

# Public Health and the Law

## Toward Justice in Health Care

RONALD BAYER, DANIEL CALLAHAN, ARTHUR L. CAPLAN, AND BRUCE JENNINGS

### *Equity and Efficiency: The Challenge of Justice*

The American health care system is in crisis. It absorbs enormous economic and human resources and yet it fails all too often to meet the needs of millions of people. The challenge facing American health care today is to fashion a system that is at once just and affordable, a system in which both greater equity and greater efficiency prevail.

The annual rate of "medical inflation" has for many years exceeded the general rise in prices.<sup>1</sup> The proportion of the Gross National Product devoted to health care is more than twice the comparable figure in 1950. The Medicare Trust Fund has come close to bankruptcy.<sup>2</sup> Despite the extraordinary increase in health expenditures over the past three decades, and the rise in government financing through Medicare and Medicaid, significant and growing inequities continue to plague the health care system. Millions of Americans either have no health insurance at all or are inadequately protected by limited and intermittent coverage.<sup>3</sup> Millions still live in geographical regions that have been officially designated as "medically underserved."<sup>4</sup>

This state of affairs should be viewed as intolerable. Instead, it is scarcely visible as a public issue. With growing alarm about the rise in health care costs, public attention has shifted from the social goal of securing equitable access for the unprotected to the issue of "cost containment." The reformist impulse of the 1960s which sought to create an equitable health care system has exhausted itself. In 1983, when the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issued an important report, *Securing Access to Health Care*,<sup>5</sup> its call for government to assume ultimate responsibility for ensuring equitable distribution of health care received only limited attention. An even more restrained response greeted the report of the National Citizens Board of Inquiry into Health in America, *Health Care USA: 1984*.<sup>6</sup>

In the face of such silence it is necessary to reassert the moral priority of equity. All Americans, rich, middle class, and poor alike, should be entitled to a decent level of health care. As a nation, it is our collective responsibility to provide all individuals with a level of care necessary to maintain and restore health, and to eliminate undue anxiety about and risk of future illness. Good health cannot be assured to everyone. But good health *care* can and should be guaranteed. Whether the demand for the reform of the health care system is framed in terms of a "right to health care" or a "societal obligation"<sup>7</sup> to guarantee access to health care is less important than

recognizing a moral commitment to one overriding goal: All Americans must have access to the full range of necessary health care services. Objective criteria, professional judgment, and community consensus will all help to define that standard. In most instances there will be agreement. Where none exists, the difficult political task of determining what a just society must provide to its members will be unavoidable.

In both academic and public policy circles, the debate over health care reform often assumes that our society is on the verge of having to make tragic choices regarding the rationing of scarce medical resources.<sup>8</sup> When the situation is so characterized, the question of priorities in reform takes on an anguished form as efforts are made to determine the most acceptable distribution of resources among, for example, the young and the old and those with different diseases.

We do not believe that assertions about the necessity of making such choices are well grounded. Indeed, we believe that given the capacity of the American economy and the technical and professional development of the health care system, it is possible to undertake dramatic efforts at reform that will meet the challenge of inequity in the health care system and that will do so at a social cost that is tolerable. Furthermore, unlike those who argue that the issue of health care inflation must be met before efforts are made to expand access to the health care system, we believe that both goals can be pursued at the same time.

The highest priority for those who seek to fashion a just and adequate health care system must be the elimination of the prevailing pattern of economic barriers to access to needed medical services. A central feature of any such reform program must be the creation of a system of universal health insurance protection. Past efforts to provide such protection have centered on the creation of a national health insurance program. That was the goal of reformers in the Roosevelt and Truman Administrations<sup>9</sup> and in the 1960s as well. Although advocates of national health insurance maintain that such a program is the only way to protect the millions of Americans who are now vulnerable to the high cost of health care, and which would guarantee uniformity in the range of available services, it seems clear from recent political history that the prospects for the adoption of such a plan are remote.

Nevertheless, the creation of universal health insurance protection is a moral imperative. Without such protection, individuals will be dependent upon the charitable impulses of the community and the availability of public clinics and hospitals established to provide services to the poor and uninsured. Neither private philanthropy nor local governments alone can provide the foundation for a just and adequate health care system.

By its very nature, charity is a voluntary act. The level of effort and commitment is determined by those who believe they ought to share their resources with others who are less

Request reprints from The Hastings Center, 255 Elm Road, Briarcliff Manor, NY 10510. This paper was written for the Hastings Center Project on Justice and Health Care, funded by the Field Foundation.

fortunate. Although modern hospitals developed as charitable institutions<sup>10</sup> and physicians historically offered their services free of charge in clinics, it is clear that the level of such provision has always been inadequate to meet the needs of the poor, the uninsured, and those whose insurance protection is inadequate.

Furthermore, the pattern of cross-subsidies through which hospitals have recently covered the costs of providing uncompensated "charity" care, by increasing the charges of those protected by insurance and of those who pay directly for their medical care, will be increasingly threatened under new prospective payment and preferred provider arrangements.

Much attention has been devoted recently to the moral implications of this threat to the institutional foundations of the provision of hospital service to the uninsured. This situation also forces us to recognize that cost-shifting practices have socially troubling dimensions. They are a morally inferior way of financing the care of the poor. The need to rethink the fiscal basis for guaranteeing care to the uninsured provides us with an opportunity to consider more equitable approaches to the problem, that would entail at the minimum universal protection by health insurance.

Finally, it is clear from the behavior of the uninsured that they are reluctant to seek out needed medical care that may be available on the basis of charity. They delay their use of medical services when they should not.<sup>11</sup> Sometimes they simply do without. In part, they may know that they may be compelled to make a "contribution" of their own that is simply too burdensome. In part, they may do so because they fear being turned away.

Historically, public hospitals have sought to provide access to health care for those who could not otherwise afford it. They continue to do so today. But under the pressure of fiscal crises local and state governments have found such institutions burdensome to maintain, so much so that at times they have made them expendable.<sup>12</sup> Both because of the resources available to them and because of the nature of their clientele, these institutions are in fact often inferior to hospitals in the voluntary, not-for-profit sector. A system of provision that is so profoundly characterized by the impoverished status of those whom it serves cannot provide care that meets the standards of equity. Though there are some striking exceptions—public hospitals that because they are great teaching institutions provide high quality care—separate in medicine can, in general, no more be equal than in the case of education.

There will obviously always be a role for public hospitals and clinics, especially in meeting the medical needs of those who live in underserved areas where physicians might not otherwise choose to establish their practices, and where voluntary associations might not otherwise choose to establish hospitals. But public clinics and hospitals are no substitute for the protection that would be provided by universal insurance. Indeed, the financial viability of such institutions, as well as their capacity to provide care to a broad case mix is dependent upon the existence of such insurance coverage.

Instituting a new pattern of universal health insurance coverage will thus be integral to any effort to create a just health care system. So, too, will be the development of a standard of "medical necessity" as a baseline for equitable care, and the development of better modes of technology assessment to guide social choices concerning the utilization and development of costly medical interventions.

### *Universal Health Insurance*

The federal government bears the primary responsibility of assuring access to health care for all Americans. It is unlikely, however, that in the foreseeable future universal insurance coverage will be made available to the American people through a single national health insurance program under the aegis of the federal government. As a consequence, it will be necessary for policy makers at the federal level to fashion a program of universal protection based upon a mix of public and private insurance that in turn will require a further elaboration of the unique social arrangement through which employers have been assigned the responsibility of providing health insurance to those in their employ. However the details of such an arrangement are ultimately worked out, certain features will be necessary if the demands of justice are to be met.

● *All workers must be provided by their employers with health insurance for themselves and their dependents.*

Since the United States has chosen to rely primarily upon employment-based health insurance for the provision of protection against the cost of health care, the moral requirement that all Americans have such coverage dictates that as a matter of public policy all employers be required to provide their workers with insurance that includes the protection of their dependents. Where the imposition of such a requirement in certain marginal industries might produce economic hardships or threats to economic viability, it is the responsibility of the government to devise appropriate mechanisms that will assure workers in such industries of health insurance coverage, either through subsidies to employers or through direct provision.

● *Unemployment must no longer result in the loss of health insurance protection.*

Because most health insurance is provided to Americans as a fringe benefit of employment, the loss of one's job typically resulted—until 1986—in a loss of health insurance, if not immediately, then shortly after the termination of employment. The loss of such protection at a moment when personal resources became constrained and when stress may actually increase the likelihood of episodes of illness represented an added burden to those who found themselves without work. In 1986, as a result of new legislation, employers were required to offer their terminated employees the option of *purchasing* continued health insurance. While an advance over the situation that had prevailed until then, this reform placed the primary burden of obtaining health insurance protection on the unemployed worker, at a cost that many would find too great. It is the government that ought to bear the responsibility for assuring the continuation of protection through either public or private insurance mechanisms.

● *Federal standards for Medicaid eligibility will be required.*

Millions of poor people are excluded from Medicaid.<sup>13</sup> In part, this failure stems from the eligibility provisions of the federal law, and in part from state-established standards that deny coverage to the medically indigent and that set eligibility standards far above the official poverty line. Medicaid must cover all those classed as poor and who are not employed or the dependents of insured employees. Whether such a shift in public policy will necessitate the federalization of Medicaid is an open question. But the principle that must undergird the new policy is that it is the responsibility of government to provide health insurance to those who otherwise would be

without it, and that it is appropriate for the federal government to ensure adequate coverage, if necessary by providing the insurance itself.

These three measures are put forth for illustrative purposes, to demonstrate that far-reaching efforts and reforms will be necessary to create a system of universal health insurance coverage that will build upon the current pattern of public and private insurance coverage in the United States. While acknowledging that continued reliance upon employment-based programs is possible, these proposals place the primary responsibility upon government to mandate coverage in the private sector and to provide such coverage itself where private efforts do not seem feasible. It must also be borne in mind that there are considerable administrative costs associated with a system that relies upon a complex relationship between private and public payers, especially one that requires of the former that certain standards are met.<sup>14</sup>

### *Standards of Health Insurance Protection*

The creation of a universal system of health insurance—one that will include coverage by Medicaid, Medicare, Blue Cross/Blue Shield, and other insurance programs—will inevitably require an assessment of the adequacy of the coverage thus provided. To mandate protection without establishing some uniform standards of what must be provided and under what terms of payment would be to create the illusion, rather than the substance, of equity.

These concerns grow out of the realities of current insurance coverage. Some policies include first-dollar coverage and a full array of ambulatory and hospital services. Others provide hospital coverage only and under conditions that require substantial insurance co-payments. Coverage for the costs of catastrophic illness is not available to many. "Preexisting conditions" clauses leave even the well-insured without protection against the costs of certain illnesses.<sup>15</sup>

The inadequacy of insurance coverage affects not only those insured by private carriers but those included in the Medicaid program. The states are free to restrict the range of "optional" services and the number of allowable hospital days.<sup>16</sup> The levels of reimbursement provided by Medicaid effectively preclude access to the services of many private practitioners.<sup>17</sup>

A just health care system must be built upon a foundation that provides a full range of medically necessary services under reimbursement criteria that provide equal access to all appropriate medical facilities regardless of the source of insurance. But how are we to define the appropriate range of covered services and adequate reimbursement procedures?

At the outset, it should be noted that considerable disagreement exists about what would constitute a morally acceptable level of coverage in a comprehensive insurance package. Some, following the broad World Health Organization definition of health,<sup>18</sup> would like to see a vast array of social and psychological services covered. There are others who feel, either for reasons of good scientific practice or on moral grounds, that the definition of a health care service should be considerably narrowed.<sup>19</sup> Some proponents of the "narrow" position have even argued that no coverage ought to be given for psychological or mental health services since these services do not constitute appropriate areas for medical or health professional interventions.<sup>20</sup> They buttress their argument by pointing out that these services are used disproportionately by the relatively advantaged in order to

enhance the quality of their lives rather than as a remedy for illness.

Economic considerations also loom large in discussions of the scope of benefits to be provided under health insurance schemes. Some maintain that, although it may be legitimate to define health care services and health care problems broadly, to do so would result in insurance programs that would simply be too costly.<sup>21</sup> Questions about the scope of medicine, the efficacy of therapeutic and diagnostic interventions, and the social burden of providing certain types of care must be considered when decisions to establish standards are made. It will be critically important to identify which factors have been considered in the process. Only then can the agreed-upon standards be subjected to moral evaluation by both the public and the health care professions.

Historically, those concerned with the provisions of health care protection to the most vulnerable have spoken of "basic minimums." Such formulations have often implied a willingness to tolerate differential levels of care in which the poor and others dependent upon the public purse would have access to a range of services that differed in quality and kind from those available to individuals protected by private insurance. If we are committed to a just, equitable health care system, we cannot accept the distinctions that would be implied by reliance upon a standard that guaranteed only a "basic minimum."

Responding, in part, to such concerns, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research elected, in its 1983 report *Securing Access to Health Care*, to frame its ethical standard for the evaluation of the health care system in terms of "adequacy."<sup>22</sup> While recognizing the essential ambiguity of this term, the Commission believed that its formulation provided a term of art that would acknowledge the importance of professional consensus and that would also incorporate broadly supported cultural standards of what the health care system ought to provide to those in need. Such a formulation represents an important step forward. Nevertheless, it may permit interpretations that allow for differences in access to health care that fail to meet our standard of justice. For that reason we have chosen to rely upon "medical necessity" as the criterion by which to judge the coverage provided by health insurance, whether public or private.

### *Ethical Foundations of Medical Necessity*

The concept of "medical necessity"<sup>23</sup> has an important legislative history linked to the enactment of Medicaid. There also is an important judicially defined standard arising out of medical malpractice cases.<sup>24</sup> For us the term captures a deeper and broader moral concern—that of guaranteeing all Americans access to the health services which can reasonably be considered appropriate for meeting their medical needs.

We acknowledge that there is a fundamental problem in analyzing the notion of "medical necessity," since like the notion of adequacy it may lend itself to multiple interpretations. "Medical necessity" might on some readings include everything that clinical medicine can do regardless of the prospects for success and cost considerations, or it might be defined more narrowly to include only those interventions of proven efficacy which involve reasonable cost. Whether organ transplantation, artificial organs, or extremely costly forms of intervention aimed at extending the lives of the

terminally ill should be available to all cannot be automatically determined by invoking the notion of "medical necessity".

As the powers of medicine have expanded and as the domain of physicians has increased, the issue of "medical necessity" and questions about the ends of medicine have become intertwined. Is a new neonatal intensive care unit "necessary," and what ought to be the criterion for "necessity of admission" to such a unit? Should age-based criteria ever be used in determining the access of individuals to costly life-sustaining therapies, out of the belief perhaps that "necessity" varies according to the age of different patients? Is the application of aggressive therapeutic intervention in the case of the terminally ill "necessary" and in what circumstances? How much potential progress must be expected from the application of rehabilitative technologies to make them worthwhile and therefore "necessary"? How much risk must exist to a given patient before a hospitalization is defined as "necessary?" Who should bear the burden of such uncertainty?

Answers to these questions require that we acknowledge that necessity in medicine is an extraordinarily complex notion, involving a mix of empirical findings regarding efficacy and moral judgments about social obligations. It is a notion that is bound to change over time, and one that is bound in some respects to reflect prevailing cultural values and the availability of resources. Societal resources, technological developments and, above all, matters of equity and fairness are thus involved. That no precise empirical or objective standard is presently available does not, however, mean that any substantive definition of the standard is morally tolerable. A standard that defined "necessity" so narrowly that many suffered or died would violate the most basic appreciation of what fairness and decency require.

Despite the disagreements noted above, sufficient consensus exists to make a standard of necessity useful. That problems remain at the margins, especially in cases of new and extraordinarily expensive technologies, should not obscure this fact. The matter of determining which of the clinical interventions at the margin of efficacy ought to be included in the definition of "necessity" will ultimately be a matter of political, scientific, and moral negotiation. The fact that negotiation is unavoidable underscores the importance of enhancing popular participation in the formulation of health policy. Such negotiation will be dependent upon sound empirical findings on the efficacy of not only innovative therapies, but of those that are part of current practice as well.

The adoption of a standard of medical necessity would have two major implications for the design of health insurance programs. In the first place, although experimental therapies or interventions of unproven efficacy could remain beyond "necessity," the current practice of excluding from coverage some medical services broadly deemed clinically appropriate given the health needs of the individual would be precluded. More important, all public and private health insurance programs would be bound by this common and basic standard.

Secondly, the current practice of establishing limits on the number of physician contacts, hospital days, and lifetime medical expenditures would no longer be morally acceptable. Such arbitrary limits can only function to shift the burden of health care onto patients themselves or onto hospitals and physicians who are forced to provide uncompensated care. Experience makes it clear that such limitations effectively

create economic barriers to care that is unquestionably medically necessary.

The recent adoption of diagnosis-related groups (DRGs) as a system for the prospective payment of hospitalized Medicare patients underscores the problems that will be faced by any attempt to impose effective cost conscious limitations on medical care. There is no doubt that the establishment of typical treatment profiles can serve as an important guide to health care providers as they attempt to limit the unwise or excessive cost of care. Nevertheless, empirical studies have already begun to reveal that elderly patients are being discharged from hospitals before optimal, effective and necessary care has been provided, in order to stay within DRG limits.<sup>25</sup> Such financially imposed determinations not only raise disturbing questions about the willingness of the American health care system to provide medically necessary care, but about the financial wisdom of discharging patients who may require rehospitalization.

### *Sharing the Burden of Cost*

Over the past 20 years it has become abundantly clear that differential levels of allowable insurance reimbursements of hospitals and medical practitioners create a marked pattern of unequal access to health care.<sup>26</sup> For those who are inadequately protected, insurance co-payments require large out-of-pocket expenditures for needed medical care. When such individuals are poor and cannot supplement insurance reimbursements with out-of-pocket payments, the consequence may be exclusion from needed health care.<sup>27</sup> Medicare patients who are well-off thus experience fewer problems when they need medical care than the less well-off elderly who find the required out-of-pocket expenditures too burdensome.<sup>28</sup> In the case of Medicaid, where out-of-pocket payments are either prohibited by law or are very limited, the consequence has been a refusal to treat those covered by the program by some hospitals and many physicians.<sup>29</sup>

A just health care system cannot permit the continuation of this pattern. Indeed, a universal insurance program that failed to address this issue would not represent an effective social response to the current levels of inequity in the health care system. When the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research discussed the issue of the costs of care, it adopted the principle that access to adequate medical care ought not create "excessive burdens."<sup>30</sup> Individuals under such a formulation would be expected to bear some part of the burden of the costs generated by their "consumption decisions." We reject the view that personal health care services are a commodity, even a precious commodity. Therefore, we cannot accept as a perspective the argument that individuals ought to pay, at least in part, for what they "buy." Like education of the young, health services ought to be considered a community good, paid for out of communal resources.

We recognize that cost-sharing schemes, virtually a universal feature of insurance programs, may, however, be a defensible way of preventing the unwise use of medical resources. When they are so used, it is imperative that such devices not create obstacles to the use of necessary medical services. Furthermore, the combined impact of premiums and out-of-pocket expenditures should not result in regressively structured burdens for the poor and middle class.

When discussion of universal health insurance centered on the form that a governmentally sponsored national insur-

ance program would take, it was possible to apply this standard of financial equity in a rather straightforward way. Progressive taxation was often deemed the appropriate source of general revenues to support the system. To the extent that premiums were deemed appropriate they too could be structured in a progressive fashion. Finally, the level of out-of-pocket payments could be adjusted to reflect the income of those who made use of the health care system.

To the extent that a universal system of health insurance will involve a mix of governmental and employer-based programs, the application of the principle of financial equity will require a complex set of policies that will permit the incorporation of the principle of progressivity. Among the possibilities might be the use of the income tax system to provide tax credits to compensate for the inevitable elements of regressivity that will characterize a system in which private insurance plays a central part. Governmental plans could with greater ease be adjusted to reflect the principle of progressivity. The experience of the elderly under Medicare makes it clear that a failure to adopt such a principle inevitably produces inequitable patterns of health care utilization.

#### *Technology Assessment and Medical Necessity*

The prospect of the creation of a just health care system in which all Americans are provided access to medically needed services is haunted by the specter of high technology medicine. With the cost of each new advance viewed as yet another challenge to the fiscal integrity of the health care system, some have argued that we cannot afford equity.

There is some controversy over the extent to which the inflationary rise in health care costs can be attributed to rapid developments in high technology medicine, or to the widespread use of relatively inexpensive procedures—often of dubious efficacy—in countless clinical encounters.<sup>31</sup> No matter how this debate is resolved, it is clear that the accelerating pace of technological innovation has had a marked impact on the cost of health care.

The irony of our current situation is that at the very moment that the prospects for technological advances seem virtually limitless, we have become aware that our resources are finite. How will we confront this situation, and how will that confrontation affect the quality of the health care to which Americans will have access?

There are those who believe that, while the cost of the ensemble of predictable advances in medical technology will be significant, our society has the economic capacity to afford them. Indeed, they believe that if adequate measures were taken to control unwarranted expenditures on unproven diagnostic technology and therapies, the American health care system could absorb the costs of truly efficacious but costly technologies now being developed. For such observers, the assertion that we now face the necessity of making tragic choices is at best premature.<sup>32</sup>

On this view, the creation of broadscale programs of technology assessment is a matter of urgency, not only for new medical procedures but also for those that are part of "customary practice."<sup>33</sup> The urgency of such assessment is underscored by the finding of the Office of Technology Assessment (OTA) of the US Congress that less than 20 per cent of all existing medical technology has been subjected to any sort of controlled clinical trial or systematic study.<sup>34</sup> A reform priority must be the creation of both state and federal bodies that have the authority, resources, and expertise to

collect standardized information about medical technologies, to analyze such data, and rapidly disseminate the results to guide policy decisions concerning access and reimbursement.

The optimistic view that technology assessment and the elimination of wasteful procedures can meet the challenge posed by health care costs is rejected by those who argue that we will soon have to choose among effective therapies.<sup>35</sup> For those who hold this view, no single technology or group of technologies is so expensive as to represent an unbearable burden for American society. It is clear to them, however, that not all of the potential advances of medicine can be afforded, especially if the demands of equity require access regardless of a person's ability to pay for treatment. In the not too distant future, they believe that choices will have to be made among the potential life-saving and life-enhancing technologies. For them, the question facing society will no longer be: Can this medical advance provide benefit to some individuals? Rather, they believe it will be necessary to ask: Does this potential advance meet the standard of medical necessity *at an acceptable social cost*? And in some cases, the decision is going to be that the cost of intervention is simply too great.

On this view, only a decision to forgo certain developments in medicine will preclude the necessity of developing rationing mechanisms that will either entail unconscionable choices about which individual lives are worth saving, or that will employ more subtle economic determinations masked by the language of medical suitability. These critics argue that the task of limiting the potential social cost of innovation must therefore begin early in the process of development, certainly before the pressure for dissemination can take hold. On a practical level, such efforts would have to take the form of restrictive decisions on the part of those public agencies that have played so central a role in the funding of biomedical research.

While techniques like cost-benefit analysis may help to clarify important aspects of the decision-making process, they cannot eliminate the need to face what are inherently moral and political questions. These decisions are the appropriate subject of broad-based discussions involving physicians, other medical experts, policy makers, and lay persons as well.

#### *Conclusion*

In this communication, we have stressed the moral priority that must be given to remedying the patterns of inequity that characterize the American health care system. This call for the necessary policy changes at the federal level comes, however, when in both the public and private sectors all energy seems devoted to cost containment, when government officials and leaders of industry have set a very different agenda for both discussion and action.

To control the level of public expenditure, Medicaid coverage has become subject to ever greater restrictions. The Medicare program has increased premiums and the requirements for out-of-pocket expenditures. In the private sector, efforts are being made to limit the scope of health insurance coverage as well as the extent to which insurance will reimburse for services. Proposals to tax employee health insurance benefits are designed to encourage the purchase of less costly, less comprehensive coverage.

In each of these cases the goals are twofold: to reduce social expenditure through the privatization of the cost of

health care; and to make "consumers" cost-conscious, thus encouraging a reduction in the level of utilization of health care services. As Lester Thurow noted in his 1985 Shattuck Lecture before the annual meeting of the Massachusetts Medical Society: "No one is ever willing to come right out and say so, but the long-run aim is to return the system to the point where a large fraction of health care costs once again comes directly out of individual pockets. The goal is to make the patient the main cost container."<sup>36</sup>

While we acknowledge that the fiscal crisis of government and the overall cost of health care in America necessitate efforts at cost control, we believe that the measures now most prominently on the public agenda represent an unfortunate trend. Cost containment is being pursued in a manner that will exacerbate inequalities—multi-tier health care is no longer viewed as anathema but as unavoidable if the health care system is not to generate unacceptable burdens for American society. Furthermore, the privatization of health expenditures assumes that medical care is like other commodities rather than a basic social good which, like education and defense, ought to be viewed as a primary social responsibility.

Can we afford the cost of justice? We do not deny that the proposals set forth in this article will entail new costs for government and for American employers. In the short run, the creation of a just and decent health care system may force some economic dislocations. Inevitably, however, the costs generated by the decision to eliminate the inequities in the health care system will force American society to adopt firm but appropriate cost containment measures. Justice and fiscal responsibility are thus not necessarily incompatible; they will only be so if there is a failure of political nerve.

Rather than ask; "Can we afford the cost of justice?", we believe it is time to pose the question: "Can we any longer afford the moral price of inequity in health care?" Tales of patients being turned away from hospitals because they lack health insurance, of the poor, the elderly, and members of the middle class forgoing needed medical care because of its cost do and indeed ought to provoke disquiet among the American people. Our moral sentiments should serve as a critical force in the face of the numbing discussions of cost containment. The political determination to turn from equity because of cost may, however, have as its ultimate consequence the subversion of our capacity to respond with dismay when those who are in need are deprived of the health care which is their due. We may come to accept as inevitable that which should be the subject of our reformist impulse. If such a process occurs, we will be the worse for it as a political community.

The United States spends more on health care than virtually any of the advanced industrial democracies of Western Europe. There is no reason to believe that we cannot achieve the level of equity that exists in those societies. The question is not cost, but rather whether we have the moral imagination and political will to strive for justice.

#### REFERENCES

1. Fuchs VR: *The Health Economy*. Cambridge, MA: Harvard University Press, 1986; 334-339.
2. Special Committee on Aging, United States Senate: *Prospects for Medicare's Hospital Insurance Trust Fund*. Washington, DC: Govt Printing Office, 1983.
3. Davis K, Rowland D: *Uninsured and Underserved: Inequities in Health Care in the US*. Milbank Mem Fund Q Spring 1983; 61(2):149-176.
4. Carpenter ES: *Concepts of Medical Underservice: A Review and Critique*. In: *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services, Volume III: Appendices—Empirical, Legal, and Conceptual Studies*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Washington, DC: Govt Printing Office, 1983.
5. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Securing Access to Health Care: The Ethical Implications of Differences in Availability of Health Services, Volume I: Report*. Washington, DC: Govt Printing Office, 1983. (Hereafter President's Commission, Report.)
6. National Citizen's Board of Inquiry into Health in America. *Health Care USA: 1984*.
7. President's Commission, Report, 22-47.
8. Aaron HJ, Schwartz WB: *The Painful Prescription: Rationing Hospital Care*. Washington, DC: Brookings Institution, 1984.
9. Starr, P: *The Social Transformation of American Medicine*. New York: Basic Books, 1982.
10. Rosner D: *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885-1915*. Cambridge: Cambridge University Press, 1982.
11. Davis and Rowland, op. cit.
12. Vladek C: *Equity, Access, and the Costs of Health Services*. *Med Care* 1981; 19(12)(Suppl):69-80.
13. Institute for Medicaid Management: *Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-1978*. Washington, DC: The Institute, 1978.
14. Himmelstein DB, Woolhandler S: *Cost without benefit: Administrative waste in United States health care*. *N Engl J Med* 1986; 314(7):441-445.
15. Oppenheimer GM, Padgug RA: *AIDS: The risk to insurers, the threat of equity*. *Hastings Center Report* October 1986; 16(5):18-22.
16. President's Commission, Report, 155.
17. *ibid.*, 88.
18. World Health Organization: *Basic Documents, 26th Ed. Constitution of the World Health Organization*. Geneva: WHO, 1976; 1.
19. Callahan D: *The WHO Definition of Health*. *Hastings Center Studies* 1973; 1(3):77-87.
20. See, for example, Daniels N: *Health care needs and distributive justice*. In: Bayer R, Caplan AL, Daniels N (eds): *In Search of Equity: Health Needs and the Health Care System*. New York: Plenum Press, 1983; 1-4.
21. Callahan D: *Setting Limits: Medical Goals in an Aging Society*. New York: Simon and Schuster, 1987.
22. President's Commission, Report, 35-43.
23. Sarro A: *Determining medical necessity within Medicaid: A proposal for statutory reform*. *Nebraska Law Rev* 1984; 63:835.
24. See, for example, Shuck PH: *Malpractice Liability and the Rationing of Care*. *Texas Law Rev* 1981; 59:1421-1427.
25. Dolenc DA, Dougherty CJ: *DRGs: The Counterrevolution in Financing Health Care*. *Hastings Center Report* June 1985; 15(3):19-29; *Hospitals reduce costs, length of stay*. *Hospitals* September 1984; 58(18):37; Gillock R, Smith H: *Considerations for effectively managing DRGs*. *Hospital Topics* March/April 1985; 63(2):6.
26. Huang LF, Koropecy O: *The Effects of the Medicare Method of Reimbursement on Physicians' Fees and Beneficiaries' Utilization*. Volume 2, Part 1. Washington, DC: Robert R. Nathan, Associates, 1973; Mitchell JB, Cromwell J: *Physician Behavior under the Medicare Assignment Option*. Final report submitted to the Health Care Financing Administration, January 1981.
27. Mitchell JB, Cromwell J: *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare*. In President's Commission, Volume III, op. cit., 121. (Hereafter, Access to Private Physicians).
28. President's Commission, Report, 152-153.
29. Mitchell and Cromwell, Access to Private Physicians, 105-130.
30. President's Commission, Report, 21-22.
31. Menzel P: *Medical Costs: Moral Choices*. New Haven: Yale University Press, 1983.
32. Angell M: *Cost containment and the physician*. *JAMA* 1985; 254(9):1203-1207.
33. Feinberg HV, Hiatt HH: *Evaluation of medical practices: The case for technology assessment*. *N Engl J Med* 1979; 301(20):1086-1091.
34. Office of Technology Assessment: *The Implications of Cost-Effectiveness: Analysis of Medical Technology*. Washington, DC: OTA, 1980.
35. Aaron and Schwartz, op. cit.
36. Thurow LC: *Learning to say no*. *N Engl J Med* 1984; 311(24):1569-1572.