [personal] property; freedom from arbitrary arrest and seizure as defied by the concept of the rule of law. These liberties are all required to be equal by the first principle, since citizens of a just society are to have the same basic rights (61) (words in brackets added).

Besides securing basic liberties as named above, the first principle also demands that these liberties are to be equal for all. That is, they are equal within the context of being "compatible with similar

liberty for others" (60). Since this is the first principle in a lexical ordering, there is no trade off allowed between the liberties of citizens and economic or social gains. The provision of liberty is the first duty of a just society.

This leads Rawls to another aspect of the first principle which protects the priority of equal liberty. This is his distinction between the equal right to liberty and the equal worth of liberty. Rawls appreciates that even in an ideal just society there will be inequalities of both wealth and power. Indeed, these are allowed by the second principle. In order then to account for these, Rawls stipulates that the right to liberty is equal for all; however, it is recognized that the worth of liberty may be unequal. To explain what he means, it may be useful to use the analogy which points out that the constant "\$100" is worth a different value to a poor woman than to a rich man. In Rawls' scheme, a person may be poor and a member of the "least advantaged," but she has the same liberties as the rich man. She is just unable to use them to her advantage as thoroughly as a member of the elite power establishment. Rawls believes that he adequately protects the "least advantaged" by the limits of the second principle and the lexical ordering of the principles of justice.

Thus liberty and the worth of liberty are distinguished as follows: liberty is represented by the complete system of the liberties of equal citizenship, while the worth of liberty to persons and groups is proportional to their capacity to advance their ends within the framework the system defines. Freedom as equal liberty is the same for all; the question of compensating for a lesser than equal liberty does not arise. Some have greater authority and wealth, and therefore greater means to achieve their

aims. The lesser worth of liberty is however, compensated for, since the capacity of the less fortunate members of society to achieve their aim would be even less were they not to accept the existing inequalities whenever the difference principle is satisfied. But compensating for the lesser worth of freedom is not to be confused with making good an unequal liberty (204).

Lesser worth of liberty is tolerated, but mitigated by the second or difference principle of justice. Unequal liberty is not tolerated and the securing of equal liberty is firmly prior to all other economic and social benefits. This protection of the liberty of the individual is at the heart of a democratic constitution and is part of an intuitive notion of justice according to Rawls. Until equal liberty of the basic structures of society can be achieved, no other principle may come into play. Rawls calls this the "priority of right over good" (244).

The Second Principle of Justice - The Difference Principle

The first principle protects equal liberty above all the other four primary social goods. The second principle defines how the other goods, namely, opportunity, income, wealth and the basis for self-respect, are to be distributed. It tells us that:

Social and economic inequalities are to be arranged so that they are both: to the greatest benefit of the least advantaged, and attached to offices and positions open to all under conditions of fair equality of opportunity (302).

Rawls has a vision of society as a "cooperative venture for mutual advantage" (76). It is a sweeping vision which attempts to encompass what is intuitively felt as the rules of fair play. Recognizing the inequalities inherent in the natural abilities and

assets of people, Rawls wants to compel the favored members of society to help the least advantaged. Rawls confirms this by noting:

Assuming the framework of institutions required by equal liberty and fair equality of opportunity, the higher expectation of those better situated are just if and only if they work as part of a scheme which improves the expectations of the least advantaged members of society (75).

The second principle gives a moral reference for judging institutions at a very basic level, taking the least advantaged as a starting point. It also envisions that this mutual cooperation will lead to a society which progressively increases the social minimums while protecting the basic liberties. It gives moral substance to concepts of equal opportunity. It is an attempt to revamp distribution of "fundamental rights and duties and the regulation of social and economic inequalities and of the legitimate expectations founded on these" (84). It is surely this distribution which does indeed measure a society, because how a society treats its poor and disadvantaged is at the heart of the meaning of fairness. It is this distribution of society's benefit to the poor and disadvantaged which is at the center of the second principle of justice.

At this point, an in-depth discussion of the concept of the least advantaged is warranted in view of this concept's importance in applying the two principles of justice.

In defining and using the concept of the "least advantaged" segment of society, Rawls is "singling out a particular position from which the social and economic inequalities of the basic

structure [is] to be judged" (75). Rawls notes that it is a difficult notion to pin down in a complex society.

Here it seems impossible to avoid a certain arbitrariness. One possibility is to choose a particular social position say that of the unskilled worker, and then to count as the least advantaged all those with the average income and wealth of this group or less. The expectation of the lowest representative man is defined as the average taken over this whole class. Another alternative is a definition solely in terms of relative income and wealth with no reference to social position. Thus all persons with less than half of the median income and wealth may be taken as the least advantaged segment. This definition depends only upon the lower half of the distribution and has the merit of focusing attention on the social distance between those who have least and the average citizen. Surely this gap is an essential feature of the situation of the less favored members of society (98).

The importance of the least advantaged person lies in his position as the focal point from which to judge the relative justice of social institutions. It is this device which in Rawls' theory protects the poor and powerless from being taken advantage of by the more favored members of society. This idea reflects Rawls' concept of the liberal tradition which tells us that the measure of a society is how it treats its disadvantaged.

The distribution of social and economic goods is regulated by the first part of the second principle, usually known as the difference principle. "The primary social goods that vary in their distribution are the powers and prerogatives of authority and income and wealth" (93). The good of self-respect or esteem is added later and it is tied to the concept of expectations of the least advantaged. Rawls supposes that "it is possible to assign an expectation of well-being to representative individuals" (64). He

goes on to note that "the basis for self-esteem [respect] in a just society is not then one's income share but the publicly affirmed distribution of fundamental rights and liberties" (544). It is through this good that men/women can meet as equals when conducting the affairs of a just society. The primary goods are an index which defines expectations, particularly for the least advantaged. The difference principle regulates the effects of distribution and justifies what he calls "excusable envy." The expectations of the least advantaged, hence their self esteem, are lowered if the distance between them and the advantaged is too great.

Rawls explains:

This expectation indicates their life prospects as viewed from their social station. In general the expectations of representative persons depend upon the distribution of rights and duties throughout the basic structure. When this changes, expectations change. I assume, then, that expectations are connected: by raising the prospects of the representative man in one position we presumably increase or decrease the prospects of representative men in other positions. The first part of the second principle refers to the expectations of representative individuals (64).

These expectations are important when discussing the distribution of personal health care services in the United States, because the delivery system has changed radically since 1966 (Medicare/Medicaid) and expectations of the least advantaged have indeed increased. Now, in the 1980's, there have been significant cutbacks in care, particularly to the least advantaged segments. Expectations also allow us to use satisfaction indexes in evaluating the social institution. This will be amplified in Chapter Six.

Rawls is aware of the inequities in the distribution of natural assets and asserts that they are not deserved whichever direction they tend. However, to simply redistribute social goods would certainly impinge on the first principle. So he uses the second principle to act as an agent of redress. His basic starting point is equal shares for everyone, recognizing that shares in an efficient and complex society would soon become very unequal. The solution is to regulate how these inequities may in a just society work. His second premise is: that which affects one group affects the other through what he calls "close knitness." This idea allows him to stipulate that "social and economic inequalities are to be arranged so that they are ... to the greatest benefit of the least advantaged..." (302). This is a part of the second principle, but he adds a clause about the just savings principle to protect coming generations from abuse in the current generation. Each representative person is entitled to a fair share of the primary goods, but that does not mandate equal shares. Unequal shares may be justified on the grounds that unequal distribution would increase the shares of the least advantaged. The lexical ordering of the principles dictates that in distributing unequal shares the constraints of the first principle of equal liberty are in effect. Then the fair opportunity clause must be satisfied. This clause stipulates that those with equal talents and abilities have equal access and chance to obtain all positions of power and prerogatives of authority regardless of their relative position in society initially.

The fair equality of opportunity means a certain set of institutions that assures similar chances of education and culture for persons similarly motivated and keeps positions and offices open to all on the basis of qualities and efforts reasonably related to the relevant duties and tasks (248).

This second part of the second principle assures that there will be institutions devised at either the constitutional or legislative stage which will mitigate the effects of poverty, race, gender, lack of education and, I will argue, lack of basic health care. The basis for fair equality of opportunity lies in the structure of society being just so that procedural justice will ensure that the principle is satisfied. Rawls uses various background institutions to affect this structure. Let us suppose that law and government are arranged so as to keep competitive markets open and free; the distributive branch will then apply taxation to keep the distribution from being unduly influenced by, say, undeserved inheritance or natural assets. The transfer branch will underwrite education for all or any other universal need which would unduly affect one's ability to participate in equal opportunity (87).

The Priority Rules

Acceptance of the principles of justice is delineated in two ways. There is strict compliance and partial compliance, or what Rawls calls the ideal theory and the nonideal. The ideal theory is operative while the parties in the original position operate under a veil of ignorance, and so is hypothetical. The nonideal theory

comes into play when the veil is lifted and actual systems and societies are being evaluated, the case of real life theory. This notion of two types of compliance is part of the justification for ordering the principles. Rawls asserts that:

Viewing the theory of justice as a whole, the ideal part presents a conception of a just society that we are to achieve if we can. Existing institutions are to be judged in the light of this conception and held to be unjust to the extent that they depart from it without sufficient reason. The lexical ranking of the principles specifies which elements of the idea are relatively more urgent, and the priority rules this ordering suggest are to be applied to nonideal cases as well (246).

This passage sets the stage for the development of priority rules. These will be added to the two principles for a full account of justice, and they demand satisfaction in the ideal conception of the theory of justice. The device Rawls uses for implementing both theories, the ideal and nonideal, is the four stages of his societal development plan. The four stages are an instrument designed for applying the principles of justice one step at a time, a simpler way than direct application. The four stages are an extension of the original position and so all circumstances and constraints which hold there also hold here, except that portions of the veil of ignorance are lifted in stages two and three and it is not in operation at all in stage four since this stage necessarily deals with individuals.

This conception of a four-stage sequence is actually, in the Rawlsian scheme, an application of the two principles of justice, plus the priority rule, to a society. In the final formulation, this will in fact be called "the general conception of justice." It

is chosen in the original position and represents the first stage, while the second stage is an ideal constitutional convention where the basic liberties and procedures for justice are adopted. The third stage is the legislative stage where actual laws are devised and background institutions adopted, and the fourth stage is the stage where laws and claims are actually adjudicated. This and the third stage are both nonideal since the veil of ignorance has been lifted and actual non-representative persons are affected. More will be said about these last two stages as they directly bear on the allocation of health care.

Rawls explains this transition:

I suppose that after the parties have adopted the principles of justice in the original position, they move to a constitutional convention... I imagine then a division of labor between stages in which each deals with different questions of social justice. This division roughly corresponds to the two parts of the basic structure. The first principle of equal liberty is the primary standard for the constitutional convention. Its main requirements are that the fundamental liberties of the person and liberty of conscience and freedom of thought be protected and that the political process as a whole be a just procedure... The second principle comes into play at the stage of the legislature. It dictates that social and economic policies be aimed at maximizing the long-term expectations of the least advantaged under conditions of fair equality of opportunity, subject to the equal liberties being maintained... Thus the priority of the first principle of justice to the second is reflected in the priority of the constitutional convention to the legislative stage (196-9).

This transition and ordering of the principles is the vital link between the first principle of justice and the second principle which deals with the expectations of the least advantaged class. This link allows Rawls to claim that his theory does express the

intuitive notion that to be just is to be fair. This link is strengthened by the addition of the priority rules to the first principle and second principle both.

First Priority Rule (The priority of Liberty)

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

Second Priority Rule (the priority of Justice over Efficiency and Welfare)

The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle (302).

These priority rules do not direct the constitutional convention and the legislative stage on which forms of government or economic systems choose, but determine what constraints the results must operate under. They direct that the principles are incorporated into the political system in a particular order. They also rank the basic structures of society as to their importance. The first priority rule tells us that liberties may be impinged upon if it will increase the total liberty available to everyone and for no other reason. Examples of this type of infringement on an individual's liberty might include rules of order which regulate debates, parliamentary discussions and the like; the lesser liberty enhancing the value of free speech is sacrificed to rules of procedure, for without these rules the ability to exercise free speech would be virtually meaningless. The second priority rule would allow programs such as Head Start to be available to the least advantaged and not necessarily to other segments of society, because the fair and equal opportunity clause is prior to allowing unequal

share of income or wealth. Allowable compensation efforts will be examined more fully in applying the second principle to health care, as opportunity and compensation for unequal talents and abilities are often used as parameters when using Rawls' theory in the distribution and allocation of health care.

The priority rules are used to rank the concepts of liberty of person, thought and conscience above other liberties when they come into conflict; and direct that social and economic systems must protect the least advantaged while preserving liberty.

With the addition of the priority rules to the two principles the theory of justice is thus formally complete.

However, there are areas which a theory of distribution does not adequately handle. Rawls covers these under the principle of common interest. Since this principle pertains to a critical aspect of health care delivery, public health and safety, and is important in my own applications of Rawls' theory, it will be reviewed here.

Rawls uses the theory of "common interest" to account for those questions of social policy which cannot be dealt with by distributive principles. Normally they do not come under the jurisdiction of the second principle. So it is important that this distinction between allocative and distributive principles be made early in the discussion of the second principle. Common interest questions are questions which involve everyone equally and involve goods or services which are not able to be divided or shared, by their very nature. Examples of goods or services which would be subsumed

under this principle are those of public order and of safety and health, for instance the goods of clean air and water.

According to the principle of common interest, institutions are ranked by:

...how effectively they guarantee the conditions necessary for all equally to further their aims, or by how efficiently they advance shared ends that will similarly benefit everyone (97).

These functions of security, order and protection from some types of health hazards are part of Rawls' non-ideal theory and are usually thought of as involving allocative questions rather than distributive. As such, these questions are handled in the fourth stage. Common interest questions presuppose that the society is just and that the point of view is that of equal citizenship. Some health questions fall very nicely into the common interest scheme, for instance universal immunization for contagious diseases, environmental issues such as non-polluted water and air, and research into widespread endemic diseases such as hepatitis. These are conditions in which "distributive effects are immaterial or irrelevant" (97).

To meet the common interest requirement the public good must be public and indivisible:

That is, there are many individuals, a public so to speak, who want more or less of this good, but if they are to enjoy it at all each must enjoy the same amount. The quantity produced cannot be divided up as private goods can and purchased by individuals according to their preference for more or less (266).

A good example of this type of good would be immunization against childhood diseases. This protects all children, even those

who have not been immunized, under what is known as an "umbrella effect." The umbrella effect is similar to the "free rider" effect --children who have not been immunized do not get the disease because those who have been immunized cut the incidence down so much that the risk of getting the disease may actually be nil. Society may deem it prudent for everyone to be immunized against these diseases not only because of their immediate dangers to specific children, but because the aftermath of outbreaks involves lost time from work for parents, increased utilization of medical and child care resources, disruption of education, etc. Under the theory of common interest, society may enforce immunization requirements. Other health related areas covered by the common interest principle would be sanitation, policies on clean air and water, toxic waste regulation, and public food handling policies. These raise issues which affect everyone equally, regardless of their social standing. The goods in question cannot be distributed in the normal sense and yet are vital for both the society as a whole and the individual.

The common interest does not cover questions of general access, research into non-contagious diseases, scarce resources or many other issues surrounding health care in general. The common interest theory is very much a part of the "well ordered society." It provides a framework for those goods society distributes, but is unable to determine who it is specifically serving. When these needs are not met, society as a whole suffers.

To conclude the discussion of Rawls' theory of justice, it

seems appropriate to discuss the ultimate goal of the theory -- the well ordered society.

The concept of "justice as fairness" is, according to Rawls, "framed to accord with this idea" of a well ordered society (454). A well ordered society is one in which its members know and accept the same principles of justice, and the basic structure or arrangement of social institutions which distributes benefits and burdens is designed using the principles of justice. A well ordered society is stable, not static, for it is a requirement of justice that "reflective equilibrium" keep pace with social changes and in fact guide those changes according to need. "Reflective equilibrium" is a Rawlsian term which indicates the ability of those in a just society to weigh and balance changes in that society and act accordingly (48). This society is then regulated by a "public conception of justice" in advancing the "good of its members" (453). Rawls thinks of this vision of society as an "aim to achieve if we can" (246). Social institutions in a nonideal, real society may be ranked by using the principles of justice as a guide to determine their contribution to a well ordered society.

The rest of this paper will be devoted to an attempt to apply Rawls' principles of justice to the distribution of health care. How these principles apply to the least advantaged, the poor, elderly, very young and women, will be the focal points. The Rawlsian tools used in this application will be the equal opportunity priority rule and the difference principle.

III. CRITICS OF A THEORY OF JUSTICE

The theory of justice John Rawls proposed has prompted some remarkable and extensive criticism. The literature on Rawls and his critics alone is a survey of contemporary moral philosophy, and the stature of the critics gives a good indication of the importance of his theory in that philosophy. Ronald Dworkin, R.M. Hare, H.L.A. Hart, Joel Feinberg, and Robert Nozick are but a few of the major philosophers representing, among themselves, very different philosophical positions in their comments on Rawls' work. There is also a body of literature by philosophers who have more in common with Rawls. This includes writings by Norman Daniels, Allen Buchanan, Louis Katzner, Tom Beauchamp, F. Childress, Charles Fried and T.M. Scanlon. Additionally, many scholars from other fields have investigated this theory. Thus there are evaluations of Rawls' theory in journals of law, economics, social theory, political science, public finance, public policy, feminist studies, and education. The theory has had a tremendous intellectual impact on those concerned with how society should or does function. Much of this criticism is presented against a background of respect and admiration for the task which Rawls set out for himself, namely, proposing a systematic, coherent theory of justice as applied to the institutions which make up whole societies.

I will attempt to review only a small fraction of the literature critiquing Rawls. In particular, I will look at major objections to fundamental aspects of the theory such as the

"original position," the first and second principles of justice, the priority rules, and Rawls' underlying assumptions about human nature. The criticisms of these factors center on Rawls' basic liberal doctrine, his claim that he is using a deontological framework, his use of intuition, the consequences of his theory for social policy, and the logical consequences of his proof for the second principle. It should be noted that no one among his critics, however, has attempted to provide such a complete theory as Rawls does

Robert Nozick says of Rawls' work, in his own Anarchy, State, and Utopia (1974):

A Theory of Justice is a powerful, deep, subtle, wide-ranging systematic work in political and moral philosophy which has not seen its like since the writings of John Stuart Mill, if then. It is a fountain of illuminating ideas, integrated together into a lovely whole. Political philosophers now must either work within Rawls' theory or explain why not (p. 183).

Nozick's theory of justice is an entitlement theory, while Rawls' is a theory of distribution. Nozick is concerned, like Rawls, with such ideas as pure procedural justice, the importance of the rights of individuals and their freedom, the use of the marketplace, and the justification of inequities. They both make use of the contractarian model, agree on the importance of a life plan, reject the idea of deserts and are influenced by Kant. Their theories, however, are not compatible, or in philosophical terms are not consistent with one another. The major differences can be found at the core of each theory, in their ideas about social cooperation and rational life plans. Nozick believes that the "why not" is because

there is no obligation on the part of the individual to share the benefits derived from gains which are acquired, or transferred justly. The only restriction he places on this is the Lockean proviso "that there be enough and as good left in common for others" (Nozick, 1974, p. 27). He further states that "people are entitled to their natural assets ... whether or not people's natural assets are arbitrary from a moral point of view, they are entitled to them and to what flows from them" (1974, pp. 225-226). According to Nozick, Rawls' view, on the other hand, "seems to be that everyone has some entitlement or claim on the totality of natural assets (viewed as a pool), with no one having differential claims. The distribution of natural abilities is viewed as a collective asset" (1974, p. 228). It would not be plausible then for a person with a rational life plan in Nozick's scheme to agree to principles which would maximize the "least advantaged." For Nozick the concept of social cooperation is not central to a "well ordered society" but strictly voluntary, and distributive justice is not a means to equalize the effects of natural abilities and social position, but a protection of what one is entitled to through just acquisition and transfer. Protection of this entitlement is one of the few legitimate uses of government, in his view. His criticism of Rawls is based on a small but central part of the theory, on his ideas of social cooperation and entitlement to natural assets and what flows from them.

Utilitarian H.L.A. Hart comments on A Theory of Justice by considering how the first principle of liberty takes priority over social and economic arrangements. Hart's basic criticisms are

centered around the idea that Rawls has demonstrated the priority of liberty over all other considerations using the "claim that principles of justice do not rest on mere intuition yet are not to be derived from utilitarian principles or any other teleological theory holding that there is some form of good to be sought and maximized" (RR231).^{*} This claim is central to Rawls' philosophical stance and to challenge it is a very serious tactic. Hart does so in five different arguments.

First Hart notes that the priority of liberty refers only to the equal distribution of liberty, not to its extent or maximization (RR232). In addition he notes that the priority of liberty in general is quickly changed to priority of certain basic liberties as enumerated in Rawls' list of primary social political goods. That the priority of liberty would be chosen by those in the original position and that this priority of liberty would coincide with ordinary judgements of ordinary people after reflection are two important initial observations in Hart's critique, because it is through these two themes that Rawls' theory may be tested.

The issue of restriction of liberty only for the sake of greater liberty is the most problematic to Hart. This is understandable when it is remembered that he is one of our century's greatest writers on jurisprudence. Any theory of justice will

^{*}Hart's article, "Rawls on Liberty and its Priority" appears in Norman Daniels' excellent anthology, Reading Rawls, 1975. Since the discussion below of both Hart's and R.M. Hare's views draws so heavily upon this anthology, and for the reader's convenience, the notation RR, along with the page number in the anthology, will be cited in the text as appropriate.

ultimately be used to clarify legal theories. The first concern of Hart's then is whether Rawls is arguing that restricting any liberty should be prohibited only for the sake of greater liberty or whether he is referring only to our basic liberties. Hart finds evidence for both interpretations and problems with both interpretations.

Second, Hart is acutely uncomfortable with the claim that all difficulties imposed by conflicts of competing liberties will be settled from the point of view of the people in the original position, that is the representative equal citizens. Hart feels that this claim is extremely difficult to understand "without appeal to utilitarian considerations or to some conception of what all individuals are morally entitled to have as a matter of human dignity or moral right" (RR244). This is so, because without the justification of these possible appeals it would seem that cases of conflicting liberties would always have to yield a clear enough distinction as to the value of the conflicting liberties so that anyone should be able to determine the outcome if they were rational. That is, they would always have to be very simple cases such as restrictions of speech in parliamentary procedure. Cases in which the freedom to practice one's religious or moral objections to war in the face of a just war are very problematic without some way for those in the position of the equal representative citizen to value various liberties. An example of this conflict might be fighting in a just war versus pacifism in the face of the excesses of a Hitler. Which moral stance is preferable? Hart is concluding that Rawls' framework would not give a clear enough decision in

cases like this to be usable as a basis for moral rules. Only in cases such as fighting an unjust war and choosing pacifism can one use Rawls, according to Hart. Hart feels that as the theory stands, these questions, along with others questions of personal freedoms (including sexual freedoms and freedoms of movement against private property ownership, to mention a few), are problematic because without appeal to a concept such as common good, the justice Rawls is suggesting is indeterminate and inconsistent. There is no single rule or standard to be used in like cases. Justice, then, according to Rawls, depends on the views of those in the position of representative citizens, not on any identifiable concept such as the common good.

Hart next questions whether limiting freedom for only the sake of greater freedom adequately protects people from conduct which would cause harm, pain or suffering. Hart thinks not and further remarks that a theory of justice which does not protect others from harm cannot possibly concur with ordinary judgements of the role justice should play in a society (RR244-7).

Hart continues his discussion with the important general point that in choosing a theory which prioritizes liberty of action as Rawls' theory does, there are necessary consequences, namely: the theory confers on individuals the advantage of that liberty but, secondly, it exposes them to whatever disadvantages the practice of that liberty by others may entail for them (RR247). Hart feels that Rawls does not recognize this fact sufficiently in his discussions of conflicting liberties and natural duties because he insists that

as a non-negotiable feature of his theory liberty can only be restricted for the sake of greater liberty and that in resolving conflicts only the amount of total liberty is of concern (RR248).

Finally, Hart argues that in mandating that the priority rule would be chosen by those in the original position in all societies which are above a certain economic subsistence level, Rawls is resting his case for the rule not on an argument that every self-interested rational person would choose the priority of liberty over all other goods but rather on his own ideals of Liberalism (RR252).

R.M. Hare, professor of moral philosophy at Oxford, argues that Rawls has fundamental problems in two areas: (1) philosophical methodology--what it is that philosophy is supposed to do and how to do it; and (2) ethical analysis--the meaning of moral words and the nature and logical properties of moral concepts. These problems lead to conclusions which may not be cogent in determining what is just or unjust. In Professor Hare's analysis, Rawls lacks "the equipment necessary to handle moral methodology effectively, so that what he says about normative moral questions, however popular it may prove, is unsupported by any firm arguments" (RR82-3). This, like Hart's criticisms, is very serious because it hits at the very core of the arguments Rawls puts forward as grounds for his theory. It is necessary to point out that Hare is a utilitarian who comes from the English tradition of twentieth century analytical philosophy which puts the emphasis on how the language of philosophy is technically used, rather than how those of us who read ordinary language would interpret the same passage. However, his critique

echoes criticism most commonly made about A Theory of Justice in a very meticulous way, namely, that Rawls uses words and concepts in ways which are confusing, vague, unique and inconsistent. This lack of precise definition is a problem for all readers. Hare points out not just the confusion this creates, but claims that this logically invalidates certain of Rawls' claims. Hare, like Hart, also does not believe that Rawls has succeeded in establishing his theory without using utilitarian concepts.

The first of Hare's critical arguments is that while Rawls states that his philosophical methodology is analogous to a theory in empirical science in that it has to conform to the facts, which in this case refer to what people will think about justice when they have been carefully thinking about it, he doesn't really appeal to those facts. Rawls in his methodology is thereby ignoring the means which moral philosophy must use to analyze the logical properties of moral concepts. He thus ignores the rules which permit valid moral argument. In short, Rawls argues from the position of a subjectivist who says that an argument is valid if you, the reader, and I, the author, agree. Further, Hare states that Rawls bases his argument on a form of intuitionism. According to Hare, Rawls uses the language of an intuitionist in the space of two pages at least thirty times (RR84). These include such expressions as, "it seems reasonable to suppose," "match our considered convictions of justice," "which we can affirm on reflection," "we are confident," and so on.

In arguing that Rawls' ethical analysis falls short of Hare's standard, Hare notes that Rawls, incorrectly in his view, thinks the

meanings of moral words or the nature, analysis and logical properties of moral concepts, are of little importance to Rawls' theory. Rawls is quoted as wishing to "leave questions of meaning and definition aside and to get on with the task of developing a substantive theory of justice" (RR85).

On the subject of how Rawls uses moral reasoning in order to validate his conclusions, Hare has a lot to say and he attacks Rawls from several stances. The first is that Rawls fails to use Hare's own methodology as set down in Freedom and Reason (1967). This requires that one carefully define the constraints of the original position and the constraints on those people in the original position because it "enables us to say that if this is how we are using the words (if this is what we mean by them), then we shall be debarred from saying so-and-so on pain of self-contradiction: and this gives oral arguments a cutting edge which in Rawls they lack" (RR88). Second, Hare points out that Rawls' use of the original position is a form of ideal observer theory and that the veil of ignorance is used only to rig the theory to rule out egoism and enforce the constraints of generality and impartiality. However, Hare feels that this is insufficient to protect Rawls from the results of having a theory whose "normative consequences are of a utilitarian sort," which is a terrible epithet for a man who has spent his whole career devising a rebuttal to utilitarianism. Hare also feels that Rawls has failed to move from using the original position as merely a suggestive picture of a theory of justice to an argument made valid by the logic of the philosophic procedures used (RR95).

Probably one of the most discussed features of Rawls' theory is the idea of the original position and its use in the proof for the two principles of justice. The use of the maximin rule under conditions of uncertainty has been evaluated especially by those in economics and decision theory. Hare believes that it is not important that Rawls rules out the use of the principle of insufficient reason which might yield different results, but the important thing is that it is the knowledge that those in the original position are denied that seals the fate of their decision. Rawls has thus once again set out the original position so as not to yield a utilitarian conclusion. Rawls however readily admits that this is his strategy (141). Hare also notes, as other writers have, that the maximin decision may protect against worst possible cases, but that many contractors would not opt for anything above a certain base minimum and some would always opt for the gamble of maximizing their position. So setting up the original position so that the outcome defines conditions which accommodate the maximin rule is in fact arbitrary and ignores important aspects of human nature.

As might be predicted, Marxists are very critical of Rawls' position and the central claims of Rawls' theory are unacceptable to the Marxist view. Rawls' view of history is one in which social cooperation is possible between classes, while Marx's view is that history is a continuous struggle for economic domination--economic determinism. Rawls believes that some degree of inequality between classes can be justified, essentially forever, while Marx holds that class dominance is not justified and economic events will eventually

overturn this dominance. Rawls' theory is a utopian theory in its grounding, which relies on a conception of justice which is grounded in social cooperation between classes. Marx's theory is grounded in a historical model of economic determinism which eliminates class cooperation as an option. On justice, Marxist doctrine would hold that, one, since justice is a concept which aids the dominant class in justifying economic principles of capitalism and thus leads to class exploitation, it is an illusion to think that Rawls' theory is in any way helpful to the lower classes. Second, as an aid primarily to societal production, Rawlsian justice is willing for all time to accept class differences and inequities (DeMarco, 1975). Thus Richard Miller (1975) critiques Rawls' difference principle from a Marxist perspective by noting that a Marxist could not agree with the presumption implicit in the second principle simply because no social arrangement that is acceptable to the best-off class is acceptable to the worst-off class. The best-off class is the class whose interests are served by the major social institutions, since they are the ruling class, and the best-off class has a much greater need for power and wealth than the rest of society. In short, he argues that rational Marxists in the original position would not choose Rawls' principles of justice because they are counterintuitive to Marxist philosophy. Miller notes that since a great number of the world's people practice some form of Marxism, Rawls' principles are hardly universal.

*For a more complete picture of the Marxist perspective see Miller's article in Reading Rawls and Demarco in Theory of Social Justice for an excellent explication of Miller's article.

The critics of Rawls fall into the categories of those who disagree with Rawls' ideology, like Nozick and Miller, those who find difficulties with the language and logic of the proofs for his principles, such as Hare, and those who question the consequences of his principles for social policy, including Hart and Dworkin. These criticisms are included for the sake of completeness and reflect more the importance of Rawls' theory than the importance of the flaws in his theory. Each of the points made has been acknowledged by Rawls as valid, but it is not his intention to have an airtight case for his theory (see A Theory of Justice, p. 141). Rather he introduced a comprehensive contemporary theory which can be used as a starting point for serious study of the subject of justice, and this he has accomplished.

With criticisms of Rawls' theory having been recognized, the next chapter will examine the application of Rawls' theory to health care. Some of the authors to be discussed have worked within the confines of Rawls' theory, but most have also noted the above limitations and criticisms and have modified the theory to account for the special nature of health care and the failure of Rawls to comment on this important segment of society.

IV. APPLICATION OF RAWLS' THEORY TO HEALTH CARE

There is a growing body of philosophical and social science literature which is concerned with the specific application of Rawls' A Theory of Justice to health care. In fact, law and health care are the two disciplines which have most utilized the theory, outside of traditional philosophical works. The interest from those philosophers and social theorists who write about health care systems is due to the appeal of A Theory of Justice as well as the lack of other theories which look at the large scale distribution of health care to various classes. This work, as mentioned before, is the first comprehensive theory of social justice to be proposed since J.S. Mill, the time-frame most often cited. Another cogent reason is of course the actual state of health care in the United States. Medicare and Medicaid seem only to deepen the distribution crisis because they have increased the expectations of those in the elderly and impoverished classes. This, coupled with technological advances and economic recession, has heightened awareness of the need for a theory which could be used to justify intuitive notions of fairness in distribution of health care.

The purpose of this chapter is to introduce the reader to various methods used to apply Rawls' theory to distributive problems in health care. An alternative to the methods reviewed will then be offered in Chapter V, one incorporating many of the ideas gleaned from reading the literature on justice and health care.

There are common themes in all of the views of health care which use a Rawlsian perspective on justice. The first is that they all accept the basic premises of Rawls' theory and agree that health care ought to be distributed using principles of justice roughly equal to Rawls'. Second, all agree that health care is a societal need and is special with respect to other goods and services purchased by income shares in society. Finally, all agree that utilitarian or libertarian schemes for distribution have serious drawbacks, especially for the disadvantaged classes, in that they are provided with procedural protection from arbitrariness or unfair discrimination and should not be used to formulate policy on the macro level.

The previous chapters have given an outline of Rawl's theory and comments on both criticisms and justifications for the theory. Comments here will be limited to why health care is special and to the drawbacks of other competing theories.

Health care is special according to The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983), as well as for the authors reviewed here, for a multiplicity of reasons. First, and the one which comes most readily to mind, is that health care services have as their goal the reduction of pain and suffering. This service has had deep moral and religious meaning from earliest recorded history. Health care services also increase the quality of people's lives by prevention of diseases and education directed at enhanced wellness and fitness. The presence of particular types of health care, such

as prenatal care, has a direct bearing on how a child enters the world -- healthy or unhealthy. Health care absence or presence can influence the opportunities a person has in society in a very direct manner with correction of congenital defects on a routine basis, for example with glasses or hearing aids. These classes of advantages available to individuals, because of their effect on the person's long range plan, are a powerful argument for using a theory of justice which addresses the issue of opportunity directly, as Rawls does. Health care, then, is special because it diminishes pain and suffering, increases health and vigor, has historical, religious, and moral connotations, and affects a person's long term goals. A final feature of its specialness is that it is unpredictable in its need, that is, it is not usually a continuous life-long need, like food or shelter, but an intermittent, unpredictable need which is not affected by social class or position. There are of course diseases or risks which are greater in one class than another. It is, for instance, unlikely that a wealthy person, who was mentally sound, would be the victim of chronic starvation, nor is it likely that a person from the poverty zone in the United States would be made ill by improperly canned French escargot or Russian caviar. However, anyone from any class may develop cancer or pneumonia. These special features of health care and the Rawlsian perspective of the disadvantaged have led a group of writers to use Rawls' theory as a basis for discussion on health care and justice.

Those who write on the subject of Rawls and health care can be roughly categorized in the following manner: those who feel that

health care should be covered by the first principle and is a primary good, those who view health care as a social good subject to free market demand, those who feel it is most appropriately dealt with in the third and fourth stages of societal development, and finally, those who see it as an issue of the second principle, either the difference principle or the opportunity rule. Each category will be reviewed, with the most detailed examination being reserved for the second principle since this is the direction of my own modifications of Rawls' views. A large body of current literature uses the second principle as a focal point, most notably Norman Daniels' writing, and my use of Rawls will be consistent with this trend.

Health Care as a Primary Good

Using the first principle and thinking of health care as a primary good is advocated strongly by Ronald M. Green (1976, 1983). Professor Green uses the first principle to argue that it is unjust to use any approach to health care access which would "make access to health care a function of one's income share in a just society" (Green, 1976). He pursues this argument by noting that modern technology has made obsolete the idea that health is dependent on nature or luck. Society's decisions regarding health care profoundly affect everyone's health and well being or self-respect. Therefore Green reasons:

Access to health care is not only a social primary good, in Rawls' sense of the term, but possibly one of the most important such goods.... even more apparently than governmental interference, disease and ill health

interfere with our happiness and undermine our self-confidence and self-respect (Green, 1976, p. 117).

Green concludes:

Despite Rawls, then, health care ought to be considered a primary social good in his terms, and ought to be directly considered by a theory of justice (Green, 1976, p. 112).

Green argues that rational agents in the original position who have general knowledge of psychology, theories of justice, etc. would provide some way for members of society to gain access to or receive health care itself. The reasoning for this runs along the same lines as the answer to the question, why is health care special? All humans know about their own mortality, otherwise the original position would be considerably changed. So they would provide for health care because all humans know that they may need some form of health care prior to their deaths. Green then claims that:

A Rawlsian theory of justice provides an appropriate way of thinking about the right to health care and that within such a theory, health care is best handled by treating it on a par with the basic civil liberties (Green, 1983, p. 374).

Translated into Rawlsian first principle terms, this means that each person in a just society is to have right to equal access to the highest quality health care his or her society can afford consistent with society's protection of this right for all (Green 1983).

Furthermore, Green asserts that this use of the first principle avoids the problem of which social goods take priority and further, that health care would then fall under the priority rule.

Access to the highest quality health services would be limited only when necessary to promote the extension and enhanced quality of such care (to promote the more basic services that contribute to the goal of health).

This means that provision of health care and health-related services comes before consideration of economic growth in the establishment of social priorities (Green, 1983, p. 373).

Green's proposal commits a given society to providing health care above any other economic good, unless it can be established that competing goods will improve health care in some way. What Green does not want is to commit society to always maintaining life when great suffering or disability is the result, or to making all medical technology available to all people (Green, 1983). What he does want is to have the status of health care and access to health care play the same role in a just society that economic conditions of the least advantaged play in assessing the society in a strict Rawlsian approach. He most emphatically does not want this second goal in the formulation of the first principle to interfere or compete with civil liberties (Green, 1983, p. 379).

There are several difficulties with this approach to using Rawls' theory. The first is the addition of a separate good, health care, to the first principle and thereby, the consequences of that addition on the theory as a whole. The priority of liberty for Rawls is the cornerstone of his theory. This priority cannot be kept intact if other primary goods are inserted. If one inserts health care at this point, using Greene's arguments, there would be no reason not also to insert education, or any other basic concept of social good into the first principle as well. But this would weaken the first principle considerably. The second difficulty is the focus the approach gives society. Health is important, to be sure. But should it be a priority over all other types of social

distribution and growth? Green would seem to commit society, particularly a sophisticated, technologically advanced society, to spending larger and larger sums on health care. To set a limit, as Green suggests, of say 10 percent of the Gross National Product (two percent less than we are currently spending), would require making the very allocative decisions he is trying to avoid. Third, Green's approach ignores a large part of Rawls' theory which was devised for setting up a system for distributing important goods to society. Since Green has made health care a primary good protected by the priority rule of the first principle, a just society must satisfy the health care needs of all its inhabitants prior to satisfying any other need except liberty. But this seems excessive in very poor and very rich societies. In very poor societies the needs for food and shelter may actually be causing the need for medical care. Would, then, rights to food and shelter need to be added to the first principle? In a very rich society the level of minimum health care to protect equality may be above the maintenance point by a long way, perhaps providing very expensive treatment to those with rare diseases and equivalent care to those without such diseases and with little need for any care.

A final problem is that under Green's system it would be very difficult to assess who is the least advantaged segment. Is it the economically disadvantaged or the sickest? This does considerable damage to the maximin rule. Green's purpose was to establish a fundamental human universal right to health care, strongly protected by priority principles similar to those established by Rawls for

liberty. While it is appealing to think of health care in this way, the cost in terms of other societal goods could be incredibly high. The addition of a primary good to the first principle would mean that decisions concerning allocation in the original position be done behind the veil of ignorance. But this type of good seems better allocated and distributed where the planners have full and specific details about their society.

Establishing Health Care Rights Using the Fourth Stage

Authors such as John Moskop have used the work done by Joel Feinberg in Social Philosophy (1973) to suggest that health care is not a universal human right, but a social ideal. The realization of this societal ideal may lead to specific legal rights. Moskop then suggests that the proper place to discuss this ideal is the fourth stage of Rawls' theory, the legislative stage. The immediate benefit of this reasoning is, according to Moskop (1983):

A society, then, may choose to provide health care among a variety of social services, basing its decision on various considerations, including its history, culture, affluence and special needs or goals. Thus, the amounts and kinds of health care provided as legal rights will obviously vary from society to society, sometimes significantly (pp. 336-7).

Moskop is quick to point out that this strategy does not absolve a society from criticism if its decisions regarding health care are arbitrary. He envisions procedural and substantive moral principles which would be used to evaluate a society's distribution patterns, both among health care and other social goods. However, they would not allow a society to expend all its resources on food or shelter

and neglect health care, or the reverse (Moskop, 1983). It should be remembered that because Moskop is working in a Rawlsian system, to get to the fourth stage, the society has already set up just procedures and background institutions which apply the principles of justice. Now, at the fourth stage, the veil of ignorance is completely removed and it is up to legislators to determine just this type of issue--which specific legal rights will citizens enjoy? The largest difficulty with this theory is that it allows the same problems we are currently facing to continue, so that it would be quite possible to legislate a legal right, such as Medicare or End Stage Renal Disease legislation, which fits all his criteria, but which denies other recipients of public health care adequate coverage. I am thinking here of the cutback in immunization programs and prenatal screening programs dropped with the budget cuts of the 1980's. Moskop's theory does not seem to adequately provide those without political resources with protective legislation which benefits them or with political power to oppose legislation which would lower their share of health care. It does allow for trade-offs with other necessary goods, unlike Green's proposal, but it does not seem strong enough to account for the special circumstances of health care. The important point is that it does not change Rawls' theory, but works within the theory as written.

The market approach to using the Rawlsian principles of justice is advocated by Lawrence Stern (1983). Stern asserts that because health care is special in the ways already outlined and because certain types of health care entail an equal risk despite

differences of class and position, the principle of average utility would be used by a Rawlsian member of the original position. To insure that there would not be age, sex and gender discrimination and to standardize the minimum health care available to all classes, he proposes a health voucher system designed after the Enthoven plan (Olson, 1983). This plan allows transfer vouchers to be issued to all who qualify, to purchase health care protection from third party (private or free market) insurers. There would be minimum standards of care which all plans would have to meet. The inclusion of the least advantaged in the general pool of those purchasing insurance would, according to the design, level the risks to any one insurer and reflect the true market value of health care. The result of being able to establish market value would ensure that a fair judgment of utility would be made, a judgment about what people would be willing to pay to avert certain risks. The public at large would vote periodically on the worth of the vouchers and on the type of minimum coverage guaranteed by the system. The use, then, of the principle of average utility in the original position would continue into the fourth stage and into the transfer branch of Rawls' "well ordered society."

This market approach is an interpretation of Rawls which appeals to the more conservative of the liberal writers on health care. The Enthoven plan is a way to blend large governmental responsibility for health care with features of private business. However, the obvious Rawlsian flaw in Stern's account is that since Rawls argued so vigorously against the principle of average utility

being used in the well ordered society, why would he apply it to one social good and not to others? The difference principle would clearly disallow this type of reasoning. There are also difficulties in equating the market and medical practice (see Arrow, 1963), for the result of using the market economy for medical delivery in this manner would almost preclude service to rural areas or treatment of rare diseases, and would slant delivery even more toward the advantaged of society. This is a situation which all writers, except those who follow Nozick or an extreme free market model, are trying to avoid, whether by using Rawls' principles of justice or some form of human rights approach.

The Second Principle and Health Care

A very prolific writer on the subject of health care and distributive justice is Norman Daniels. In the last several years he has published twelve articles in major philosophical and social theory journals, along with two books, Just Health Care (1985) and Reading Rawls (1975). He is also very frequently cited in the literature on Rawls.

Daniels is the chief proponent of subsuming health care under the second principle, opportunity clause. His argument can be briefly summarized in the following manner. A right to health care can only be justified if it can be derived from a general theory of distributive justice. Health care is a social good, but a special type of social good, as has been previously argued in this paper. A general theory of distributive justice is concerned with the

distribution of social goods, but does not adequately deal with the special nature of health goods distribution. Thus the principle which would be central in a general theory must be at least nominally operative for health care. According to Daniels, a theory of health care distribution must also allow prioritizing of health care needs. The theory must be intended to guide allocation decisions of a general or "macro" type.

In short, a theory of health-care needs must come to grips with two widely held judgements: that there is something especially important about health care, and that some kinds of health care are more important than others (Daniels, 1981, p. 160).

Daniels argues that it is the second premise which gives direction to applying a theory of justice to health care. The second principle dictates kinds of health care important enough to be brought under a general theory of justice which would then obligate someone to meet them. In the strongest formulation of his claim, Daniels states: "We ought to subsume health care under a principle of justice guaranteeing fair equality of opportunity." His weaker normative claim urges: "If an acceptable theory of justice includes a principle providing for fair equality of opportunity, the health care institution should be among those governed by it" (1981, pp. 161-2).

Questions of what ought to and should be done, or judgments of what is required by virtuous conduct, are normative ethical questions. Daniels and Rawls are both normative ethicists. They construct moral systems and do not comment on the meanings of ethical words or the function of moral language, as Hare, the

metaethicist, does. Daniels is arguing that a just society ought to govern health care institutions using the principle of equal opportunity. The questions are then: What are health care needs?, What does he mean by "equal opportunity?", Why put health care under this particular principle? and, finally, What theory of justice would satisfy his normative claim?

Health Care Needs

When Daniels talks of "needs" he does so in a specific sense. Since talking of need ascribes characteristics to a class of things which are more important than wants or desires, it is necessary to determine in what ways they are more important. The type of needs we are speaking of are health care related and, according to Daniels, have two properties which distinguish them from other needs we could come to have. First, they are objectively ascribable; they can be identified as belonging to a person even if that person does not realize he has them or may wish to ignore them for his own reasons. Thus a person with juvenile diabetes needs insulin, and denying it or not knowing that one is a diabetic would not reduce the need for insulin. Second, such needs are also objectively important: a special weight is attached to them regardless of the person's own opinion or any competing claim. Thus the need for medical attention at the scene of sudden trauma or auto accident is deemed so important in this society that "Good Samaritan" laws have been passed to protect medical personnel from most legal suits that would result from giving aid to strangers.

To determine what needs are important in the delivery of health care, the purpose of health care and the function of disease are examined by Daniels. Daniels (1975) uses a biomedical model of disease and health, a model which comes from the writer, Christopher Boorse, a philosopher of biology. This model basically defines health as the absence of disease, and disease is defined as deviation from the natural functional organization of a typical member of a species. Humans under this definition would, according to Boorse, have not only purely physical functional goals, but also social ones which result from their use of language, knowledge, communication and social cooperation. In using the biomedical model, Daniels is assuming that at some stage in the near future there will be exact parameters of what it is to be a normally functioning human being. This is a much narrower interpretation of health and disease than the definition of the World Health Organization, namely: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Callahan, 1973, p. 77)

Daniels defines health care needs, then, as "those things we need in order to maintain, restore or provide functional equivalents (where possible) to normal species functioning (1981, p. 158). These include adequate nutrition, shelter, safe living and working conditions, healthy lifestyle, personal medical services and non-medical social support services. It is important to Daniels to determine that disease is a deviation from normal species

functioning and that the above categories be included in health care needs because he ties opportunity to a normal range of human functioning.

Opportunity Range

Daniels is constructing a picture here of a range of function which is normal. The next step is to define an opportunity range in a society as normal, and this he identifies as the "array of life-plans reasonable persons in it are likely to construct for themselves" (1981 p. 158). This is a general statement which means that each society will have a different opportunity range because the possible life plans for a reasonable person will change with the level of wealth, technology and cultural sophistication reached by that society. However, for that given society a clear picture of normal opportunity range will emerge. The consequence of knowing the normal species function and the normal opportunity range is that if the function is impaired (disease), one can evaluate the impact on the normal opportunity range. From here Daniels concludes that impairment of the normal opportunity range can be used to gauge the importance of health care needs for a given society. The more the opportunity range is curtailed, the more important the health care need.

Fair Equality of Opportunity

Since Daniels has tied opportunity to health care needs, he goes on to note that people in society have an interest in

maintaining a fair and roughly equal opportunity range, and so it is easy to see why health care needs are deemed special. They play a large part in maintaining that fair and equal opportunity range. If health care needs are so important to society, they must be governed by fair and just principles which provide specifically for equal opportunity ranges. We have thus returned to Daniels' claim about health care: "We ought to subsume health care under a principle of justice guaranteeing fair equality of opportunity (1981, p. 160)

Daniels wants health care under the equal opportunity provision so that he can plausibly extend Rawls' theory to health care without adding to his list of primary goods or disrupting the basic rule of priority. His intention is to move from the knowledge that health care is special and has strong ties with maintenance of normal functioning, to the conclusion that there is a reason to obligate society to provide enough health care through its institutions to maintain an equal opportunity range for members of society.

Rawls' Theory of Justice and Daniels' Health Care Claim

The general theory of justice which comes closest to accomplishing what Daniels wants is Rawls' theory of justice. This is not surprising since that is precisely the outcome desired by Daniels. How does Daniels extend Rawls' theory to include health care? He does so by a fairly straightforward acceptance of the connection between health care and opportunity. As has been noted already in this paper, Rawls is concerned with the role played by social institutions in social justice. His view is that the proper

subject of justice is the basic institutions and further that these institutions are to be understood as providing the framework by which the benefits and burdens of society are distributed. In a just society this framework is governed by the principles of justice with respect to liberty (the first principle) and to fair and equal opportunity (the second principle). Individuals operating within this framework use income shares to pursue their own rational life plans. Since Daniels has shown that achieving a rational life plan depends on meeting one's health care needs, then the institutions which deliver health care should be included in the list of basic institutions that the second principle regulates.

Rawls clearly wants to protect equal opportunity, as he makes it a condition which has to be met in a society prior to allowing unequal income shares to be distributed by the second principle. In his book, however, he refers directly only to opportunity with respect to jobs and positions of power. Rawls indicates that opportunity is important because it determines the amount of primary goods available to the individual. But it is not enough for Rawls to only have laws which eliminate formal legal barriers to jobs; positive steps also have to be taken to ensure that everyone has an equal chance at all jobs. At this point Rawls gives the example that his theory requires programs to equalize education in order to ensure fair equality of opportunity. Daniels however extends this reasoning to include cases where one must even out the disadvantages of disease by providing health care. Both health care needs and educational needs are unevenly distributed throughout society. Both

may be influenced by factors such as race, gender, class and family background. So it stands to reason that both may be regulated by the same principle of fair and equal opportunity. Daniels notes that there is a relationship between health care and education.

The combination of unequal distribution and the great strategic importance of the opportunity to have health care and education puts these needs in a separate category from those basic needs we can expect people to purchase from their fair-income shares (1981, p. 167).

Daniels believes that placing health care under the equal opportunity principle keeps this theory very close to Rawls' original theory. Because Rawls worked in an ideal framework in which there were no illnesses and all parties of the original position were physically equal, it is necessary to strive for that ideal. Daniels deals with this in a way similar to the Rawls discussion of the four stages of society. Since normal opportunity range and normal species functioning are the ideal, health care's goal is to maintain or reestablish that ideal. Maintaining that ideal is the function of those institutions which provide for public health, water and air safety, preventive personal medical services and the like. Restoration of the ideal is accomplished by institutions which provide acute care intervention and rehabilitation with the goal of complete restoration of normal function. Examples might include setting a broken leg and providing physical therapy to restore one's original strength or providing glasses which correct to near 20/20 vision. When the ideal cannot be maintained, it is the responsibility of the third stage of health care institutions to bring the individual as close as possible to

normal function. Rehabilitation of the blind or stroke rehabilitation are good examples of this type of institutional service. The fourth stage institutions are brought into play when there is no possibility of return to normal function. Terminal hospice care and long term institutional care such as nursing homes and mental institutions may fit into this category. At this stage Daniels suggests that justice is not the most appropriate virtue to govern these situations. With the staging of health care needs, Daniels completes his claim that health care is special. Therefore, society has an obligation to provide it using institutions which are a part of the basic fabric of society, and those institutions must operate under a fair equality of opportunity principle.

The strengths of this approach to health care are that it works well within Rawls' theory. It accounts for the special nature of health care needs, and it allows for different goals of health care delivery, depending on the needs of the treated and the resources of society.

Difficulties lie in identifying the health services it would and would not cover and in its implications for health policy decisions. Daniels' list of services covered by health care needs includes items which are easily covered by Rawls' principle of common interest, such as environmental safety from toxic wastes, clean air and water, and public health. Assurance of adequate nutrition and shelter apparently come under both the categories of health care needs and of items to be purchased with income. But this is inconsistent with any of the other "special needs," for food

and shelter belong under the social good of income and wealth, not health care. The addition of a healthy life style to the list of goods covered by health care needs in any sense but as a goal of education presents enormous difficulties in resource allocation and enforcement which may conflict with questions of liberty. The question would be to determine how a society would guarantee a healthy life style or, on the other side of the coin, what would be the consequence of choosing a non-healthy life style. Daniels includes too much in his list of health care needs. Certainly if all were included it would medicalize almost every aspect of life. What he does not include is any way to allocate resources by any other measure than determining how disease potentially or actually affects normal functioning, and this leads to real problems in distribution. The more severe the deviation from normal, according to Daniels, the more society's resources should be allocated. Very severe handicaps would thus require large resource investment, in comparison with less severe handicaps such as myopia which could be corrected on large numbers of people for less investment. What is lacking is any kind of a cost/benefit evaluation of services offered. The classes of persons which a just distribution of health care must protect with strong force are those who have no further utility or opportunity or any hope of normal functioning. However, Daniels basically abandons these classes of people to satisfy other virtues. Perhaps he has in mind the virtues of charity or beneficence, but his procedure is unacceptable since the truly least advantaged, without income or power or personal resources to protect

themselves, would be left to their own resources. If the theory cannot account for the needs of these classes, it fails, in my opinion, to take justice in health care seriously.

Summary

The application of Rawls' principles of justice to health care have been done in a variety of ways. Ronald Green argues that because of the special nature of health care, it qualifies for inclusion in the primary goods to be protected by the first principle. Lawrence Stern is persuaded that the proper sphere for discussion of health care needs is the second principle, and inequality of ability to pay for health care would be augmented by a voucher system to provide an equal minimum for all. John Moskop places the discussion of health care in the fourth stage of the theory of justice--the legislative phase. Here the ideal of health care can evolve into legal rights to health care. Norman Daniels places health care needs under the fair and equal opportunity principle using as an index of need, normal species functioning. Each approach has its own problems, a sample of which was uncovered in each case. When looked at critically, each author either guaranteed too much or did not protect certain segments of the society.

V. AN ALTERNATIVE APPROACH TO THE APPLICATION OF JOHN RAWLS' PRINCIPLES

Unlike the authors just considered, I wish to fit the problem of health care needs into Rawls' theory, rather than adapt the theory to fit the problem. I will view the purpose of Rawls' theory of justice to be to evaluate how health care in the United States fares taking a pure Rawlsian approach.

Like the other authors, I believe that health care needs are special. Health care reduces pain, suffering and death, improves the work and home environment, and plays a role in our life opportunities and plans. Additionally, it is special because it has become an expected service, and now it is argued that it is a universal right (Beauchamp, 1979).

The expectations are those of both the provider and the recipient. We now are able to transplant heart and lung combinations supplemented by artificial corporal circulation until donors are found, we can now manipulate genotypes, and we are now only inconvenienced by once fatal diseases such as influenza. Some diseases like smallpox have been essentially eliminated. But one hundred years ago medical care was at best a palliative and at worst an onlooker to suffering. There was no need to fit health care needs within a theory of justice then, because there were no major disparities between health care and the capabilities to meet those needs. The physician and midwife had an oath of conduct to follow which included duties to their profession and their patients, and the conventional virtues of duty and beneficence were more than

equal to the intellectual task of explaining one's professional obligations. Now, however, technology has rapidly outstripped the medical profession's ability to adjust to the new demands on old ethical ideas. For one thing, in a system of health care delivery such as ours, delivery is fragmented. The patient sees more than one physician, and, in an acute care setting, has a different nurse each eight hours, along with a wide variety of support personnel. The result is that the earlier ideas of duty and beneficence which were set up for a close relationship between the provider and the recipient no longer apply.

Another aspect of health care needs which has radically changed is the extent to which government is funding health care. In 1960 public funding of health care needs amounted to 5.8 billion dollars, or 20.8 percent of the total national health care expenditure. In 1984 public funding had increased to 151.2 billion dollars and 39.0 percent of the total spent on health care.* In 1985 the government spent \$461 per capita on health care (see Figure 1, data from Statistical Abstract of the United States, 1986), and the gap between public and private funding is rapidly closing in the United States (see Figure 1). This increased public funding, even in an era of public service and welfare cuts, coupled with rising expectations on the part of the health care consumer, is the most persuasive reason for extending Rawls' theory of health care. Rawls' theory was developed to deal with any social institution and its relationship to a just society. It is concerned with general,

* This total does not include the funding of the 78 medical schools which are publicly owned (Raffle, 1984).

large-scale features of societies and not with individuals. An institution or practice, Rawls argues, is just when it meets the procedural requirements for "justice as fairness."

Before extending Rawls' theory to health care it should be noted that health care needs are multifaceted; they should be treated as such and not lumped together. First, those which are in the public interest should properly be placed under the common interest principle, while those which are discretionary personal health services such as cosmetic surgery or the choice of extra eyeglasses, should come under the difference principle, just as any other goods or services would. Second, those needs of previously or presently disadvantaged groups should invoke the equal or fair opportunity principle, but for different reasons than those held by Daniels' advocates. Third, those needs which are already mandated should be evaluated using both of the principles of justice. Finally, those which are proposed for legislation should be evaluated using reasoning derived from fourth stage principles. These various needs will be considered separately.

How to extend Rawls' theory to cover health care needs without changing the basic thrust of the theory has been the focus of the other authors reviewed. Four different approaches to this problem have been explained. Whether it was the first principle, the fourth stage, the second principle, or the idea of opportunity range, they all had an entry point into the theory which covered all health care needs. But these approaches did not take advantage of

one of the more obvious aspects of Rawls' theory, namely, that it presents a very complex, multitiered matter with many nooks and crannies. For example, one of the points made by each of the authors was the unpredictable nature of health care, but this is true only of personal health services. All other aspects of health care which are public in nature are predictable, at least within a certain range, because they do not deal with the individual, but with long term trends. For instance, infectious disease control, air and water pollution control, toxic waste disposal, training of health care providers, and per capita expenditures on legally mandated programs are examples of long-range health care needs, as they may take years or decades to identify and implement, and results are measured in terms of large populations, not individual cases. Expenditures for these matters are provided for in a distinctly different way than is true for personal health care expenditures and should not be considered in the same category as personal health services.

Rawls uses the class of least advantaged individuals to roughly index the distribution of social goods. The difference principle basically states that in relationship to the least advantaged, if an unequal distribution of a social good improves the position of the least advantaged, an inequality may be just if and only if it also satisfies the priority rule. Health care not covered under the common interest principle is a societal good. In order for unequal distribution of it to be just, we need to know how the unequal distribution will affect the least advantaged and who the least

advantaged are, and we must consider whether the other conditions for unequal distribution have been met.

Those institutions which are responsible for health care needs, such as agencies which provide safe water and air, which monitor toxic wastes, control infectious diseases, and regulate the licensing and training of health care professionals are part of Rawls' non-ideal theory. They come under the regulation of the common interest principle. This principle deals with those services which benefit everyone equally and cannot be divided. Thus it makes little sense to talk about distribution of clean air by income, wealth, power or position. It makes a lot of sense however to place them in the fourth stage deliberation where there is full knowledge of the particular society's needs and resources. There they can then be included in the design of background institutions whose functions and funding are determined by the needs of the particular society, following the principles of justice. Here it may be easily decided that certain public health needs are to be postponed in favor of agricultural research, because to do otherwise would harm the least well off and would only be advantageous to those already eating enough. It is true though that only a special class of health care needs falls under the provisions of common interest.

The largest class of health care needs in the United States is personal health care needs. In 1970 these amounted to 65,350 million dollars and in 1984, 341,835 million dollars (Statistical Abstract of the United States, 1986). How this much income and wealth is distributed should be evaluated by a theory of justice

which protects individual liberties, as well as accounts for just treatment of the poor and disenfranchised. These are the real tests of Rawls' theory, and the theory passes these tests if and only if its health care distribution provides just treatment for the poor and disenfranchised. Rawls' theory succeeds because the distribution of such an important social good fits very nicely under the second principle of justice, though the theory demands that the first principle be satisfied prior to the second principle--the priority rule.

The first principle tells us that each member of society is entitled to equal liberties compatible with others having the same amount of liberty. The question for health care from a first principle perspective is, Does everyone have equal freedom of access to personal health care needs? What this asks is not whether everyone has equal access to the most advanced life saving technology, but rather whether there are any barriers to gaining technological access which would be an infringement on civil rights. That is, are any citizens barred from personal health care services because of race, creed, ethnic origins or sex? Are they barred because of lifestyle or sexual preferences? These types of barriers are inadmissible under a Rawlsian scheme because they limit personal freedoms in unequal ways which cannot be accounted for by increased liberty for the entire society nor accepted as moral by those discriminated against. The next chapter will look at race, color and sex in relation to use of the personal health care system. If

the first principle can be satisfied, the actual distribution of care will then be examined, using the second principle.

The second principle provides for the distribution of the social goods income and wealth, power and position, and the means to achieve self respect. According to Rawls, inequalities in this distribution are to be arranged in such a manner as to be reasonably expected to be to the advantage of all citizens, and the positions and offices in society which lead to these social goods must be open to all. The priority rule for the second principle states that the second principle is to be satisfied in preference to efficiency and that equal and fair opportunity is to be satisfied before the inequalities of social distribution are tolerated.

What does this mean for health care? First remember that we are concentrating in this section on personal health care needs. These are both produced and purchased by income and wealth: there are offices and positions open which produce income; and the means to self respect may involve both income and wealth. Rawls is not interested in the individual case, but in how institutions work. So within the framework of a Rawlsian perspective, personal health care needs ought to be covered by the difference principle and by the fair opportunity clause because the health care industry is an institution.

According to the second priority rule, fair opportunity is prior to the difference principle (302). Fair opportunity in relationship to health care can mean a number of different concepts. The first concept that is consistent with Rawls' work refers to the

jobs and positions generated by the institution itself; this includes jobs for professors of health-care sciences, physicians, nurses, midwives, physical therapists, health care social workers, nursing assistants, and many others. Rawls' equality of fair opportunity principle would demand that all these offices and the privileges which accompany them be open to all. And further, that disadvantaged groups have some type of enhanced training or encouragement to allow them to enter these jobs. This requirement that the jobs and benefits of an institution be open to all insures that the distribution of benefits generated by the institution will be fair initially. As will be seen in the next chapter, the health care system in the United States has a long way to go to satisfy this first demand of the second principle. For instance, the first black nurse graduated from an Oregon school of nursing in 1967!

The second way fair opportunity is applicable to health care is in questions of access to personal health care, again not by individuals accessing the system, but by classes. The system must be designed so that the opportunities afforded by the personal health care institution are open to all. A policy which denied some type of service to all those non-white, would not be allowed on the grounds that competition for the service was not initially open to everyone. This is parallel reasoning to that which Rawls uses for job opportunities and I think works well for health care services. It does not demand equal availability or universal services, but that the competition for these services be fair initially.

After satisfying the fair opportunity clause of the second principle, the connection between the difference principle and the personal health care institution can be explored. The difference principle states that unless an unequal division of social goods is to the advantage of both the advantaged and the least advantaged, equal distribution is the morally favored practice. The health care institution which is not completely socialized—equal care for everyone and no private care for the wealthy—must justify the unequal distribution of personal health care services. This justification must proceed on the basis that increased health care services for the advantaged will increase the level of health care services enjoyed by the disadvantaged. However, the justification is also subject to the fair opportunity clause. Services must be designed initially so that they are open to all, and they must be available for an extended period of time not only to the advantaged segment of society but to the disadvantaged as well. A Rawlsian perspective then allows only as just those services and research which will eventually benefit the society as a whole and which do not harm the least advantaged.

But, could spending 10 billion dollars on artificial heart research be justified on Rawlsian principles given that it would primarily help the advantaged, white male members of society at the expense of prenatal and obstetric research, which in contrast benefits all members of society? On the surface, there would not be enough 'trickle down' to offset the gain of the advantaged. On the other hand, sophisticated treatments of non-life-threatening

athletic injuries have generated spin-offs which have helped all who are treated for orthopedic problems. People who once would have had no opportunity to work because of severed arms or legs are now routinely returned to productive lives as a result of such an expenditure. Children born with orthopedic deformities such as club foot are completely returned to a normal state. The expenditure thus has a beneficial "trickle down" effect on health care; it produces good for the advantaged that eventually helps the disadvantaged. Following Rawls, the priority rules would help the evaluation of what is allowed and what justifies prioritizing distribution of resources. Under the difference principle social goods, in this case personal health care services, must be distributed equally to all members of society, unless unequal distribution is to the advantage of both the advantaged and disadvantaged. The primary justification then must always substantiate how unequal distribution of health care services is to the advantage of the least advantaged. Since this country has unequal distribution of health care services, the question would be, are the inequalities just using Rawls' principle as a guide?

Conclusion

Applications of Rawls' principles of justice which change the principles to fit the special needs of health care services, do not take into account the multifaceted reality of health care needs. Due to this narrowing of the theory, these methods do not adequately

apply the principle. To use this theory correctly as a policy-making guide for the institution of health care, the theory must determine how well a health care system distributes its goods, services and benefits using the principles stated by Rawls. I believe that this can be done and that Rawls' theory is the best method for assessing the health care institution in the United States, for the following reasons:

1. The theory provides the foundation for the equal treatment for all persons regardless of race, creed, sex or personal life styles.
2. The theory demands equal distribution of personal health care services unless unequal distribution is justified by greater advantage to all.
3. The theory accounts for those needs of a clean environment, public health, etc. which are not divisible and are enjoyed by all on a society-by-society basis.

By using the theory to evaluate health care needs and society's response to those needs, we are able to judge existing practices and weigh proposed policy against a general conception of what a just health care system would demand. It is this general conception of justice that Rawls provides which is so necessary when talking about an institution like health care, something that provides such a broad range of services.

An evaluation of a health care system using the principles of justice in relation to disadvantaged classes is the topic of the next chapter.

VI. THE HEALTH CARE SYSTEM OF THE UNITED STATES
AND THE LEAST ADVANTAGED

The least advantaged in Rawlsian terms are those who have the lowest shares of income, wealth and opportunity and, by extension, self-respect. A rule of thumb for Rawls is that those who have less than one half of the median income for a given society are the least advantaged (98).

I assume that in using the concept of median income Rawls is referring to the median income of all male households in the society being discussed, since the vast majority of households are headed by males. The median income for all male households in the United States in 1984 was \$27,301; one-half the median would then be \$13,650 (see Figure 2). This makes identifying the least advantaged quite easy. According to the Statistical Abstract of the United States, 106th Edition, women, blacks, the elderly--over 65--and of course the poor are included in this class by Rawls' own definition. The task for this chapter is to evaluate how the current health care delivery system affects the personal health care of those classes when the majority of the members of these classes fall into the least advantaged definition. This group of people is the starting point for determining whether or not a policy will be accepted under the difference principle. They are not necessarily the sickest, since we are not addressing the issue of health care delivery by an index of need, but rather by how the system treats those in a particular position in relation to the rest of society, the position of being least advantaged. It is acknowledged that severe illness

can easily reduce a whole family from an advantaged to the least advantaged position.

Who are the least advantaged? The poor is the obvious answer, but not the complete answer. The categories I have chosen to look at are classes in which the majority of the members are by income definition least advantaged: this includes the elderly, non-white, women and poor. There will be some class overlap, especially in the case of women, who may have four strikes against them: being poor, elderly, non-white and a female. And quite often three strikes: being elderly, non-white and female. It will not be surprising then that this chapter will emphasize the position of women, as they are easily the largest part of the disadvantaged class.

The goal is to use the principles of justice to determine whether or not the current health care institution of the United States is just--not merely efficient, not the most technologically advanced, and not whether it serves more persons--but whether it is just. Is it a fair system?

Health care expenditures in the United States represent at present 11.3 percent of our GNP and are projected to continue to escalate. By 2003 it is estimated this country will spend in excess of 185 billion dollars on personal health care (Statistical Abstract of the United States, 1986).* That personal health care is big business is quite obvious. The economic model used to describe the personal health care system in the United States is the market

* These figures represent physician service, hospital care and nursing home care only.

model, according to Kenneth J. Arrow (1963), and there is theoretically free market competition. The neo-classical economic model would say that the price of health care services reflects the "marginal utility" of that service, which is equivalent to how much the consumer is willing to pay. However this picture of health care is complicated because the vast majority of personal health care is paid for by some form of insurance, either government or private (third party carriers). Thus it is no longer a simple market. It is no longer based on simple transactions between buyers and sellers. Its complexity is compounded by the presence of people who cannot pay the market price and yet have no other option, except non-utilization of the health care market. This however is unacceptable from a moral point of view, for the idea that people who have strong health care needs should have treatment is an intuitive idea which is deeply rooted in our culture and is reflected in previous discussions about why health care is special. How then do the poor fit into a system of free market economics? The answer seems increasingly clear, they do not very well.

Rawls allows for market competition in his theory of justice as long as the distribution is fair and just. By this he means that the distribution satisfies the two principles of justice. However, personal health care distribution in the United States has a very disturbing element to it. There are increasing reports that those who are applying for care are not getting it, that the unemployed, especially the non-white unemployed, are being turned away from physicians' offices and hospitals (Minkler, 1985; Hellinger, 1985).

From a Rawlsian perspective this is very serious, for if this can be substantiated, then the institution does not meet even the requirements of the first principle, and can be judged unjust.

In using Rawls' principles of justice, the requirement for the first principle was that persons not be discriminated against by inequitable treatment on the basis of race, class, age or sex. If a race or class of people could be shown to be consistently treated in an unequal manner this would indicate that the health care system was unjust. Whether this is true of the health care system in the United States has been studied over the last several years, as budget cuts and economic down-turns have caused a general tightening of the health system's belt. In a study done by Aday, Anderson and Chen (1986) using the five indicators of death, disease, disability, discomfort and dissatisfaction to determine health care status, the results showed that whites consistently enjoyed in all categories a higher health care status than blacks. The indicators were chosen because they reflect both objective criteria of utilization and the causes of mortality plus subjective consumer-oriented evaluations of how well an individual's health care needs are being met.

Death rates are often used to indirectly measure health status. The death rate measures the number of persons who do not live to the life expectancy of their age cohorts. Despite the fact that the death rate fell to an all-time low in 1983 of 549.6 per 100,000, the rate for both black men and women continues to exceed that of white men and women by 40-60 percent and the infant mortality rate among

blacks is twice that among whites (see Figure 3 for death and mortality table).

The indicator "disease" measures the relative risk of dying from major causes of death. Aday et al. (1986) studied the three major causes of death: diseases of the heart, cerebrovascular disease and malignant neoplasms (cancer). Although death rates from these three diseases have declined in the overall population over the last ten years, the risks for blacks have remained high, especially for black females. The same can be said for cerebrovascular disease. The relative risk of stroke is twice as high for the black female as for white females or males. The risk for cancer has risen most dramatically in the black male, but is higher for the black female as well; furthermore the ratio of cancer has increased for blacks overall relative to whites since 1970.

The indicator "disability" measures the extent to which people have to change their day-to-day activities due to illness. The Aday et al. study measured both reported illness days and bed days, which are those in which the person is totally confined to bed, a serious reflection of activity limitation. Blacks reported 30-40 percent more illness days than whites. The bed days for whites, while remaining stable, reflected a relative increase on the part of blacks.

"Perceived discomfort" is a subjective gauge of health status, based on the person's own perceptions. The proportion of the population of the United States reporting their health as fair or poor has been around 11-12 percent since the early 1970's. Blacks

however report a proportion of 20-21 percent, while whites report 10-11 percent. Blacks, then, concerning their health status, report proportionately twice the dissatisfaction ratio as do whites.

The indicator "dissatisfaction" reflects both a general assessment of health and well-being. Populations are polled on their satisfaction with their general level of health and their general happiness. Blacks reported being dissatisfied with their health and general happiness two to two and a half times more frequently than whites according to data from the periodic General Society Survey conducted by the National Opinion Research Center at the University of Chicago (Aday, 1986).

The results of this and many other studies show, then, that the overall health of the nation is improving, but the health of the black population continues to lag far behind that of whites.

There have been increasing reports and stories in the media about refusals by physicians to care for the poor (Siegler, 1983; Hadley, 1985; Farley, 1985). Few documented studies have been done to verify this, partly because the populations are so diverse and the settings difficult to control, and partly because only recently has it been reported on a large scale. A study done by Bradford L. Kirkman-Liff (1985) has shown that the poor are being refused care and that the incidence is increasing yearly.

Methodology for the Kirkman-Liff study was as follows: Randomly selected self-weighted cluster samples of low-income families were drawn from within Arizona census tracts or geographical areas with 20 percent or more of the households below the federal poverty line

(the householder federal poverty line for 1982 was \$6,487). In these households which passed the family size and income screen, an interview was held with a randomly selected adult. The interviews were conducted in both English and Spanish. There was a 90 percent completion rate for interviews.

Each interview covered four types of cases related to refusal of care by providers for the poor: (1) the case where a family member tried to obtain care but was refused for financial reasons; (2) the case where a family member tried but was initially unable to obtain emergency care; (3) the case where a family member tried but was initially unable to obtain care for a sick child in the household; and (4) the case in which a family member tried but was initially unable to obtain prenatal care.

The results indicate that there are serious barriers to the poor receiving even emergency care and that the race factor once again is significant. In each type of case the percentage of Hispanics who were refused care was higher than that of the whites.

For event category one, refusal of care for financial reasons, the overall rate was 5.4 per 100 poor Arizona households in 1982 and 6.9 per 100 in 1984. Arizona does not participate in Medicaid, but has the Arizona Health Care Cost Containment System (AHCCCS), whose mandate is to care for the poor. Included in the samples were people enrolled in this program. The program is a capitation program in which providers are paid by the state to treat a specific population of the poor. In a capitation program the provider is paid a set sum for the health care need of a patient; whether he

needs more or less service the payment remains the same. The idea is modeled after the concept of an HMO and is currently being tried in Portland, Oregon, among other places. Disturbingly, 39 percent of those refused treatment under the system were enrolled under this plan by providers of the plan. Thirty-eight percent of the refusals occurred at county hospital outpatient clinics, emergency rooms and free standing clinics. Thirty-seven percent were refused care at noncounty hospital outpatient departments, clinics and emergency rooms. The number of Hispanics refused was one and a half to two times greater than for whites.

The overall rate for cases where a member of a family tried but was initially unable to obtain emergency care was 2.9 per 100 low income Arizona households. Again the hispanic refusal rate was 1.75 to 2.0 times greater than the rate for whites.

The overall rate for cases where a member of a family tried but was initially unable to obtain care for a sick child was 1.3 per 100 in 1982, but rose to 4.4 per 100 in 1984. Thirty-five percent of these refusals involved a very serious illness or injury!

There were ten cases in which a member of the family tried but could not get prenatal care. This category was not broken down into hispanic/white, nor was the total population of those women who needed prenatal care given, so I have come to no conclusions about this category due to insufficient data. I will, however, explore this topic more fully under the section on women.

There is a trend or pattern which emerges from studies like these on the non-whites served by the health care system in the

United States. One sees that the poor in this country are at a disadvantage, but the non-whites are extremely disadvantaged. Both the Aday and the Kirkman-Liff studies showed that in the same income and need categories, whites and non-whites were treated differently. This of course violates the first principle of justice.

Health care for the elderly in the United States is the focus of tremendous controversy. The elderly population is escalating at a significant rate as this life expectancy increases. The demand for care from this sector is increasing likewise, and the cost for that care has become the largest single budget item in the government health care budget. These facts have provoked conflicts of values and ethical dilemmas.

These dilemmas involve the very core of our value foundations and raise questions regarding the meaning and values of life, the rights and responsibilities of families, the distribution of scarce resources among generations, and the tensions between the autonomy of the individual and the common good (Wetle, T., 1985, p. 19).

The actual and projected size of the elderly population is part of the conflict, while at the same time being a matter for celebration. Contrary to the predictions made when Medicare/Medicaid was introduced 20 years ago, the death rate has dropped and life expectancy has increased. Fully 84 percent of those born in 1980 will reach the age of 65, and the death rate in those over 85 has dropped 25 percent (Wetle, T., 1985, p. 18). There were 18 million people over the age of 65 in 1965, while there were 26 million people over the age of 65 in 1983 according to the Statistical Abstract of the United States, 1986. In 1983 those 26 million people spent 57.8 billion dollars through Medicare and

another 25 billion out of pocket expenses, and the average cost per elderly patient was about \$3,200 (Gaitz et al., 1985, p. 5).

The focus of the debate about the care of the elderly narrows down to dollars and cents. Thirty-three percent of the total health care expenditures in the United States are being spent on 11 percent of the population. One-third of the Medicare budget is being spent on patients in their last year of life (Gaitz et al., 1985).

So, what is the problem? Medicare is a universal coverage scheme, which pays on the basis of utilization; not on income, race, class or sex. We are spending a disproportionate percentage of the health care budget on the elderly's last year, and yet life expectancy has not been greatly improved. What are the "conflicts and dilemmas" which hit at the heart of our ethical system? Prior to 1980 most would have said the system was working well, except for runaway costs. There were a few reports of physicians refusing to treat Medicare patients, because the reimbursement was not 100 percent of usual and customary charges. There were occasional discussions of two system care, one for the regular patients and one for the Medicare patient. But at this point, hospitals were being reimbursed for full patient cost, so there was little evidence of a two-level system. The deductible or co-insurance share for the elderly person was \$60 on hospital admission, a sum most could live with. The gaps in coverage were in long-term care and post hospital home care, but hospital stays were generally long enough to allow the patient to almost fully recover to prehospital condition prior to discharge.

By 1980, however, the spiraling costs of the Medicare system had brought cost-containment into the picture and there developed several possibilities for cost containment reduction of physician fees, reduction of cost of plant facilities and non-physician personnel, less purchase and use of high-cost technology, the capping of hospital costs and increasing the cost sharing ratio of the Medicare recipient.

To understand what happened to cost-containment, the role of the physician in the health care delivery system needs to be examined. The physician is the "gate-keeper" of the health care system in the United States. He, only, has the authority to admit a patient to the hospital, prescribe drugs (except for the few a nurse may prescribe under the Nurse-Practitioner law), do surgery, and order lab and other tests. The physician is extraordinarily powerful in this system and controls indirectly the hospitals and medical high-technology (Starr, 1983; Daniels, 1985). It was highly unlikely, then, that reduction of his fees or reduction in the sophistication of the equipment or personnel he uses was going to easily take place and thus reduce the cost of health care. That left capping hospital costs and co-sharing of costs as the alternatives, and these were indeed the avenues chosen.

A Medicare patient today (1986) pays \$472.00 on admission to the hospital. Hospitals are now reimbursed by a prospective payment scheme known as DRG's or Diagnosis Related Groups. The hospital is

paid, not for how much the care actually costs, but a set fee determined by the patient's diagnosis at the time of discharge. The goal is to more effectively utilize hospitals and contain costs. The result is a rapidly developing two-level health care system with the elderly as the losers.

An examination of the income and expenditure profile for the elderly population shows the following.

- Male makeup: 51.4 percent of the population above 65 have incomes below \$10,000 per year, while 25.2 percent have incomes below \$6,000.
- Female makeup: 76.5 percent of the population over 65 have incomes below \$10,000 per year, while 54.4 percent have incomes below \$6,000, with a median income of \$5,599.
- The poverty level for 1984 for a householder 65 years of age or older was \$4,979.00.

(Data from Statistical Abstract of the United States, 1986, for the years of 1984 to the last year available.)

It should be clear that the elderly in the United States live on considerably less than do the rest of the population and that the elderly female is at double risk. The co-payment required now by Medicare, combined with the fact that fewer and fewer physicians accept Medicare rates and thus patients are paying more out of pocket, are causing serious financial difficulties among the elderly. Since the elderly are now using 30 percent of their median incomes for out-of-pocket health care expenses, this may very well

mean "a choice between a clinic visit and the bus fare to get there" (Minkler, 1985, p. 76).

The more ominous problem for the elderly is the DRG system of prospective payment for their care, which is undertaken by the government to the hospitals. Hospitals have faced two problems simultaneously, decreased revenue from medicare patients and an estimated 30 million people who are not insured at all. The past method for dealing with charity cases has been to cost-shift, that is hospitals charge more to their commercially insured patients than they do to other patients, while giving the same level of care to all. However, this method has not come close to covering the deficit. This deficit is caused partly by the ceiling on payments of commercial insurers and the decrease in Medicare revenue. After the usual remedies were tried, hospitals were put into a position of having to deny some forms of care to patients. This was nicely called 'adjusting the case mix' (Hadley, 1985). Hospitals quit accepting as many charity cases and also stopped treating certain types of patients for whom medicare payments did not cover actual costs or who needed very expensive care. These patients were at first transferred to county and teaching hospitals, but they were soon in the same position as community and for-profit hospitals (Hadley, 1985, pp. 68-80). The once universal medical coverage was thus the victim of budget cuts, economic downturns, and political manipulation. The result has been inequities in treatment, not because of specific characteristics such as race or sex, but on the basis of diagnosis, unless, of course, one can afford to supplement

medicare coverage with private insurance or direct payment. This option is open, but again unequally. According to the United States Department of Health and Human Services, 80 percent of black unmarried elderly women and 49 percent of white unmarried elderly women are among the poor and near poor. Their options to buy extra health insurance are considerably less than those of their male counterparts or of married couples, of whom only 13 percent are at or below the near poverty line. Women not only enter old age poorer, but become poorer with age as a consequence of being widowed, of having higher health care expenditures, and because of pay and pension differences (Minkler and Stone, 1985, p. 353).

The end result of budget cuts and prospective payments for care of the elderly is that hospitals are refusing to care for certain patients, and thus patients who are already in the poverty zone and cannot afford more out-of-pocket expenses, are not seeking medical care until they are very sick. This escalates costs further, and because they begin poorer, women are thus bearing the brunt of the cuts. One consequence has been more and more calls for rationing plans, an outcome which would make some care not available to those over 65. We in fact do have a two level system of health care in a system which was designed to give universal care. The winner in all this seems to be the physician, whose average income after expenses and before taxes has risen from \$56,400 in 1975 to \$99,500 in 1982 (Raffle, 1984).

Using the criterion of Rawls' second principle, that distributions should be equal unless to the advantage of the least

advantaged, the ability to justify Medicare as it is evolving under the Reagan administration is thus rapidly vanishing. Should the trend of co-payment increase and rationing of care become more prevalent, it is clear that the benefits of Medicare may only accrue to those above the poverty line with private insurance. Medicare is evolving into another transfer payment to the advantaged.

Women and the Health Care System of the United States

The case against inequities in the health care system is most easily made with reference to women. Health care distribution in the United States is an institution which accounts for 11-12 percent of our country's Gross National Product. The health care institution is a patriarchal institution in every respect. The institution treats the poor, elderly, non-whites and women unequally. In this section I will talk about both health care providers and recipients and show why women are as a class, regardless of income, treated unfairly.

Since women are most likely to go to male practitioners when seeking medical care, it is fair to ask whether their treatment shows any bias against them. Although women enjoy greater mortality, they live longer than men. They also suffer greater morbidity, that is they experience more illness than men. While for both men and women, cardiovascular disease is the number one killer, men are more likely to die from an acute episode, while women live but experience more chronic diseases.

Women are in the category of "least advantaged" as a class because of their median income as a class. A female head of household in 1983 had a median income of \$12,764, while her male counterpart's median income was \$27,301. The female who is married, but with an absent husband, had a median income of \$9,641, while the male earned \$17,884. The widowed female had a median income of \$9,215, the widower \$11,809. The only two female categories which come close to their male counterparts in median income are divorced women and those who never married. These two groups had median incomes of \$15,216 and \$14,189 respectively, while their male counterparts earned \$22,190 and \$18,838 respectively. In families headed by a female, 42 percent were below 125 percent of the federal poverty level. This makes it very clear that women are disadvantaged by Rawls' definition. They are at a disadvantage in our society by income in all categories. I have not broken these categories down by race because I previously discussed non-whites. I will say, however, that every category is more dismal by about half in the case of non-whites. Given that health care in this country is distributed by a modified market system, the finding that women are treated unequally will come as no surprise since they don't have the financial resources to compete fully. The paradox is that women use more health care services and comprise 80 percent of the health care workers, and yet, as will be demonstrated, remain disadvantaged. It is not surprising, then, that this state of affairs has become an agenda for the women's movement.

One of the distinguishing features of the modern women's movement is a concern with the health care establishment. This is evident in both Great Britain, where the system is socialist, and in the United States, where the system is aggressively capitalistic. The titles of many of the feminist writings give the first clue to this concern.* The writers of these books range from liberal feminists to radical and Marxist feminists. All are concerned with the treatment of women by the health care institution, the inequalities in the health care professions, and the patriarchal nature of the institution and its implications for women.

Why talk about feminism in a work on Rawls? Rawls' use of the principles of justice and his framework for judging social institutions provides the ethical defense for feminist concerns about health care. If an institution consistently treats and regards one-half of the population as subordinate for no other reason than their sex, then the first principle is violated. If there have been concerted and planned denials of opportunities for jobs and positions of power to women, then Rawl's "equal and fair opportunity" clause has been violated. If there has been unequal distribution of the benefits and income generated by that institution without corresponding advantage to the disadvantaged, then the second principle has been violated. If by the treatment of

* Some of these titles are, for example: Seizing Our Bodies, Witches, Midwives and Nurses, Vaginal Politics, Women and Madness, Our Bodies, Our Selves, Gynecological Self-Help, The American Health Empire, Power, Profits and Politics, Complaints and Disorders, The Sexual Politics of Sickness, Women, Health, and Healing, and Women and Health--The Politics of Sex in Medicine.

older women, their resources and the resources of their children have been unfairly used, then the principle of just savings between generations has been violated. If all of this can be shown, then the total institution itself is unjust and a just society would have an obligation to change it. This is what Rawls' principles of justice were designed to do--to assess the basic institutional structures of society. Health care is part of two of those basic structures in the United States: patriarchy and capitalism. It is also a background structure like education, which has an important place in assigning opportunity, income, wealth, and, to a very real degree, self-respect to individuals. The feminist writers understand the importance of health care to the society as a whole. That is the reason for concern in this era of feminism. One hundred years ago, as has been said before, there was little need for concern about the health care establishment, for it did not exist.

Health Care Providers

The first and most obvious place where the health care delivery system intersects with the principles of justice is the "fair and equal opportunity" rule. Rawls wrote of this rule in relationship to jobs, for opportunity is reflected in the distribution of jobs. In the health care delivery system jobs are highly regulated and segregated by sex and color. In 1980 women medical graduates numbered 3,497, and they were entering a mostly male (87 percent) profession numbering 449,500. Women were overwhelmingly outnumbered and out-powered in the male medical world. At that time

there were no women delegates to the powerful American Medical Association House of Delegates; of the 4,000 women who were in academic medicine only 4 percent of the professors were female and there were no female presidents of any of the 178 medical schools in this country. Few women, less than 2 percent, were in a high income field like surgery. Even the field of obstetrics/gynecology included only approximately 8 percent women, presumably because this was one of the top three money makers and power centers, with many of the presidents of the AMA coming from this specialty. The lower median income specialties and those whose focus is on children, nurturing and other "female" traits were, however, well represented with women; pediatrics had about 21 percent women, psychiatry 14 percent and general practice and internal medicine about 12 percent. This distribution corresponds to the amount of money female physicians were not making, since pediatrics, psychiatry and general or family practice are the lowest categories on the physician pay scale, with incomes ranging from \$70,000 to \$80,000 compared to average incomes of \$128,000 for surgeons in general and above \$1 million for cardiovascular specialists (Raffel, 1984, pp. 574-577). According to a study done at the University of California at San Francisco in 1975, women physicians had incomes averaging \$7,000 less than their male counterparts with the same training, experience and productivity (Fee, 1981). These women were obviously not the least advantaged by income, but were subject to blatant discrimination in job opportunity and excluded from positions of prestige and power in the field of medicine by reason of their sex.

Registered nurses comprise the largest segment of licensed professionals in the health care field. In 1980 there were 1,678,000 RNs practicing, with 93 percent being female. The number of males who enter nursing is increasing, but they tend to gravitate quickly to supervisory positions and have a slightly higher income than female nurses, despite less training, experience and productivity (Oregon State Board of Nursing Biannual Report, 1985). With the exception of dentists, optometrists, pharmacists and veterinarians, the vast majority of health care workers from RN down the nursing scale are female.

The health care industry is a service industry with high labor intensity. It represents the largest single industry employer of black and other minority women. The wages are low, but, given the other choices for women without education, this industry represents a reasonable choice for women. At the same time, what we see is actually a dual labor market: (1) the part which consists of physicians, administrators and other high paying health professionals with job security, equity provisions in relationship to supervisors and job advancement, the part which is predominantly male, and (2) the part consisting of low paying jobs, low job security, and poor advancement, the part which is predominantly female. The middle ground is held by RN's who are white with average incomes of about \$23,000, depending on what part of the country one works in.

There are no longer legal barriers to women becoming physicians, dentists, pharmacists, or veterinarians, but there are

societal barriers, including financial ones. There are few role models for women in the top echelon of health care jobs. Much research has concentrated on how females have been socialized to avoid these types of careers. Discrimination against women in the health care industry is evidenced by their clustering in low paid jobs. This is a reflection of a patriarchal society whose values have been integrated into both women's and men's behavior. The treatment of women in general is part of society's basic structures of patriarchy, and it is very clearly mirrored in the health care delivery system. Rawls' principles of justice would be an appropriate tool with which to examine this aspect of our society.

Women as Health Care Consumers

Women intersect with the health care delivery system at critical points in their lives; when giving birth, at menopause (for some), and in old age. Since men do not give birth and do not have a physical climatic; their interaction is usually restricted to their old age. How the health care delivery system treats women, then, is much more significant in terms of judging the justness of the system, for they must use the system more extensively throughout their lives. This means that women interact more frequently with a system which is patriarchal in nature. That is, they must contend with a system which is dominated by men who believe in their own inherent right to a superior role. It is not surprising, then, that a model to describe health care is the patriarchal family, where the physician corresponds to the father, the nurse to the mother,

and the patient to the child. The medical profession has been characterized as paternalistic (Lindeman, 1982). But this paternalism, while being rejected by some, is still the dominant attitude (Laslie, 1982). Patient autonomy is one of the current struggles in the health system and is being met with strong resistance by the medical profession (Whitback, 1982). The struggle of patients for personal autonomy when dealing with the health care delivery system has been assisted by RN's who have radically changed their perception of themselves from "handmaidens" to the current professional and legal description as patient advocates (Sandelowski, 1981).

Child Bearing

The activity of child bearing is one arena where a struggle between physicians, nurse midwives, and patients, as well as radical feminists, exists. Until the beginning of the 20th century women delivered women. However, by 1920 the AMA was attempting to make the profession of Nurse Midwives illegal--a battle which is still being fought in 1986! Child birth in this country has been thoroughly medicalized. There is some revival of home delivery and maternity clinic models, but fundamentally birth is still confined to hospitals. The infant is delivered not by the mother or her female aid, but by the physician. The problems surrounding childbirth are basically ones of paternalism and exploitation rather than health. There is an increasing body of current literature which describes the non-essential chemical or mechanical intervention of male physicians in the childbirth process.

Thus Wisconsin researchers (Rindfuss, Ladinsky, et al., 1981) found that there is an unusually high percentage of births on Tuesdays, Wednesdays and Thursdays. Their research concluded that physicians were inducing labor by chemical means, such as the use of Pitocin, for the physician's convenience and not because of conditions which would endanger the mother or child. This is so despite the warnings against such practice in textbooks on obstetrics.

As for mechanical intervention, the rate of Caesarian sections for women is being critically monitored throughout the United States because of the dramatic rise in numbers of this practice in the last decade (Laslie, 1982). This kind of intervention has long-term implications for women because, in general, births after a C-section must also be C-section. Often the procedure is used without clear-cut medical indications.

Research on Obstetrics tends to be centered around the use of high-technology procedures and technical intervention, even though national statistics show that 90 percent of births are without complication. Apparently such research is necessary because of a doubling in low birth weight births and in congenital birth-defect rate in the last ten years. Prenatal care and counseling are still very low on the research dollar ladder, while these invasive procedures loom high (Laslie, 1982).

There is evidence that the outcomes (mortality and morbidity) for women who bear children are related to their socioeconomic status. The only direct figures are for race, but by extension since it has been demonstrated that race and income are

interrelated, looking at the outcomes of fetal, infant, and maternal deaths gives an indication of whether or not income plays a role in obstetrical care. These figures are for deaths per 1,000 live births, except for maternal deaths, which are given per 100,000 births. Thus the Statistical Abstract of the United States in the year 1982 showed that the infant death rate for white children was 10.1 and was 19.1 for black children. The neonatal death rate for white babies was 6.8, while for black babies it was 13.1. Fetal deaths for whites were 7.9 and for blacks 12.7. Maternal deaths for white women were 5.8 and for black women 18.2. Not only do these figures show that black mothers are three times more likely to die in childbirth, but their babies are twice as likely to die prior to one year of age. Clearly, class and income are once again indicators of unequal health care in the United States. (See Figure 4.)

The Child Bearing Years and Menopause

The connection between child-bearing years and menopause, besides the obvious one of being part of a health continuum, is estrogen replacement therapy (ERT). Women now take estrogen for birth control, for prevention of lactation and of miscarriages, as a morning after pill, as replacement following premature surgical removal of the ovaries, for relief of menopausal symptoms, and now, prophylactically, for osteoporosis. Yet thousands of women have died from the "mild" and "acceptable" side effects of ERT, and many children have been born with a thalidomide-like syndrome, involving limb defects. The controversy surrounding this subject has all the

components which cause writers to judge the United States health delivery system as fundamentally hostile to women and as being more concerned with profits than lives.

DES (diethylstilbestrol) was given to more than 6 million women to maintain pregnancy from the period of 1943 to 1975. The exact numbers are not known for several reasons: the women themselves did not know, physicians have been uncooperative in opening their files and notifying those women, and DES was used in large clinics for the poor where there was often no record kept. The side effect of DES therapy was a very rare form of clear cell, vaginal adenocarcinoma. Until 1971 this was an almost non-existent disease at the age it was then being found, under 20 with some reported cases*5 of eight year olds. Two hundred twenty cases were reported between 1971 and 1974, and presently, with colposcopy examination and tissue-staining techniques, the percentage of DES daughters who presently have been shown to have benign tumors of the genital tract has reached 90 percent. The most incredible fact about this is that in 1971 the FDA sent a bulletin to physicians stating that DES was contraindicated in pregnancy. Then, after great pressure from the drug companies, the agency decided not to require that patient information sheets be given to women. However, since this drug was being used in treatment of prostatic cancer, a warning sheet is and was given to men stating the dangers of estrogen therapy. That DES is a carcinogenic is no longer argued, but it is currently being used as a "morning after" pill, again without warning to female users. (See Dreifus, 1977; Fee, 1981; and Sandelowski, 1981).

The Pill has had serious side effects also. The most pronounced are cerebral and pulmonary emboli and thrombus, or what male physicians label "non-fatal" heart attacks in women as young as 19.

Estrogen replacement therapy for menopausal symptoms has all the same side effects as does the Pill, plus an increasing chance of developing uterine or breast cancer.

The case against ERT and the way the health care system has handled it raise serious questions about who benefits from the system. It is becoming increasingly clear that drug companies and the physicians they service are endangering the health of women on a large scale with little government interference or objection. Is it a result of an underlying diminishing of the value of a woman as a person, being less valuable than men? Is it because women are actually thought of as child-like and not capable of making health care decisions? Or is it pure greed? Whatever the reason, it is certainly not a fair situation.

Old Age and Women

Should a woman survive until she is 65, and many do, she has a one-in-two chance of living her next 20 or so years with an annual income of less than \$5,000 (Minkler, 1985). Not only will she be poorer than her male counterpart, she will have a higher morbidity. She will utilize health care services extensively and is more likely to end her life in a nursing home than a man is. Since she began poor it is unlikely she will have the private means to pay for

long-term care (LTC). She can apply for Medicaid, but after selling her home and transferring all her assets to the LTC facility under the infamous Medicaid "spend down program," she will pay for minimal care. If she holds assets with her children, they also can be seized. So not only is she poor, but any assets which would have been left to her daughters (who statistically take care of 85 percent of her needs prior to admission to an LTC) go to the facility instead (Minkler, 1985).

The diseases which cause morbidity in older women have very low priority in the medical research budget. In the case of arthritis, for example, one of the most frequent causes of disability among elderly women, private foundations mostly sponsored by women themselves are researching disease. Another low priority item and a major morbidity cause for females is diabetes, which contributes to hypertension, strokes and heart disease (Gaitz et al., 1985).

Women are disadvantaged, then, from both the standpoint of income and responsive treatment for their health care needs. Further, they are not being given the amount of information they need to make informed decisions about their diseases and must then themselves be the ones who bear the brunt of often unnecessary and dangerous treatments. They have less opportunity to participate in the wealth and power of the health institution in society. They have higher morbidity rates and more poverty, and they are therefore in every aspect the least advantaged members of society and the health care delivery system, compared to men.

VII. THREE MODELS OF HEALTH CARE DISTRIBUTION

The three most prevalent models for distribution of social goods including personal health care are the market model, the socialist model and the mixed model. The previous chapter has demonstrated some of the problems of the market model when one uses Rawlsian principles of justice to evaluate it. Those who are in the least advantaged class are discriminated against primarily because they do not possess singularly or as a class the power or wealth in the health care system to insure that they have adequate personal health care available to them. From a Rawlsian perspective, if the social good cannot be distributed in such a fashion as to satisfy the two principles of justice, the distribution method is unjust and should be changed. Two questions, then, naturally need addressing: first, is the United States distribution system for personal health care a true market model; second, if so and it is not just, what model would better satisfy the criteria of the principles of justice?

Market Model--the United States

An overview of the American health care delivery system is in order prior to addressing the type of model represented by the system.

The United States health care delivery system is complex and large, serving over 200 million people in 1984. The United States covers a land mass that stretches 3,000 miles from east to west and

2,100 miles from north to south. The greatest population density and concentration of health care resources is in the northeast section of the country with 242 physicians per 100,000 population. The lowest population density and second greatest concentration of resources is in the western section of the country with 207 physicians per 100,000 population (Statistical Abstract of the United States, 1986). In 1981 there were 6,965 hospitals representing 1,364,516 beds (Raffel, 1984).

The funding for this system is roughly broken down into three areas: federal, state, and local government; patient direct payment and private insurance; and third party payers. The health dollar in 1981 was broken down as follows (Raffel, 1984):

Hospital care	\$.41
Physician services	\$.19
Other personal health care (drugs, supplies, glasses)	\$.21
Other health spending (other than physician or hospital)	\$.11
Nursing home care	\$.08

The funding for these expenditures was as follows:

Federal government	\$.29
State/local government	\$.13
Direct patient payment	\$.29
Private health insurers and other private third parties	\$.29

The United States was spending almost 400 billion dollars on health care expenditures as of 1984 (Statistical Abstract of the United States, 1986). The health care system accounted for 10.7 percent of the Gross National Produce and approximately \$1,580 per

American, with great variation by the geopolitical division of the country. The Index of Medical Care Prices has risen from 100 in 1967 to 379.5 in 1984 for total medical care; for physician services the index rose from 100 to 346.1 and for hospital care the index in 1984 was 670.9 (Statistical Abstract of the United States, 1986). Recall that it was in 1966 that Medicare/Medicaid was enacted into law and a type of universal coverage funded by the federal government was made available for those over 65 years of age. The increase in health care expenditures and the projected increased numbers of persons over 65 as the "baby boomers" of the late 40s and early 50s move into the 65 years of age and older category are causing pressure to be exerted on the health care delivery system both in financing and manpower. The financing is largely third party, with the first party being the patient, the second party the physician or health care institution, and the third party the payer. In the United States the government pays the physician through a third party, so the combined third party financing accounts for about 70 percent of all health care expenditures (Statistical Abstract of the United States, 1986).

Registered nurses make up the largest single component of the labor pool with 740 RNs per 100,000 population, followed by physicians with 242 per 100,000, and then pharmacists, with 63 per 100,000. Physician services account for almost 20 percent of the entire health care budget. The high incomes of physicians in the face of education subsidies estimated at as much as 91 percent (Raffel, 1984), has brought the traditional methods of financing

into question as ways of controlling health care costs are sought. Cost of care in the United States is related to a complex interplay between government and private enterprise. As the percent of government contribution has risen, so has the degree of government intervention in price setting. The prospective payment of hospitals based on diagnosis-related groupings or DRG is a prime example. The United States health care delivery system is a large and complex system that is difficult to characterize by a specific economic model. The model which comes closest to it is the market model, but, as many writers have noted (Kessler, 1984; Fuchs, 1983; Olson, 1981), it is far short of being a perfect model.

A market model for distribution is one in which a good or service (commodity) is supplied in exchange for an equal value of the exchange medium used by that society (dollars in the United States). The total value of the exchange medium in the society is identical to the total value of goods (including the money flow) supplied (Becker and Baumol, 1952). Personal health care in the United States is fee-for-service based, where services are exchanged for their monetary value. This holds for all physician transactions except the approximately 3 percent who operate within HMOs where a prepaid plan exists. Hospitals are paid on a prospective payment plan which is based on diagnosis, not service; this plan might aptly be called a fee-for-diagnosis basis. But both physicians' and hospitals' fees can be described as commodity exchanges; the commodity is personal health care and the exchange is dollars,

whether supplied directly by the customer, a third party insurer or a government agency such as Social Security.

The free market or capitalist model of health care is the one under which our health care system operates. But, using Rawls' principles of justice in the last chapter, we saw that the justice of that system is in serious doubt for all but the middle and upper classes of white males. This judgement was made in light of an examination of the classes of least advantaged persons who had health care needs. We found that the poor were not being given equal care and indeed, using indicators of mortality, morbidity, satisfaction and perceptions of health care status, the poor could not be said to have met even a Rawlsian minimum of care. The elderly, who had been given a mandated right to health care, experienced refusal of care and increasing copayment to the point of assuring that they would no longer meet the minimums of housing and food. In addition, we saw that women were discriminated against in the health care system at every turn, both because they lacked opportunities as providers and because they were victims of special interest groups who influenced the FDA to not warn about a very serious health threat. We concluded that women are consistently treated with disrespect by the health providers and have last place on claims for research money to decrease their morbidity. Additionally, the mortality of both mothers and infants in the United States is extremely high for an industrialized country--at this writing, thirteenth in the world--and one would have expected something completely different under a just health care system.

Since the United States health care system relies so directly on the market model of distribution of health care and that system has been shown to be unjust using Rawlsian principles, other forms of distribution need to be examined. Guaranteed minimums in health care are not possible within the context of the present system in the United States. However, other industrialized countries with better health care delivery systems have gone to some form of guaranteed minimum. There are powerful economic forces in the United States, for example the American Medical Association, whose aim is to protect the traditional fee-for-service model. Paul Starr's (1982) book gives an excellent commentary on this subject. The protection of the physician's income is unjust when analyzed in a Rawlsian perspective because large discrepancies in income between providers and the least advantaged may create envy. The tension between the need for guaranteed minimums of care for the elderly and chronically ill and the wish to protect the fee-for-service model was seen clearly in the debates over the Medicare bill and the End Stage Renal Disease bill (see Cabrey, 1982).

An interesting point about the market mentality is that it seems out of phase with the claim that health care is special. Health care is said to be special because it involves conditions of uncertainty, dire consequences and scarcity, coupled with dependency on providers. Health care is also seen as special because it is linked with virtues and in many cultures with religion. Robert M. Cunningham (1983) has articulated the feeling that many of us have had who worked in the health care field prior to the megabuck era of

the seventies. He has asked, "What has become of the underlying, care-before-cost philosophy—the system of motivating beliefs and concepts that created our hospitals and guided their activities for so many years?"

The implication for social policy of applying Rawls' principles of justice to the health care delivery system in the United States is that a different means of distribution needs to be instituted, as the present distributive model is unable to guarantee just minimums of care for those in society who are least advantaged.

What other models are available? Two will be briefly explored here: the socialized medicine model where all citizens by virtue of their citizenship are guaranteed a minimum of health care and freedom of access to the system; and the mixed model, which has mechanisms for guaranteeing a just minimum of care and also requires some form of co-payment or transfer payment from the more advantaged members of society. The first type is well represented by the Swedish system of medicine and the second by the Canadian system. The English system also represents the first form, however it is in a chaotic state of flux currently and is extremely difficult to assess.

The Swedish and Canadian Systems

The Swedish system is, for all intents and purposes, a wholly nationalized system. Medical, dental and pharmaceutical needs are met for all citizens by government-sponsored agencies. Although there are both private medical and dental care, the ceiling charges

are set by the National Institute for Planning and Rationalization of Health Services. Health care itself is not centrally directed however, but controlled by 23 county councils whose members are elected every third year. The councils are responsible for providing health care, for health care promotion and for exploring factors behind diseases. On a concrete level, they are responsible for directing care through physicians, nurses and ambulances. An association of county councils owns the actual hospital and health care institutions.

Health care is financed by those who work and live in Sweden, through mandatory taxation. The distribution of health care is done through the National Social Insurance Board. The board is financed by employers' contributions (85 percent) and state grants (15 percent). The board pays part of the costs of ambulatory service, outpatient services in hospitals, and consultation for inpatient treatment; half of the cost for dental treatment, drugs and traveling expenses are covered after a certain "self risk" level. Sickness benefits for loss of income due to illness or injury amount to about 90 percent of normal income up to a maximum. Parental benefits, payable in the case of the birth or adoption of a child, allow either parent to be off of work for one year.

Swedes pay high taxes for their health care system, 12 percent to the county council and 17 percent in municipal taxes, plus a progressive income tax and a value added tax (VAT) on all purchases. They spend 10 percent of their Gross National Product on health care and have indicated that they would stand for increases in

county council health taxes if they would improve care for the elderly. Sweden, like the United States, is a country which will have 25 percent of its population over 65 in the year 2000.

Physicians are salaried and work specific hours. They may go into private practice, but are restricted as to the number of patients they can see and the fees they can charge.

The basic thrust of the system is to keep people well. As a result, the Swedish people enjoy some of the best health care in the world, and their infant and maternal mortality rate is one of the lowest in the world.

From a Rawlsian perspective the Swedish system has several promising features: universal access and equity of care, participation by the public in the allocation process, regulation of the private sector to insure against vast income disparities and a philosophy which emphasizes wellness and the dignity of the person. Rawlsian principles would judge it to be more just than the United States system of health care delivery on the basis of the treatment of the least advantaged. The Swedish system does not allow unequal treatment on the basis of wealth or income shares below a certain minimum. In addition, there is not a vast income discrepancy between the provider and the patient, so there is no reason for envy on the part of the least advantaged.

The Canadian system is a mixed system. There is universal coverage for health care, including dental care. Health care is basically set up on a fee-for-service basis for hospitals and physicians, as it is in the United States. The difference is that

it is the provincial government directly which reimburses the provider, not an intermediary as in our Medicare/Medicaid programs. There are federal ceilings on charges and an emphasis again on prevention; there are adequate but not excessive diagnostic and surgical procedures. The physician's income is about half that of his peer in the United States. Total health care expenditures in Canada are also about half what they are in the United States, namely, about eight percent of the Gross National Product. Interestingly, about 30 percent of Canadian doctors are women. budgets are controlled by a Provincial Hospital Rate Board and board membership is appointed rather than elected. The system is mandated to have universal access for its citizens; also, benefits travel from province to province and must be comprehensive.

The Canadian system also has positive points from a Rawlsian perspective: universal coverage and access, regulation of rates to allow for private enterprise without large income discrepancies, and regulation by local boards.

From a Rawlsian perspective, using only the indicators of equality of access and universal coverage, the models represented by Sweden and Canada provide more equitable distribution of health care services. The economic class of the health care consumer is in principle not an issue in either model; the requirement for coverage is residence in the country. No other parameters of health care, such as comparisons of technology level or numbers served, or other health care indicators were investigated.

VIII. CONCLUSION

The question that this paper set out to answer was: Can the principles of justice derived by John Rawls in his book A Theory of Justice be applied to health care distribution in the United States? The corrolaries to that question which were addressed are: If the principles can be applied, is the distribution just? and, What is the implication of those findings for social policy?

In response, I have argued that John Rawls' principles of justice can be applied to health care distribution in the United States, and, by applying those principles to the care of the least advantaged, the system can be judged to be unjust. The main implication derived from this application is that the underlying basic structure, in its method of health delivery, is unjust. At the heart of the health care delivery system are patriarchy and capitalism, both of which are hampering the system's ability to give just care. I have concluded that those fundamental features of our social system will have to be changed if just health care is to be secured. One of the benefits of using Rawls' principles of justice in determining whether a distribution of social goods is just, is that it reveals the deeper fabric or basic structure of society and delineates the structural causes, rather than just the effects, of injustice.

The conclusion that health care distribution in the United States is unjust was reached by the following steps.

First, health care was demonstrated to be a moral issue applicable to Rawls' theory of justice.

Second, an analytical review of Rawls' theory was presented, focusing on Rawls' derivation of the principles of justice from the vantage point of the social contract, on the two principles themselves, and on a discussion of the common interest principle and the idea of a well-ordered society. No attempt was made to apply the principles to health care at this stage. This was done for two reasons: first, the theory itself is complicated, and second, Rawls does not explicitly include health or health care as an integral part of his theory. Rawls' theory is formulated in a technical language peculiar to him, so where appropriate, I explained the use of those technical words and concepts.

Rawls' theory is new and in many senses radical. It is a significant departure from the philosophical concepts which have been used in the last century to discuss justice. Thus a review of current philosophical criticism of Rawls' theory is presented in order to clarify some important points. To this end, Robert Nozick, H.L.A. Hart, Joel Feinstein, and R.M. Hare's views on the theory were reviewed, as well as the Marxist critique of R. Miller. These five philosophers represent different major traditions and perspectives in contemporary political and social philosophy, and their comments on Rawls are illuminating. No attempt was made, however, to answer their criticisms, as my purpose was simply to outline how Rawls' theory had been received.

Third, authors such as Norman Daniels, John Moskop, and Ronald Green were examined as models for applying Rawls' principles to health care and for insights one could use to evaluate the existing health care system in the United States. All of these authors modified Rawls' theory to their detriment, I argued, and a brief critique of those modifications was presented. I concluded that each posed either a serious conceptual problem or distorted the original theory to the point that its overall usefulness was invalidated.

Fourth, my own approach to using Rawls' theory of justice as an evaluative tool was developed. A distinction between personal health care and the public or common interest domain was drawn. The advantages of using the theory as it stands were noted. The usefulness of the theory is grounded in the second principle and the fair opportunity rule. The place which the "least advantaged" have in Rawls' theory was reviewed and this concept was used as the evaluation tool in applying Rawls' theory to health care.

Fifth, using this tool, the plight of the least advantaged in relationship to the health care system was described. The poor, non-white, elderly and women were classified as least advantaged and their position evaluated using the second principle and the fair opportunity rule.

Sixth, the market components of the health care system were related to the classes of least advantaged. The conclusion was that the market model could not adequately meet the needs of the least advantaged. Two alternative models of health care delivery--the

socialist model represented by Sweden and the mixed model represented by Canada--were investigated using the Rawlsian criteria of care for the least advantaged and equal access to care. Both alternative models were looked at in terms of their distribution of health care for the least advantaged, and both were tentatively found to be more responsive to this class of persons.

In summary, I have concluded that using Rawls' theory to evaluate the health care system in the United States is fruitful in determining what social policy is just, and I further conclude that this is justified by the findings in this paper. Since finding an answer to this question is the primary aim of this study, that aim has been satisfactorily accomplished.

BIBLIOGRAPHY

- Aaron, Henry J. and William B. Schwartz. The Painful Prescription: Rationing Hospital Care. Washington, DC: The Brookings Institution, 1984.
- Aday, Luann, Ronald Anderson and Meei-shia Chen. "Health Status and Health Care Utilization." Health Affairs 5:1 (Spring 1986) 154-171.
- Arrow, Kenneth J. "Uncertainty and the Welfare Economics." The American Economic Review 53:5 (December 1963) 941-973.
- Beauchamp, Tom L. and James F. Childress. Principles of Biomedical Ethics. Oxford: Oxford University Press, 1983.
- Beauchamp, Tom L. and Seymour Perlin. Ethical Issues in Death and Dying. Englewood Cliffs, NJ: Prentice Hall, 1978.
- Beauchamp, Tom L. and Ruth R. Feder. "The Right to Health and the Right to Health Care." The Journal of Medicine and Philosophy 4:2 (1979) 118-130.
- Bell, Nora K. "The Scarcity of Medical Resources: Are there Rights to Health Care." The Journal of Medicine and Philosophy 4:2 (1979) 158-168.
- Berk, Marc L. and Gail R. Wilensky. "Health Care of the Poor and Elderly." The Gerontologist 25:3 (1983) 311-314.
- Boston Women's Health Book Collective. Our Bodies, Our Selves. New York: Simon and Schuster, 1971.
- Bowie, Norman. "Some Comments on Rawls' Theory of Justice." Social Theory and Practice 3:1 (Spring 1974) 65-74.
- Branson, R. and Robert Veatch (eds.). Ethics and Health Policy. Cambridge, MA: Ballinger, 1976.
- Brownmiller, Susan. Against Our Will. New York: Simon and Schuster, 1975.
- Buchanan, Allen E. "The Right to a Decent Minimum of Health Care." Philosophy and Public Affairs 13:1 (1984) 55-78.
- Cabrey, Kathryn A. "An Ethical Perspective on the Allocation of Scarce Medical Resources as Exemplified in the Federal Financing of Care to Renal Patients." Diss. Georgetown University, 1982.

- Callahan, Daniel. "The WHO Definition of Health." The Hastings Center Report 1:3 (1973) 77-88.
- Chapman, John W. "Rawls' Theory of Justice." The American Political Science Review 69:2 (1975) 588-593.
- Crocker, Laurence. "Equality, Solidarity and Rawls' Maximin." Philosophy and Public Affairs 6:3 (Spring 1977) 262-266.
- Daniels, Norman. "Fair Equality of Opportunity and Decent Minimums." Philosophy and Public Affairs 14 (Winter 1985) 106-110.
- Daniels, Norman. Just Health Care. Cambridge: Cambridge University Press, 1985.
- Daniels, Norman. "A Reply to Some of Stern's Criticisms and a Remark on Health Care Rights." The Journal of Medicine and Philosophy 8 (1983) 363-371.
- Daniels, Norman. "Health Care Needs and Distributive Justice." Philosophy and Public Affairs 10:2 (1981) 146-179.
- Daniels, Norman. "Rights to Health Care and Distributive Justice." The Journal of Medicine and Philosophy 4:2 (1979) 174-180.
- Daniels, Norman. "On the Distinction between Disease and Illness." Philosophy and Public Affairs 5:1 (Fall 1975) 49-68.
- Daniels, Norman (ed.) Reading Rawls. New York: Basic Books, 1975.
- Daniels, Norman. "On Liberty and Inequality in Rawls." Social Theory and Practice 3:2 (1974) 149-159.
- DeMarco, Joseph P. "Rawls and Marx." In: John Rawls' Theory of Justice, H.G. Blocker and Elizabeth Smith (eds.) Athens, OH: Ohio University Press, 1980, 395-430.
- DeNicola, Daniel R. "Genetic Justice and Respect for Human Life." Zygon 11:2 (1976) 115-136.
- Dreifus, Claudia (ed.) Seizing Our Bodies: The Politics of Women's Health. New York: Random House, 1977.
- Dworkin, Ronald. "What Is Equality?" Philosophy and Public Affairs 3 (1981) 185-246.

- Ehrenreich, Barbara and Deirdre English. For Her Own Good: 150 Years of the Expert's Advice. Garden City, NY: Anchor Books, 1978.
- Engelhardt Jr., Tristram H. "Rights to Health Care." The Journal of Medicine and Philosophy 4:2 (1979) 111-117.
- Farley, Pamela J. "Who are the Underinsured?" Milbank Memorial Fund Quarterly Health and Society 63:3 (Summer 1985) 496-503.
- Feder, Judith, Jack Hadely and Ross Mullner. "Falling through the Cracks: Poverty, Insurance Coverage and Hospital Care for the Poor." Milbank Memorial Fund Quarterly Health and Society 62:4 (1984) 544-565.
- Fee, Elizabeth (ed.) Women and Health. Englewood Cliffs, NJ: Prentice Hall, 1981.
- Feinberg, Joel. Rights, Justice and the Bounds of Liberty. Princeton, NJ: Princeton University Press, 1980
- Feinberg, Joel. "Justice, Fairness and Rationality." The Yale Law Journal 81 (April 1972) 1004-1030.
- Fiskin, James. "Justice and Rationality: Some Objections to the Central Argument in Rawls Theory." The American Political Science Review 69:2 613-629.
- Foster, James C. and Mary C. Segers. Elusive Equality: Liberalism, Affirmative Action, and Social Change in America. New York: Associated Faculty Press Inc., 1983.
- Frankel, Charles. "Justice, Utilitarianism and Rights." Social Theory and Practice 3:1 (Spring 1974) 27-47.
- Frankfort, Ellen. Vaginal Politics. New York: Bantam, 1972.
- Fuchs, Victory R. Who Shall Live. New York: Basic Books, 1983.
- Gaitz, C.M., G. Niederehe and N. Wilson (eds.). Aging 2000: Our Health Care Destiny. New York: Springer-Verlag, 1985.
- Gantenbein, Douglas. "The Doctor Glut." Northwest, The Oregonian November 9, 1986 6-13.
- Gardner, Michael R. "Rawls on the Maximin Rule and Distributive Justice." Philosophical Studies 27:4 (April 1975) 265-270.
- Gauthier, David. "Justice and Natural Endowment." Social Theory and Practice 3:1 (Spring 1974) 3-26.

- Gordon, Linda. Woman's Body, Women's Rights. New York: Grossman Publishers, 1976.
- Gourevitch, Victor. "Rawls on Justice." The Review of Metaphysics 28:3 (1975) 485-520.
- Green, Ronald M. "The Priority of Health Care." The Journal of Medicine and Philosophy 8 (Nov. 1983) 373-380.
- Green, Ronald M. "Health Care and Justice in Contract Theory Practice." In: Ethics and Health Policy, R. Branson and R. Veatch (eds.). Cambridge, MA, Ballinger, 1976.
- Hadley, Jack and Judith Feder. "Hospital Cost Shifting: Care for the Uninsured." Health Affairs 4:3 (Fall 1985) 69-80.
- Hare, R.M. "Rawls Theory of Justice." In: Reading Rawls, Norman Daniels (ed.). New York: Basic Books, 1975, 81-100.
- Hare, R.M. Freedom and Reason. Oxford: Clarendon Press, 1967.
- Harsanyi, John C. "Can the Maximin Principle Serve as a Basis for Morality?" The American Political Science Review 69:2 (June 1975) 594-606.
- Hellinger, Fred Jr. "Recent Evidence on Case Based Systems for Setting Hospital Rates." Inquiry 22:2 (1985) 78-91.
- Hobbes, Thomas. Leviathan. London: Penguin Books, 1981.
- Kirkman-Liff, Bradford L. "Refusal of Care: Evidence from Arizona." Health Affairs 4:4 (Winter 1985) 15-23.
- Kuttner, Robert. "The Poverty of Economics." The Atlantic Monthly (Feb. 1985) 75-84.
- Laslie, Adele. "Ethical Issues in Childbirth." The Journal of Medicine and Philosophy 7 (1982) 179-195.
- Leach, Steve. "In Defence of the Rational Model." In: Approaches in Public Policy, Steve Leach and John Stewart (eds.). London: George Allen Ltd., 1982.
- Lewis, Irving and Cecil G. Sheps. The Sick Citadel. Cambridge, MA: Oelgeschlege, Gunn and Hain, 1983.
- Lindeman, S.K. and Elizabeth L. Oliver. "Consciousness, Liberation and Health Delivery Systems." The Journal of Medicine and Philosophy 7 (1982) 135-152.

- Lovell, Margaret I. "John Rawls' Social Justice and Health Care Delivery System." Diss. University of Tennessee, 1985.
- McCullough, Laurence. "Rights, Health Care and Public Policy." The Journal of Medicine and Philosophy 4:2 (1979) 204-215.
- McKinlay, John B. (ed.) Politics and Health Care. Cambridge, MA: The MIT Press, 1981.
- Miller, R. "Rawls and Marxism." In: Reading Rawls, Norman Daniels (ed.). New York: Basic Books, 1975, 206-230.
- Millet, Kate. Sexual Politics. New York: Avon, 1969.
- Minkler, Meredith and Robyn Stone. "The Feminization of Poverty and Older Women." The Gerontologist 25:4 (1985) 351-357.
- Moskop, John C. "Rawlsian Justice and a Human Right to Care." The Journal of Medicine and Philosophy 8:4 (Nov. 1983) 329-338.
- Nozick, Robert. Anarchy, State and Utopia. New York: Basic Books, 1974.
- Olson, Mancaur (ed.) A New Approach to the Economics of Health Care. Washington, D.C.: The American Enterprise Institute for Public Policy Research, 1981.
- Oregon State Board of Nursing. Biannual Statistical Report. Portland, OR, 1985.
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. "Securing Access to Health Care," Vol. 1 Report. Washington, D.C.: U.S. Government Printing Office, 1983.
- Raffel, Marshall W. (ed.) Comparative Health Systems. University Park: The State University Press, 1984.
- Rawls, John. A Theory of Justice. Cambridge, MA: Harvard University Press, 1971.
- Raymond, Janice G. "Medicine as Patriarchal Religion." The Journal of Medicine and Philosophy 7 (1982) 197-216.
- Rosenwaite, Ira. "A Demographic Portrait of the Oldest Old." Milbank Memorial Fund Quarterly Health and Society 63:2 (1985) 187-319.
- Ruggles, Patricia and Marilyn Moon. "The Impact of Recent Legislative Changes in Benefit Programs for the Elderly." The Gerontologist 25:2 (1985) 153-160.

- Sandelowski, Margarete. Women, Health and Choice. Englewood Cliffs, NJ: Prentice Hall, 1981.
- Sass, Hans-Martin. "Justice, Beneficence or Common Sense?: The President's Commission Report on Access to Health Care." The Journal of Medicine and Philosophy 8 (1983) 381-388.
- Scanlon, T.M. "Preference and Urgency." Journal of Philosophy 77:19 655-669.
- Scharr, John. "Reflections on John Rawls' Theory of Justice." Social Theory and Practice 3:1 (Spring 1974) 75-100.
- Sher, George. "Health Care and the Deserving Poor." The Hastings Center Report, August 1983.
- Siegler, Mark. "Treating the Jobless for Free: Do Doctors have a Special Duty? Yes." The Hastings Center Report, August 1983.
- Starr, Paul. Social Transformation of American Medicine. New York: Basic Books, 1982.
- Sterbe, James. "Justice as Desert." Social Theory and Practice 3:1 (Spring 1974) 101-116.
- Stern, Laurence. "Opportunity and Health Care: Criticisms and Suggestions." The Journal of Medicine and Philosophy 8 (1983) 339-361.
- Stewart, John. "Choice in the Design of Policy Making Systems." In: Approaches in Public Policy, Steve Leach and John Stewart (eds.). London: George Allen and Unwin Ltd., 1982, 238-245.
- U.S. Department of Commerce and Bureau of Census. Statistical Abstract of the United States, 1960, 1979, 1984, 1986.
- U.S. Department of Health and Human Services. Proceedings of the International Collaborative Effort on Perinatal Infant Mortality, Vol. I. Hyattsville, MD, 1985, 37-55.
- Van dyke, Vernon. "Justice as Fairness: For Groups." The American Political Science Review 69:2 (June 1975) 607-612.
- Veatch, Robert M. "Just Social Institutions and the Right to Health Care." The Journal of Medicine and Philosophy 4:2 (1972) 170-173.
- Waitzkin, Howard. The Second Sickness. New York: The Free Press, 1983.

Weatherford, Roy C. "Defining the Least Advantaged." The Philosophical Quarterly 33:130 63-69.

Wetle, Terri. "Future Society's Outlook toward Aging, Illness and Health Care of the Aged." In: Aging 2000: Our Health Care Destiny, C.M. Gaitz, G. Niederehe and N. Wilson (eds.). New York: Springer-Verlag, 1985.

Whitbeck, Caroline. "Women and Medicine." The Journal of Philosophy and Medicine 7 (1982) 119-134.

APPENDIX

Figure 1. National Health Expenditures.

Year	Total Spending (billions)	Dollars per Capita	% of GNP	Private Spending (billions)	Public Spending (billions)	Medicare (billions)	Public Assistance (billions)
1960	26.9	146	5.3	13.0	5.6	(x)	.5
1965	41.9	207	6.1	18.5	8.9	(x)	2.1
1970	75.0	350	7.6	26.5	24.9	7.5	6.3
1975	132.7	591	8.6	38.1	52.3	16.3	15.1
1980	247.5	1049	9.4	62.5	97.7	36.8	28.1
1984	387.4	1580	10.6	95.4	151.2	64.6	40.6

Source: Statistical Abstract of the United States, 1986

Figure 2. Median Household Income in Current Dollars, 1970-1980, by Race and Sex.

Type of Household	1970	1975	1980	1984
All households	8,734	11,800	17,710	22,415
White	9,097	12,340	18,684	23,647
Black	5,537	7,408	10,764	13,471
All other races	(na)	8,865	13,651	16,992
Male householders	9,012	12,999	17,519	27,301
Female householders	5,093	6,844	10,408	12,766

Source: Statistical Abstract of the United States, 1986

Figure 3. Death Rates, per 100,000 Population, for Male/Female and Black/White (all ages adjusted).

Group	Total	Heart Disease	Neo-Plasms	Cardio-vascular Disease	Flu/Pneumonia	Diabetes	Arthero-sclerosis
All Races	2885.2	1156.4	824.4	193.5	47.6	60.1	20.6
65-75 yrs	6329.8	2801.4	1238.7	675.1	183.4	124.4	102.9
75-84	15048.3	7341.8	1598.6	2000.8	747.8	212.1	563
All Races - Male							
65-75 yrs	3929	1639.2	1093.2	228.2	68.8	60.8	27.4
75-84	8391.4	3612.4	1797.6	736.7	268.4	125.6	122.3
85+	11782	8221.3	2409.7	1908	1084.4	191.8	568.7
All Races - Female							
65-74 yrs	2084.7	786.2	619.2	167	312	59.6	15.4
75-84	5120.7	2325.8	910.7	639	133.6	125.3	91.6
85+	13895	6970.8	1256.5	2039	633.7	220.7	560.8
White male	706	262.1	159.4	36.6	14.3	9.2	5.7
White female	393	127.4	108.2	31.0	7.6	8.3	4.2
Black male	1035.0	309.4	235.2	68.9	23.2	16.1	6.0
Black female	581.4	185.3	128.7	54.7	10.1	19.8	4.4

Source: Statistical Abstract of the United States, 1982, 1975, 1980, 1986

Figure 4. Infant and Maternal Mortality by Race, 1950-1982.

Category	Deaths per 1,000 live births					
	1950	1960	1970	1975	1980	1982
Infants, total	29.2	26.0	20.0	16.1	12.6	11.5
White	26.8	22.9	17.8	14.2	11.0	10.1
Black	43.9	44.3	32.6	26.2	21.4	19.6
Maternal, total	83.3	37.1	21.5	12.8	9.2	7.9
White	61.1	26.0	14.4	9.1	6.7	5.8
Black	223.0	103.6	59.8	31.3	21.5	18.2

Source: Statistical Abstract of the United States, 1986