

# SOCIAL JUSTICE AND HEALTH CARE MANAGEMENT: AN ELUSIVE QUEST

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## I. INTRODUCTION

Contemporary healthcare policy making is faced with a fundamental dilemma: how to control costs, limit access to health care delivery systems, and constrain informed choices within both.<sup>1</sup> National priorities are being determined because of unchecked rises in health spending.<sup>2</sup> Annual health care costs have reached more than \$2 trillion, approximately sixteen percent of national income or gross domestic product. It has been estimated that by 2030, that percentage could exceed twenty-five percent.<sup>3</sup> In 2006, overall spending for health care in the United States rose 6.7% to a per person cost of \$7,026.<sup>4</sup>

Of equal concern is the dramatic ongoing wealth transfer from the young to the old.<sup>5</sup> Representing an eighth of current population demographics, Americans who are sixty-five years-of-age and older account for roughly one-third of total health care spending.<sup>6</sup> This share of spending for the elderly will rise about twenty-percent by 2030, which could translate to nearly one-half of total health spending costs.<sup>7</sup>

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<sup>1</sup> JAMES F. CHILDRESS, PRACTICAL REASONING IN BIOETHICS 259-62 (1997).

<sup>2</sup> Robert J. Samuelson, *Rx for Health Care: Pain*, WASH. POST, Dec. 6, 2007, at A29 (drawing on projections made by the Congressional Budget Office).

<sup>3</sup> *Id.* at A29.

<sup>4</sup> Christopher Lee, *Medicare Helps Push Drug Spending Up*, WASH. POST, Jan. 8, 2008, at A3. The actual overall cost of health care spending for 2006 was \$2.1 trillion. *Id.*

<sup>5</sup> Samuelson, *supra* note 2 (drawing from reports by the Centers for Medicare and Medicaid Services).

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

One overriding point is very clear from these statistics: so long as restrictive levels of use for health resources exist, “some principle of maximum societal benefit” is required.<sup>8</sup> Accordingly, the individual’s unfettered right to access and equality of use must—to some extent—be compromised in order to safeguard the general need or the common good.<sup>9</sup>

No definitive structure for normative decision making in health care resource management will be developed in this article. Indeed, finding what may be considered a “just” solution to the selective distribution of finite health care resources is a task of overpowering magnitude and perhaps a “near impossibility.”<sup>10</sup> The health care compromises made, the values and public policies used to shape them, and the framework within which they operate presently will, however, be analyzed. To that end, the economic, medical, ethical and socio-legal underpinnings of the frameworks or models for decision making will be examined critically as well as the conflicts and challenges arising from their application.

The vast complexities and philosophical nuances of the subject area, together with limitations of space imposed, dictate an analytical approach that is restricted in the scope and depth of its criticism. What will emerge, however, is a foundational evaluation of the core considerations, or perhaps principles, which—of necessity—will guide in conflict resolutions regarding allocations of health care resources. These considerations, in turn, need to be addressed and, where appropriate, re-evaluated to assure that—to the extent possible—a level of distributive justice can be achieved in accessing and distributing limited health care resources to all citizens within the national, global, or transnational communities.

## II. INDIVIDUAL OR COMUNITARIAN RIGHTS?

Many Americans assume that, as part of their inalienable rights

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<sup>8</sup> J.K. MASON, R.A. MCCALL SMITH & GRAEME T. LAURIE, *LAW AND MEDICAL ETHICS* 416 (7th ed. 2002).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 417.

to life, liberty, and the pursuit of happiness, any health care plan sponsored by the government must validate and thus support these fundamental rights which in turn support their claim to whatever courses of action are necessary to make them "healthy and happy."<sup>11</sup> Thus, "essential care" or a "decent minimum" of health care is thought to be an integral part of the very right to health care.<sup>12</sup> These claims of access to health care are all set within a culture that is technologically driven, individualistic, wasteful, and death denying;<sup>13</sup> and one that refuses to accept limits to health care.<sup>14</sup>

The net effect of the near compulsive obsession with "rights talk" or the supremacy of the "ethics of rights" in healthcare has challenged both the width and depth of the common or community life.<sup>15</sup> The common good is, thus, compromised—all in order to advance or maintain private entitlements to more and more health "products."<sup>16</sup> These products are in ever-growing abundance because of the phenomenal successes of medicine, not its failures.<sup>17</sup>

Since the potential demand for health care is virtually unlimited, finding a compromise between demand and supply associated with the distribution of scarce resources presents one of the most serious ethical problems of the day.<sup>18</sup> Sadly, medicine today is little more than a very, very "expensive article of commerce."<sup>19</sup>

In contemporary society, medicine is seen as a marketplace—where "emphasis is placed on efficiency, profit maximization,

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<sup>11</sup> GEORGE J. ANNAS, *SOME CHOICE: LAW, MEDICINE AND THE MARKET* 44 (1998).

<sup>12</sup> John F. Kilner, *Allocation of Health Care Resources*, in 2 *ENCYCLOPEDIA OF BIOETHICS* 1067-1084 (rev. ed. 1995).

<sup>13</sup> See MASON ET AL., *supra* note 8, at 412, 419.

<sup>14</sup> See Willard Gaylin, *Faulty Diagnosis: Why Clinton's Healthcare Plan Won't Cure What Ails Us*, 287 *HARPER'S MAG.* 57-65 (1993).

<sup>15</sup> See generally, MARY A. GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* 111 (1991); see generally, AMITAI ETZIONI, *THE SPIRIT OF COMMUNITY: THE REINVENTION OF AMERICAN SOCIETY* 14 (1994).

<sup>16</sup> *Id.*

<sup>17</sup> See Willard Gaylin, *Health Unlimited*, 20 *WILSON Q.* 38, 38 (1996).

<sup>18</sup> MASON ET AL., *supra* note 8, at 414; see also CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TROYEN A. BRENNAN, *HEALTH CARE LAW AND POLICY* 179 (2nd ed. 1998).

<sup>19</sup> MARK A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 11 (1993).

customer satisfaction, ability to pay, planning entrepreneurship, and competitive models.”<sup>20</sup> Thus, the “ideology of medicine is displaced by the ideology of the market place.”<sup>21</sup> “Trust is replaced by *caveat emptor*” with price disparities abounding.<sup>22</sup>

In order to correct this imbalance, patients must be placed at the center of the health care marketing system. Today, the focus in health care maintenance is on organizations instead of individual physicians.<sup>23</sup> Individual-oriented medicine is thus, being displaced by “institutionally practiced, community-oriented health care.”<sup>24</sup> As a consequence, the dialogue and dialectic between the medical profession and the society it serves is strained.<sup>25</sup>

### A. Societal Shift?

In the United States, the tenets of egalitarianism, seen properly as the very “moral economy” upon which the ideology of healthcare distribution is anchored, hold fast to the notion that only when legal rights are equalized among all citizens can “equity of access,” here-to healthcare resources–be achieved.<sup>26</sup> In fact, this is seen as the moral economy upon which the system was originally erected.<sup>27</sup>

Whether society is moving slowly, albeit almost imperceptively, from a state of materialism grounded in “economic values” to one of “post materialism where other values such as ethics are as

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<sup>20</sup> ANNAS, *supra* note 11, at 46.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*; see Edmund D. Pellegrino, *The Goals and Ends of Medicine*, in *PHYSICIAN AND PHILOSOPHER: THE PHILOSOPHICAL FOUNDATION OF MEDICINE* 56-69 (Roger J. Bulger & John P. McGovern eds., 2001); see Mary Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 AM J. L. & MED. 363, 363 (2003).

<sup>23</sup> George Khushf, *Organizational Ethics and the Medical Profession: Reappraising Roles and Responsibilities*, in *THE HEALTH CARE PROFESSIONAL AS FRIEND AND HEALER: BUILDING ON THE WORK OF EDMUND D. PELLEGRINO* 148 (David C. Thomasma & Judith L. Kissel eds., 2000).

<sup>24</sup> *Id.*

<sup>25</sup> Pellegrino, *supra* note 22, at 56; MARGARET BRAZIER, *MEDICINE, PATIENTS AND THE LAW* 37 (3d ed. 2003).

<sup>26</sup> DEREK G. GILL & STANLEY R. INGMAN, *ELDERCARE, DISTRIBUTIVE JUSTICE AND THE WELFARE STATE* 257 (1994).

<sup>27</sup> *Id.*

significant” is speculative at best.<sup>28</sup> If ethics have relevance, however, it is to be found within the principle of distributive justice which seeks a fair way to distribute scarce commodities.<sup>29</sup>

Within this new idealized environment, individualism is not recognized as the sole basis for rights. Rather, when taken together with individual responsibilities, individuals recognize responsibilities to the community and engage with a spirit of activism to fulfill those obligations.<sup>30</sup>

It makes good sense to realize that since individuals form part of any and every community, they must assume their fair share of the burden of paying for the cost of the community’s health care in an equitable manner. In this way, accessing health care is seen as a “special public good” – one grounded in basic principles of justice as well as on the basis that respect for persons and their essential human dignity requires communal action in order to safeguard the good, itself.<sup>31</sup> Moral traditions, thus, can be seen as not only undergirding, but defining, the “common community.”<sup>32</sup> Ultimately, there can be “no true common good if all do not have the good in common.”<sup>33</sup>

### III. STANDARDS OF JUSTICE

There are essentially five standards of justice: commutative, distributive, general or social, modulated, and retributive.<sup>34</sup> Some contemporary philosophers view corrective justice as yet another independent standard,<sup>35</sup> while others see it collapsing into

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<sup>28</sup> MARGARET SOMERVILLE, *THE ETHICAL CANARY: SCIENCE, SOCIETY AND THE HUMAN SPIRIT* 259 (2000).

<sup>29</sup> Pellegrino, *supra* note 22, at 280, 281.

<sup>30</sup> SOMERVILLE, *supra* note 28, at 259.

<sup>31</sup> *Id.* at 268.

<sup>32</sup> CHILDRESS, *supra* note 1, at 241.

<sup>33</sup> Kilner, *supra* note 12, at 1071.

<sup>34</sup> Edmund D. Pellegrino, *Rationing Health Care: Inherent Conflicts within the Concept of Justice*, in *THE ETHICS OF MANAGED CARE: PROFESSIONAL INTEGRITY AND PATIENT RIGHTS* 2, 3 (W.R. Bondeson & J. W. Jones eds., 2002).

<sup>35</sup> See Jules Coleman, *Corrective Justice and Wrongful Gain*, 11 J. Legal Stud. 421, 427-28 (1982).

distributive justice<sup>36</sup> or not a form of justice at all.<sup>37</sup> Still others consider social justice and distributive justice as either interchangeable or equivalent.<sup>38</sup>

Commutative justice may be viewed, properly, as the level of responsibility which exists—in clinical medicine—between physician and patient.<sup>39</sup> Distributive justice pertains to what is owed by society to its members in the microallocation of health care resources while general justice charts what a proper standard of obligation and use is for individuals in the *macro* sense of sustaining the common or communal good.<sup>40</sup> Modulated justice, or *epikeia*, pertains to the preservation of equity in the three other standards of justice; while retributive justice, as a hue of social justice, pertains to providing compensation to those suffering injustice under commutative, distributive, or general justice.<sup>41</sup> In this regard, it can also be seen as corrective.<sup>42</sup> Efforts to reduce levels of social justice, seen especially in the criminal justice system, are termed restorative justice.<sup>43</sup>

### A. Distributive Justice in a Just Society

Tracing back, historically, some two millennia to the time of Aristotle and Plato who explored the mechanisms within social groups for allocating scarce resources among competing uses and to Talmudic prohibitions on the extent of creditors' claims on estates of deceased creditors, notions of distributive justice have been both debated and seen as in play.<sup>44</sup>

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<sup>36</sup> Peter Benson, *The Bases of Corrective Justice and Its Relation to Distributive Justice*, 77 IOWA L. REV. 515, 516 (1992).

<sup>37</sup> Emily Sherwin, *Why is Corrective Justice Just?*, 15 HARV. J.L. & PUB. POL'Y 839, 840 (1992).

<sup>38</sup> DAVID MILLER, *PRINCIPLES OF SOCIAL JUSTICE* 2, 5-6 (1999); JOHN S. MILL, *UTILITARIANISM* 92 (1861), reprinted in *THE ENGLISH UTILITARIANS* 225 (H. Plamenatz ed., 1949).

<sup>39</sup> Pellegrino, *supra* note 34, at 3.

<sup>40</sup> *Id.* at 5.

<sup>41</sup> *Id.*

<sup>42</sup> See generally, Coleman, *supra* note 35, at 423.

<sup>43</sup> John Braithwaite, *Restorative Justice and Social Justice*, 63 SASKATCHEWAN L. REV. 185, 185 (2000).

<sup>44</sup> JOHN E. ROEMER, *THEORIES OF DISTRIBUTIVE JUSTICE* 1 (1996).

For most contemporary thinkers, distributive justice attempts to supply to individuals or groups their "due proportion of goods, services or opportunities."<sup>45</sup> In this regard, justice is seen as calculating simply because it measures what is to be given or withheld.<sup>46</sup> "Operational justice" is viewed, then, as entailing the exercise of power as the central mechanism "for giving or taking away according to proportional deserts."<sup>47</sup>

Any discussion of distributional justice within the American health system is linked to the issue of power.<sup>48</sup> Indeed, it has been suggested that "without power there can be no justice, because justice is the form that power actualizes in the conflict between the haves and the have-nots between claim and counterclaim."<sup>49</sup> In order to resolve these inherent conflicts, power must often be exercised coercively through appropriate laws and policy. For these actions to be accepted, they "must rest on moral reasons that the public in whose name the policies are effected could be expected reasonably to accept."<sup>50</sup>

## B. Theoretical Weaknesses

While the search for an overarching economic theory of distributive justice was forsaken long ago by "honest economists," political philosophers nonetheless continue to posit and reposit theories of distributive justice—none of which ever succeeds in structuring a universally acceptable principle of justice.<sup>51</sup> Perhaps the

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<sup>45</sup> WILLIAM M. FINNIN, JR. & GERALD A. SMITH, *THE MORALITY OF SCARCITY: LIMITED RESOURCES AND SOCIAL POLICY* 79 (1979).

<sup>46</sup> *Id.*; see also James S. Fishkin, *The Complexity of Simple Justice*, 98 *ETHICS* 464 (1988).

<sup>47</sup> FINNIN, *supra* note 45. Indeed, it has been suggested that the main constituents of distributive justice are the principles of desert, need, and equality, together with the establishment of criteria for distribution. See MILLER, *supra* note 38.

<sup>48</sup> See Harmon L. Smith, *Distributive Justice and American Health Care*, in *THE MORALITY OF SCARCITY*, *supra* note 45, at 67.

<sup>49</sup> *Id.* at 79; see also MILLER, *supra* note 38, at 1.

<sup>50</sup> James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 *J.L. MED. & ETHICS* 170, 171 (2004).

<sup>51</sup> Uwe Reinhardt, *Uncompensated Hospital Care: Rights and Responsibilities*, in *HEALTH CARE LAW AND ETHICS* 91-92 (Mark A. Hall, Mary A. Bobinski & David Orientlicher eds., 6th ed. 2003).

central reason for this failure is that there can never be such a principle in the first place because any philosophical theory or justice must be anchored on some fundamental value which, in turn, is but a subjective determination.<sup>52</sup> Largely for this reason, the term has been seen as but an “empty label” or “hollow as an echo.”<sup>53</sup> Ultimately, “honest” political philosophers conclude “justice, like beauty, rests in the eye of the beholder.”<sup>54</sup>

Even with this acknowledgment of uncertainty, the intellectual debates continue between those libertarians who advocate liberty as an overriding social value which in turn can never be traded off against other subordinate values, and egalitarian thinkers who posture “equal respect for all” or “equality of opportunity” as the central or core value of a just society to which all other values (including liberty) must be subordinate.<sup>55</sup> For egalitarians, then, this equality of opportunity requires a set minimum: namely, equal access to a range of “certain basic commodities” including “health care, food, shelter, and education.”<sup>56</sup>

So long as the questions raised by political philosophers remain problematic, they will continue to be raised time and again. Once a question becomes clear and resolvable, philosophical interest is lost.<sup>57</sup> No other nation in the industrialized West, other than the United States, has sought so boldly and naively to attempt to “accommodate simultaneously both the egalitarian and the libertarian theories of justice.”<sup>58</sup> It is because of this very accommodation that the present American health care system is in so much disarray and seemingly incapable of finding one clear focus or direction.<sup>59</sup>

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<sup>52</sup> *Id.*

<sup>53</sup> Laura Hoyano, *Misconceptions about Wrongful Conception*, 65 MOD. L. REV. 883, 905 (2002).

<sup>54</sup> Reinhardt, *supra* note 51, at 92.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> JOHN E. ROEMER, *THEORIES OF DISTRIBUTIVE JUSTICE* 1 (1996).

<sup>58</sup> Reinhardt, *supra* note 51, at 92.

<sup>59</sup> *Id.*; see also ROEMER, *supra* note 58, at 1-11.

#### IV. FOUNDATIONS OF THE JUST SOCIETY

All modern theories of the just society rest, fundamentally, on the same foundation—namely, notions or principles of equality.<sup>60</sup> For Aristotle, equality was seen as the very means of justice.<sup>61</sup> Justice, under Rawlsian theory, must always be seen as prevailing over efficiency and liberty, in turn, must prevail over social and economic advantage.<sup>62</sup> In a just society, then, justice requires equality of opportunity and is thus equated with fairness.<sup>63</sup> This, in turn, requires society to guarantee for its members a fair share of what is required for them to pursue their individual ends.<sup>64</sup> Although Rawls fails to include health care as a primary social good, since a fair share of health resources allows for—or includes—liberty and opportunity, it has been asserted that under the fair equality of opportunity principle, health care is, indeed, a social good to which all, regardless of social rank or status, have an unqualified right.<sup>65</sup> As such, in regulating the design of a health care system, a principle of protecting equality of opportunity is paramount.<sup>66</sup>

In order to assure this opportunity is open to all and not unduly burdensome, a principle of just sharing designed to equalize the financial costs to illness is advanced. This principle recognizes that “the financial burdens of medical misfortunes ought to be shared equally by well and ill alike unless individuals can be reasonably expected to control those misfortunes by their own choices.”<sup>67</sup> In today’s practical world, however, noble though this sentiment may be, the sick have neither financial nor moral claim on their fellow

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<sup>60</sup> David M. Smith, *Social Justice Revisited*, 32 ENV'T & PLANNING 1149, 1156 (2000).

<sup>61</sup> Ernest Weinrib, *Corrective Justice*, 77 IOWA L. REV. 403, 406 (1992).

<sup>62</sup> JOHN RAWLS, *A THEORY OF JUSTICE* 261-62 (1971).

<sup>63</sup> See generally PUBLIC HEALTH LAW AND ETHICS 90-91 (Larry D. Gostin ed., 2002); IAN N. OLIVER, IS DEATH EVER PREFERABLE TO LIFE? 132, 133 (2002); but see ROBERT NIZICK, ANARCHY, STATE, AND UTOPIA 6 (1974) (discussing anti-egalitarian positions).

<sup>64</sup> Norman Daniels, *Justice, Health, and Health Care*, in MEDICINE AND SOCIAL JUSTICE 6, 8 (R. Rhodes, M. P. Battin & A. Silvers eds., 2002); Gostin, *supra* note 63, at 90.

<sup>65</sup> Daniels, *supra* note 64, at 8; Gostin, *supra* note 63, at 90.

<sup>66</sup> Daniels, *supra* note 64, at 8; Gostin, *supra* note 63, at 90; see also Paul Menzel, *Justice and the Basic Structure of Health Care Systems*, in MEDICINE AND SOCIAL JUSTICE, *supra* note 65, at 118.

<sup>67</sup> Menzel, *supra* note 66, at 34.

citizens and this will, no doubt, continue to be the situation for the foreseeable future.<sup>68</sup>

### A. Social Justice in Practice

If, under any given theory of justice, there is genuine hope that the practice of public institutions will be effected by its acceptance, there must first be an understanding that the principles of social justice be understood contextually—with proper sensitivity being given to empirical data and various patterns of actual human association.<sup>69</sup> These, in turn, are drawn on the beliefs of ordinary people—tested empirically—about their social attitudes on the fairness of various distributive practices.<sup>70</sup> For example, empirical evidence from throughout the world discloses the fact that “most people when asked to comment on prevailing social inequalities appear to believe that greater equality in distribution would be fairer.”<sup>71</sup> There is also a popular consensus that in order to be legitimate, “economic inequalities must . . . be deserved—they must correspond to real differences in social contribution . . .”<sup>72</sup>

In the final analysis, whether social justice seeks to become an operative ideal which guides everyday behavior or is seen as a highway to “full fledged socialism” and a chief outlet for moral emotion, as Hayek termed it,<sup>73</sup> depends upon one major fact: the extent to which “sufficient assurances are given to those concerned that the restraints they show, by following what are considered to be fair principles and procedures, will in turn be matched by similar restraint by others.”<sup>74</sup>

Because of pluralistic beliefs about justice, “no single principle

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<sup>68</sup> See Benson, *supra* note 36, at 16; see generally, Ronald Dworkin, *Justice in Health Care Decisions*, 38 MCGILL L.J. 883, 884, 887 (1993).

<sup>69</sup> MILLER, *supra* note 38, at 259.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 230.

<sup>72</sup> *Id.* at 259.

<sup>73</sup> Friedrich A. Hayek, *The Mirage of Social Justice*, in 2 LAW, LEGISLATION AND LIBERTY 64-66, 97, 100 (1976).

<sup>74</sup> MILLER, *supra* note 38, at 19.

seems able to capture all the judgments people make or the distributive procedures they follow."<sup>75</sup> One popular theory holds simply that under a self-interest hypothesis, most "people select whichever conception of distributive justice best serves their material interests."<sup>76</sup> In order to put in place a process that is both fair and legitimizes decisions regarding the allocation of critical resources, there must first be public consensus regarding the shape and vitality of the principles of distribution.<sup>77</sup> Thus far, at least in America, this process can be seen as evolving.

## B. Justice and The New Medicine

Efforts to apply justice to the new medicine through genetic control, which have the effect of shaping the limits and/or quality of the human gene pool, are bound to be met with opposition—especially from those who would view such efforts as violating a more fundamental and profound ethical ideal: namely, that of respect for human life. Within this ideal are found such ambiguous terms as "sanctity," "dignity of human life," and "reverence for human life"<sup>78</sup>—all of which, as abstract principles, lack the specificity of a rule but nonetheless have the social power to be taken as either unyielding *a priori* standards of conduct or, in fact, rules for which no exceptions are tolerated.<sup>79</sup>

Love is seen as the "driving force" behind any true vision of a just society which, in turn, validates the dignity of the human person. Indeed, the inner fullness of justice is only attained in love.<sup>80</sup> Since all

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<sup>75</sup> *Id.* at 78, 79.

<sup>76</sup> *Id.* at 82.

<sup>77</sup> Daniels, *supra* note 64, at 7.

<sup>78</sup> See George P. Smith, II, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 709 (1984).

<sup>79</sup> Daniel R. DeNicola, *Genetics, Justice and Respect for Human Life*, 11 ZYGON 115, 124-25 (1976). See generally, Michael Kirby, *Bioethical Decisions and Opportunity Costs*, 2 J. CONTEMP. HEALTH L. & POL'Y 7 (1986).

<sup>80</sup> Referencing the Synod of [Roman Catholic] Bishops, *Justice in the World* 293 (1971), reprinted in CATHOLIC SOCIAL THOUGHT: THE DOCUMENTARY HISTORY (D.J. O'Brien & T.A. Shannon eds., 1998); see Lucia A. Silecchia, *Reflections on the Future of Social Justice*, 23 SEATTLE U. L. REV. 1121, 1138 (2000); see also Joseph Fletcher, *Love is the Only Measure*, 83 COMMONWEALTH 427 (1966).

laws are set with a hierarchy whose foundation is, according to Augustine, to be found in love, the ethics of love is viewed properly as the very essence of justice.<sup>81</sup> In the end, if a spirit of love, humaneness or compassion guides the shape and direction of the new medicine, its response will be a reasonable and proper one—one directed toward minimizing human suffering and maximizing the social good which, in turn, allows attainments of the “good life.”<sup>82</sup>

## V. CONFLICTS OF DISTRIBUTION

### A. Economic Issues

Libertarian philosophers see individual liberty as the predominate social value which can never be traded off, while egalitarian philosophers espouse “quality of opportunity” as the central or foundational value of a just society.<sup>83</sup> It remains for public policy advocates and especially politicians, to listen carefully to the language of the law and the competing voices of religion and morality, love and friendship, custom and compromise, and of pragmatism and social accommodation,<sup>84</sup> in trying to fashion a sustainable social compromise from these struggles for access to and maintenance of health care.<sup>85</sup>

Because of rising health care costs during the past fifteen years, societal concern has focused on whether the world’s health care resources are being distributed fairly and wisely.<sup>86</sup> More and more, contemporary medicine demands of its practitioners—particularly those in America—that the principle of justice be made a distinct

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<sup>81</sup> Jerome Hall, *Religion, Law and Ethics: A Call for Dialogue*, 29 HASTINGS L.J. 1257, 1267 (1978) (quoting William Temple, Archbishop of Canterbury).

<sup>82</sup> GEORGE P. SMITH, II, THE CHRISTIAN RELIGION AND BIOTECHNOLOGY: A SEARCH FOR PRINCIPLED DECISION-MAKING 2 (2005); see also George P. Smith, II, *The Province and Function of Law, Science, and Medicine*, 11 U. NEW SO. WALES L.J. 103, 123 (1987).

<sup>83</sup> See Reinhardt, *supra* note 51 at 92.

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> William Andereck, *Money, Medicine and Morals*, in THE HEALTH CARE PROFESSIONAL AS FRIEND AND HEALER, 233-35 (David C. Thomasma & Judith L. Kissel eds., 2000).

factor in the decision making process.<sup>87</sup> Increasing governmental pressures continue to stress the need to follow cost control policies, eliminate waste and inefficiency and implement the principle of distributive justice in patient care.<sup>88</sup> As a consequence of these three competing policy concerns, more and more, patient interests become secondary to health care delivery.<sup>89</sup> The central conflict for physician-gatekeepers, who are responsible for seventy-five percent of the national expenditures for health care,<sup>90</sup> thus, is to assure and maintain a patient-centered ethic in their professional work while, at the same time, from a macroeconomic standard, safeguard their responsibility to preserve society's resources.<sup>91</sup> Ancillary to this conflict is the harsh reality that implementing distributive justice at the patient bedside, without any real societal consensus on how it is defined and practiced, most often means employing an arbitrary process that depends largely upon the individual value system of the person, typically a physician, assigning worth to the medical intervention or procedure put in issue.<sup>92</sup>

In considering applications of distributive justice, physicians are required to evaluate this operative principle at two levels: the statistical patient or the identifiable patient.<sup>93</sup> The more direct example of statistical applications of distributive justice is seen within the process of establishing guidelines for utilization review.<sup>94</sup> Another example is found in the work of capital budget committees.<sup>95</sup> Although decisions made under utilization and budget reviews affect, assuredly, real people, it is considered more

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<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 235-36; *See generally* DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987).

<sup>89</sup> Andereck, *supra* note 86, at 234.

<sup>90</sup> EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* 189 (1988).

<sup>91</sup> *See* Andereck, *supra* note 86, at 236.

<sup>92</sup> *Id.* *See generally* EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *THE VIRTUES IN MEDICAL PRACTICE* (1993).

<sup>93</sup> *See* Andereck, *supra* note 87, at 236.

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

appropriate and safer by physicians to consider and evaluate their rationing decisions prospectively rather than be forced to evaluate issues of this nature at the bedsides of their patients.<sup>96</sup> Alternatively, when the particular financial resources of each patient are factored into their identifiable medical treatment profile, the unstable second level of distributive justice is seen in bold relief which may well involve bedside rationing.<sup>97</sup>

All countries of the world community—regardless of their widespread differences in financing and organizing healthcare systems—have a common problem: maintaining efficiency.<sup>98</sup> Simply put, the “[e]fficient use of resources in medical care . . . requires that the benefit from the last dollar spent in any activity be no lower than the benefit obtainable from spending an additional dollar on some other procedure or from some other product.”<sup>99</sup> Stated otherwise, when healthcare resource allocations are seen as efficient, it then becomes “impossible to increase the total medical benefits by diverting any money away from one service . . . and spending it on another.”<sup>100</sup>

The most significant difficulties in both structuring and then making rationing policies operational are to be found within issues of “marginally beneficial health care.”<sup>101</sup> More specifically, it becomes not only difficult but distasteful when attempts to “fine-tune rationing policies to the degree that they select the treatments, diseases, and people from whom marginal benefits are as great as opportunity costs.”<sup>102</sup> Consequently, age becomes a “quotient in determining success of treatment,” as well as a factor in determination, in the first instance, of healthcare delivery.<sup>103</sup>

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<sup>96</sup> *Id.* at 237.

<sup>97</sup> *Id.*

<sup>98</sup> GEORGE P. SMITH, II, *Legal and Healthcare Ethics for the Elderly* 25 (1996).

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *See* SMITH, *supra* note 98, at 26.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

## B. Rationing as a Fact

Three particular settings serve to illustrate contemporary uses of rationing.<sup>104</sup> “First, it is implicit in all systems where limited amounts of money are available for healthcare” for clinical physicians to become the primary gatekeepers making initial decisions regarding the use of medical resources.<sup>105</sup> This is the preferred model in those health insurance programs which are written, and clinical judgments are seldom challenged provided that funds are sufficient to cover medical uses.<sup>106</sup> Explicit cases of rationing can be seen, however, where “third parties fail to fund specific treatments medically indicated . . .”<sup>107</sup> Here, physician discretion is eliminated altogether even though a medical judgment is made that certain treatments are needed.<sup>108</sup> Unless a patient has independent sources upon which he may draw to fund these treatments, or can somehow induce the physician to render the services gratis, the medical care is simply unavailable.<sup>109</sup>

Even though individuals may have adequate finances and health insurance coverage, market forces impose mechanisms for rationing, primarily through co-payments and deductibles, which have the effect of forcing patients to decide whether the specific care that they want is within their financial means.<sup>110</sup> For those either strained financially, or who find themselves without funds altogether and ineligible for any kind of public assistance, rationing is not even an issue because they have no access at all to healthcare services.<sup>111</sup>

So long as funds allocated under Medicaid health assistance programs are sufficient, the individuals within coverage of these programs have no real concerns about expenses for healthcare delivery because “virtually everything their physician recommends is

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<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> See SMITH, *supra* note 98, at 26.

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> See SMITH, *supra* note 98, at 26.

available.”<sup>112</sup> To the extent healthcare delivery issues can be regulated, the suggestion has been made that at the beginning of each fiscal year, serious illnesses should be presented.<sup>113</sup> Even though a considerable number of families are not wealthy, their levels of financial support disqualify them from membership in public health programs which has the effect of denying them “even a minimum level of the most critical care because they simply cannot pay.”<sup>114</sup> An additional suggestion moves the idea that if some Medicaid program benefits are judged to be of less importance than others, and can thereby be eliminated, “funds could then be released so more people could become eligible for coverage even though overall fewer benefits would be available.”<sup>115</sup>

## VI. SPECIFIC DECISIONAL FRAMEWORKS

Since no resource is infinite (and health resources are among them), selective distribution is inevitable. When considering issues of health care allocations, two classifications or levels of decision making are seen: microallocation and macroallocation.<sup>116</sup> While microallocation issues are often regarded as “patient selection” issues and choices among patients, both of which involve resources available for specific kinds of health care services,<sup>117</sup> macroallocation issues are focused on highly political matters such as the amount to which a nation is devoting its health care resources to primary and preventive care—as opposed to new biotechnology medicine—as well as the budget percentages being expended by hospitals.<sup>118</sup>

Lacking a clear and unambiguous definition of rationing, it may nonetheless be seen as a process whereby some are, “temporarily and against their wishes, without particular forms of health care that

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<sup>112</sup> *Id.* at 27.

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> See Kilner, *supra* note 12, at 1067.

<sup>117</sup> *Id.* at 1067, 1075.

<sup>118</sup> *Id.* at 1067. See also MASON, *supra* note 8, at 366.

might benefit them."<sup>119</sup> In addition to referring to these general limitations, rationing "may also encompass [very] specific treatment decisions for particular patients."<sup>120</sup> Alternatively, "rationing is also often proposed as a means of guaranteeing every citizen a basic level of health care by excluding from coverage those treatments outside this package."<sup>121</sup> One point in this analysis is certain: rationing is the central health care policy issue of the day.<sup>122</sup>

Long viewed as haphazard and unprincipled, rationing occurs today as it always has.<sup>123</sup> Yet, the term is softened considerably by referring to it as merely allocations of health care resources.<sup>124</sup> No doubt, the most direct example of massive rationing is to be found in the field of health insurance, which is denied routinely to those who lack it because they work for an employer who simply does not provide it or because their personal level of poverty has yet to fall to that level required for eligibility under Medicaid.<sup>125</sup>

The fundamental question raised in issues of health care resource allocation is who decides what care is not worth the costs? The decision maker can be the patient, the physician or third parties (primarily private and governmental insurers).<sup>126</sup> Two central approaches are normally considered: those "oriented primarily toward making the most productive use of [the health] resources" and those designed to ensure equality of "access to treatment through some form of impartial, or random, selection" for all suitable candidates.<sup>127</sup> Among the specific criteria used in determining proper microallocations are: social value (with treatment preference being given to those judged of greatest social value to society), socio-

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<sup>119</sup> See Kilner, *supra* note 12, at 1067.

<sup>120</sup> *Id.* at 1075. See also Mark Hall, *Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms*, in HEALTH CARE LAW AND ETHICS, *supra* note 51, at 98.

<sup>121</sup> ROBERT H. BLANK, *THE PRICE OF LIFE* 96 (1997).

<sup>122</sup> See Hall, *supra* note 51, at 98.

<sup>123</sup> *Id.* at 96.

<sup>124</sup> *Id.* at 96-97.

<sup>125</sup> *Id.* at 96.

<sup>126</sup> See RODWIN, *supra* note 19, at 14.

<sup>127</sup> See Kilner, *supra* note 12, at 1082.

medical (*e.g.*, age), psychological balance, nature and quality of supportive environment, medical (determining the basic merits or extent to which a benefit is conferred), and personal (the patient's willingness to accept treatment).<sup>128</sup>

"Some of the approaches to rationing that are widely used are a 'first come, first served' system of queues", random selection (which takes no account of the gravity of either the patient's conditions or of the medical benefit), ability to pay, "triage systems based on medical urgency, and, more recently, systems based on computation of quality adjusted life years (QALYs)," which are designed to test the appropriateness of treatment.<sup>129</sup> It has been suggested that treatment considered to be "unsuccessful, unsafe, unkind, or unwise" is inappropriate and should be withheld.<sup>130</sup>

At the *micro* level, *ad hoc* decisions are made routinely and instinctively without need for any profound analysis. Accordingly, the bedside physician will inevitably choose the patient in greater pain for immediate treatment—despite the fact that this will delay simultaneously the treatment of patients in lesser pain.<sup>131</sup> Interestingly, there is no precedential case law measuring societal attitudes with respect to judging the allocation of resources at the *micro* or individual level—since, presumably, decisions are taken in good faith and are based on principles seen as respectable to a responsible body of medical opinion.<sup>132</sup>

In considering how to limit the use of health care costs, ethical conduct which respects one's autonomy and his right to decide for himself those treatments that he wants or, alternatively, does not wish, can well lead to a reduction in costs.<sup>133</sup> Minimally life prolonging treatments which are also invasive and expensive are often refused.<sup>134</sup> Education in "lateral thinking" can also affect cost

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<sup>128</sup> *Id.* at 1076-81. See also MASON, *supra* note 8, at 380-81.

<sup>129</sup> See BLANK, *supra* note 121, at 96. See also MASON, *supra* note 8, at 379-86.

<sup>130</sup> See BLANK, *supra* note 121, at 96. See Roger Crisp, *Deciding Who Will Die: QALYs and Political Theory*, 9 *POLITICS* 31 (1989).

<sup>131</sup> See MASON, *supra* note 8, at 378.

<sup>132</sup> *Id.* at 385.

<sup>133</sup> See SOMERVILLE, *supra* note 28, at 262.

<sup>134</sup> *Id.*

and resource savings.<sup>135</sup> Thus, assisting individuals to deal with their death fears by offering palliative care options presents a wider range of potentially cost-saving choices available for the care and treatment at the conclusion of their lives.<sup>136</sup>

Other decision making mechanisms for health care resource allocations are found in internal hospital policies—for example, those that set standards for use of do not resuscitate orders. It is within these internal guidelines that institutional policies are in turn formulated.<sup>137</sup> As well, hospital ethics committees serve as an important source for setting policies which govern not only access to health care, but to allocations of health resources and egress therefrom.<sup>138</sup> Through medical malpractice decision making, the courts also become a mechanism and structure for determining efficacious uses of resources.<sup>139</sup> Finally, health care advocacy groups are becoming a growing and forceful voice in resource management in the United States.<sup>140</sup>

#### A. Artificial Hearts: A Case In Point

When, in September, 2006, the Federal Food and Drug Administration (FDA) gave limited approval for use of the first totally implantable artificial heart, a complicated allocative issue was presented: namely, the cost-effectiveness of such an approval and subsequent use. The device, costing \$250,000.00, will be available to a maximum of 4000 people.<sup>141</sup> Approved under the FDA “humanitarian device exemption,” which lowers the bar effectively

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<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.* at 266. See generally George P. Smith, II, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance in End-of-Life Cases*, 10 HEALTH MATRIX J. 175 (2000).

<sup>138</sup> See SOMERVILLE, *supra* note 28, at 271. See also George P. Smith, II, *The Ethics of Ethics Committees*, 6 J. CONTEMP. HEALTH L. & POL'Y 157 (1990); Gaylin, *supra* note 14.

<sup>139</sup> See SOMERVILLE, *supra* note 28, at 274. See also *Moore v. Regents of the Univ. of Ca.*, 763 P.2d 479 (Cal. 1990).

<sup>140</sup> See SOMERVILLE, *supra* note 28, at 274.

<sup>141</sup> David Brown, *Artificial Heart Gets Limited FDA Approval*, WASH. POST, Sept. 6, 2006, at A8. See generally George J. Annas, *Death and the Magic Machine*, 9 WES. NEW ENG. L. REV. 89 (1987).

for such devices, they are then subject to approval only if they are shown to advance “safety” and be of “probable benefit.”<sup>142</sup> In calculating the degree of benefit conferred by the device, largely subjective measurements are allowed and include improvement in the quality of life.<sup>143</sup> If not granted the humanitarian exemption, the artificial heart would have had to demonstrate both “safety and effectiveness.”<sup>144</sup>

Powered by a battery with no wires or tubes piercing the skin, the new artificial heart—unlike its prototype in 1982 which was powered by a four hundred pound air compressor—has its battery recharged with an inductive coil placed against the skin and allows the recipient to be away from an external power source for approximately an hour.<sup>145</sup>

Previous recipients of artificial hearts survived, after implantation, an average of 5.2 months—with the longest living seventeen months; of these fourteen patients, ten left the hospital only with occasional day passes, one resided in a hotel near his hospital and one returned home, while two died during the initial surgery.<sup>146</sup> With a life expectancy of a month or less when the device was implanted, the net gain for all of them was 4.5 months.<sup>147</sup> Obviously, any honest and accurate computation of quality adjusted years is simply not possible for this procedure. For past recipients of artificial hearts, assuming a total cost of \$350,000.00, the “incremental cost-effectiveness ratio” of the treatment was \$940,000.00 per year of life gained.<sup>148</sup> Improved familial interaction together with improved levels of activity—ranging from moving from bed to chair and walking with assistance—set the parameters of the quality of life achieved with the device.<sup>149</sup> Because of these limited and, indeed,

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<sup>142</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>143</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>144</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>145</sup> *See* Brown, *supra* note 141. Over time, it is hoped a second-generation device, being tested presently in animals, will have a target life of five years and be considerably less expensive.

<sup>146</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>147</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>148</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

<sup>149</sup> Brown, *supra* note 141, at A8; *see generally* Annas, *supra* note 141.

marginal results, the adequacy of truly informed patient consent remains of serious concern to this procedure—especially because of the lack of full understanding regarding the wide range of serious complications which may result in additional surgeries and many days of unconsciousness from implantation.<sup>150</sup>

The record of past use of artificial hearts is, to be sure, checkered at best.<sup>151</sup> This, in turn, raises the question whether the long term value of the investment will be sustained.<sup>152</sup> Indeed, it has been suggested that instead of approving and developing this expensive therapy, the monies would be better spent “vaccinating children and helping people with hypertension get better treatment—things that are of proven benefit but cost much less.”<sup>153</sup>

Whether implantation costs (set at \$100,000.00) of the new artificial heart will be covered by insurance companies and Medicare is also another major issue. For the federal Medicare program, at least for the present, controlling regulations list artificial hearts as “uncovered devices.”<sup>154</sup> The extent of products liability for defective implantable medical devices remains, as well, a potential drawback to the full development and utilization of this new procedure.<sup>155</sup>

## B. Prioritization

The pressing question, if such a change as this is advanced, is how to determine those benefits that could be retained.<sup>156</sup> The clearest and most direct approach to resolving this question would be to assemble—as the state of Oregon did—a group of experts or health commissioners to develop a list, in order of importance to health, of medical procedures and surgical interventions.<sup>157</sup> This, then, is

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<sup>150</sup> ARTHUR L. CAPLAN, *AM I MY BROTHER'S KEEPER?* 35 *passim* (1997).

<sup>151</sup> See Brown, *supra* note 141.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> Case Note, *Product Liability: Getting to the Heart of the Matter*, 36 WASHBURN L. J. 319, 338 (1997).

<sup>156</sup> See SMITH, *supra* note 98, at 27.

<sup>157</sup> *Id.*

labeled *prioritization* or, alternatively, rule-based rationing.<sup>158</sup> A cut-off level could be set by the legislature or even by a private insurance company.<sup>159</sup> Although a legislature would simply make the cut-off (the limit for present or even future funding determined actuarially for the number of citizens eligible in the state), private insurance companies would probably use this priority list by writing policies at different rates and then offering them for various cut-off points on the list.<sup>160</sup>

A legislative decision to impose points of limitation on prioritized lists where groups (or individuals) are consequently excluded from healthcare is seen correctly as rationing.<sup>161</sup> Similarly, the private insurance company could be thought of as rationing according to the levels private citizens could afford to pay for themselves.<sup>162</sup> Certainly it is not unfair, in any sense of the word, to expect some limit for a public health program of this design—especially if the program were not restricted unconscionably.<sup>163</sup> Indeed, an argument can be advanced which acknowledges that limits of one type or other for public health programs must be set if the goal of maintaining a wise and just allocation of funds under the program is to be achieved.<sup>164</sup>

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<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* See also Timothy B. Flanagan, *ADA Analysis of the Oregon Health Care Plan*, 9 ISSUES L. & MED. 397 (1994); MARTIN A. STROSBURG ET AL., *RATIONING AMERICAN MEDICAL CARE: THE OREGON PLAN AND BEYOND* (1992). There is a growing effort among many of the chronically ill, who are insured, to have the lifetime cap of \$1 million—found routinely in many health insurance policies—lifted by Congressional action requiring that they be raised by the insurance companies to as high as \$10 million. It is argued that many of the caps have neither changed nor even kept up with health-care inflation and have failed, as well, to make adjustments for the near astronomical costs of using the products of the new medical technologies. Organ transplants alone can, for example, range anywhere from \$250,000 to \$600,000. Costs for hemophilia care have been known to run as high as \$750,000 annually. Christopher Lee, *More Hitting Cost Limit on Health Benefits*, WASH POST Jan. 27, 2008 at A3.

<sup>161</sup> See SMITH, *supra* note 99, at 27.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

## VII. NECESSARY HEALTH CARE NEED VARIABLES

Rationing can be avoided as a national policy if an agreement can be reached in identifying “really necessary” health care interventions and a process was then designed to ensure that all patients have equitable access to them.<sup>165</sup> Thus, objective criteria, which could possibly take the form of clinical guidelines, must be established and identify real health care needs, as opposed to mere desires. These guidelines would be termed “necessary care guidelines” and would give the indicators or types of patients for whom specified services would be considered necessary.<sup>166</sup> Applied as standards of care, these guidelines would specify patient management strategies required for patients with certain medical problems.<sup>167</sup> Physician adherence to these guidelines would serve as a defense in a malpractice action.<sup>168</sup> Ideally, these policies or guidelines would be developed by bodies or panels drawing on outcome data, public testimony, and expert consensus.<sup>169</sup> In measuring treatment, “*net benefit*” would be defined in terms of longevity plus quality of life.<sup>170</sup>

### A. Ethics of Rationing Health Care

Richard Lamm, in suggesting a working ethical principle for distributing healthcare resources for the elderly, created quite a furor among the elderly when he urged healthcare resources be distributed along a utilitarian principle, so as to maximize the long-run general happiness of the entire community and not only the debilitated,

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<sup>165</sup> *Id.* at 28.

<sup>166</sup> See SMITH, *supra* note 98, at 28.

<sup>167</sup> *Id.*

<sup>168</sup> Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1843 (1992). For an in depth consideration of the British approach to rationing, see Jonathan Herring, *The Structure of the NHS and the Rationing of Health Care Resources*, in MEDICAL LAW AND ETHICS (2006).

<sup>169</sup> David C. Hadorn & Robert H. Brook, *The Health Care Resource Allocation Debate: Defining Our Terms*, 266 JAMA 3328, 3330 (1991).

<sup>170</sup> *Id.*

chronically ill, or very elderly as individual members of it.<sup>171</sup> In other words, he argued that the greatest health resources should go to the greatest number of individuals capable of using them effectively. The reality of this harsh statement meant that, in Lamm's view, "the very elderly had a moral duty to forgo further healthcare and to accept their deaths."<sup>172</sup> Children, he maintained, have more opportunities to flourish and achieve happiness; therefore, it was only logical that they should deserve a greater share of health resources than the elderly.<sup>173</sup> This, of course, once again raises the issue of intergenerational equity or justice.

A society surely cannot consider itself a noble one if it does not respect the individuality of its members—even when to do so creates the appearance of running counter to the general happiness of the community at large.<sup>174</sup> Any society runs the risk of dividing itself if it seeks to withhold healthcare from the elderly based on the argument that the "return" of such an investment can never be realized economically because of the limited lifespans of the recipients.<sup>175</sup> The Lamm thesis challenges society to reallocate its healthcare resources in a way that does not abandon the elderly yet achieves a balance in providing long-term health protection and happiness for its members as a whole.<sup>176</sup> Sadly, current evidence discloses that this challenge is going unmet.<sup>177</sup>

## B. Intergenerational Justice

The concept of intergenerational equity arises from the

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<sup>171</sup> Mark H. Waymack, *Old Age and the Rationing of Scarce Health Care Resources*, in *AGING AND ETHICS: PHILOSOPHICAL PROBLEMS IN GERONTOLOGY* 247, 248-49 (Nancy S. Jecketer ed., Humana Press 1991).

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* at 249-50.

<sup>176</sup> *Id.* at 250.

<sup>177</sup> Evelyn M. Barker, *Rethinking Family Loyalties*, in *AGING AND ETHICS: PHILOSOPHICAL PROBLEMS IN GERONTOLOGY* 187, 195-97 (Nancy S. Jecker ed., Humana Press 1991); see also Richard Lamm, *Rationing of Health Care: Inevitable and Desirable*, 140 U. PA. L. REV. 1511 (1992).

association between the increased number of persons over the age of sixty-five, the probability that they are frequently using healthcare resources, and the resultant increase in healthcare costs.<sup>178</sup> The government is not able to bear without restraint the growing social and economic health care costs associated with the elderly. During the presidency of Ronald Reagan, federal funding in America failed for the first time to keep pace with demand, as the demand for resources "far outdistanced the available supply."<sup>179</sup> Every dollar given to programs for the elderly meant one less dollar for other groups.<sup>180</sup> Addressable economic issues included then, as now, the proper delivery of care, the allocation of resources, effective and affordable methods of insurance, and defining research priorities.<sup>181</sup>

The fastest growing population in the United States is people over the age of eighty-five.<sup>182</sup> "A corresponding shrinkage occurs in the population under sixty-five years-of-age who will have to bear the burdens of providing for the prior and the future generation."<sup>183</sup> Furthermore, the elderly are disproportionate consumers of healthcare as hospitalization of elderly persons on the average costs three times more per healthcare dollar than those under sixty-five years-of-age.<sup>184</sup> "Rationing should be distinguished from cost containment measures that merely result in withholding medical services that are of no expected benefit to patients."<sup>185</sup> Thus, age rationing occurs only in those cases "when elderly patients are denied access to medical services that are of *expected benefit* to

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<sup>178</sup> Dorothy C. Rasinski-Gregory & Miriam Piven Cotler, *The Elderly and Health Care Reform: Needs, Concerns, Responsibilities and Obligations*, 21 WES. ST. U. L. REV. 65, 81-85 (1993); see generally Tyler Cowen, *Caring about the Distant Future: Why It Matters and What It Means*, 74 U. CHI. L. REV. 5 (2007).

<sup>179</sup> Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L. J. 683, 707-08 (1991).

<sup>180</sup> See *id.* at 708.

<sup>181</sup> DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* 117 (1987).

<sup>182</sup> David C. Thomasma, *The Ethical Challenge of Providing Healthcare for the Elderly*, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 144, 148 (1995).

<sup>183</sup> *Id.*

<sup>184</sup> See *id.*

<sup>185</sup> Mark R. Wicclair, *Age-Rationing, Ageism, and Justice*, in *ETHICS AND THE ELDERLY* 80 (1993).

them.”<sup>186</sup>

There is some merit to the argument that the elderly must be compensated for their work earlier in life and not be required to make additional healthcare sacrifices.<sup>187</sup> Due to their advanced years, the elderly earn some degree of public sympathy and respect because of what they have accomplished before approaching the end of their lives.<sup>188</sup> In coming to this end, they have discharged already many of the obligations that society has required and should not bear a disproportionate burden in their later years.<sup>189</sup>

Arguably, there is a shared intergenerational duty between both the elderly and those who are younger. Assurances against neglect and abuse come from the moral obligations and relationships that the young have with the elderly.<sup>190</sup> At the same time, the elderly “are stewards of the world they helped fashion” and their purpose should be to aid the young and future generations to come.<sup>191</sup> Therefore, the proper role for all societal groups should recognize a life cycle where the elderly have come before the young and made life easier for those who follow, while the young have the burden of supporting the elderly when they are unable to take care of themselves. The extent of that burden remains the open and truly vexatious question of this century.

Although recognizing *de facto* rationing as a current feature of contemporary healthcare delivery systems, it has been suggested that any further expansions should be delayed until the irrationalities of the current national system are resolved.<sup>192</sup> This suggestion is

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<sup>186</sup> *Id.*

<sup>187</sup> See Thomasma, *supra* note 182, at 156 (noting that the elderly are responsible for building “the roads and bridges, symphonies, and schools we now enjoy”).

<sup>188</sup> Frolik & Barnes, *supra* note 179, at 712-13.

<sup>189</sup> See Thomasma, *supra* note 182, at 156 (“While the elderly may gobble up inordinate relative amounts of healthcare dollars, while doing so, they are not using other resources of society ...[G]eneral resources use equalizes out in the end.”).

<sup>190</sup> See CALLAHAN, *supra* note 181, at 83 (noting familial relationships and government programs such as Social Security and Medicare).

<sup>191</sup> *Id.* at 82.

<sup>192</sup> Daniel C. Maguire & Edith A. McFadden, *The Ethics of Health Care Rationing: The Missing Voice*, in HEALTH CARE RATIONING: DILEMMA AND PARADOX 147, 149-54 (Kathleen Kelly ed., Mosby 1994).

impractical simply because rationing is seen as an inextricable (if not unavoidable) given in the present system and its "irrationalities" are beyond correction within any reasonable period of time. Others might suggest that this effort to distribute scarce resources in an equitable manner, that is, rationing, is not irrational at all.<sup>193</sup>

The harsh reality of enforcement in healthcare resource allocation can be seen vividly as an ethical conundrum when either a healthcare system or a hospital seeks to limit the actual range of treatments available to a patient—this, because either the limitations, in and of themselves, or actions taken to exceed them, "can mean that the physician is acting unethically."<sup>194</sup>

Because healthcare services, providers of healthcare, and the means to pay for these services are all scarce, procedures must be established and followed to allow for a fair distribution of them. As observed, physicians engage regularly in rationing by their regulation of the extent of participation in Medicare as well as in health maintenance organizations (HMOs).<sup>195</sup> Historically, during times of military engagement, field physicians decided routinely whom they would treat because they were "salvageable" and those from whom treatment would be withheld until others were treated. Some were even denied treatment because of the futility of such actions. Even today, medicine practiced in emergency wards of major hospitals and in times of local or state disaster utilizes the principle of *triage*.<sup>196</sup> A strong argument could be advanced that, indeed, the very bedrock of modern rationing is to be found, to one degree or other, within the principle of *triage*. Surely an analogy can be seen between a military battlefield and the crisis in healthcare management. In both, efforts must be made to balance the costs with the benefits of all actions taken.<sup>197</sup>

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<sup>193</sup> Amy Marie Haddad, *Ethical Issues in Health Care Rationing*, in HEALTH CARE RATIONING: DILEMMA AND PARADOX 11, (Kathleen Kelly ed., Mosby 1994).

<sup>194</sup> SOMERVILLE, *supra* note 28, at 261-62.

<sup>195</sup> Haddad, *supra* note 193, at 12.

<sup>196</sup> George P. Smith, II, *Futility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. & POL'Y 1 (1996).

<sup>197</sup> DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS (1990); see Daniel Callahan, *Symbols, Rationality, and Justice: Rationing Health Care*, 18 AM. J.L. & MED. 1 (1992).

### VIII. THE VALUE OF LIFE

Economists seek to place an actual monetary value for people's lives by employing two models. The first, called the human capital model, calculates the value of life only in terms of productivity or the present discounted values of one's future earnings.<sup>198</sup> The second model is described as willingness to pay.<sup>199</sup> Here, the monetary value of life is directly a function of one's willingness to use resources to increase one's chance of survival.<sup>200</sup> Thus, in a hypothetical situation in which an individual annually demands an extra \$500 in order to perform work that runs an additional 1-in-1000 risk of dying, \$500,000 is the monetary value of that person's life.<sup>201</sup> No more than \$500,000 need be spent under this hypothetical model to save a particular life.<sup>202</sup>

In 2003, the federal Office of Management and Budget (OMB) focused on this issue of intergenerational justice when it chose to consider the value of human lives within the context of undertaking cost-benefit analysis in order to determine whether new administrative rules and laws were justified within agency rulemaking.<sup>203</sup> During its study of this issue, it was learned that various regulatory agencies used widely varying values in making their computations.<sup>204</sup> The Environmental Protection Agency (EPA),

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Yet, one commentator has suggested that today's *triage* is an "empty" principle since the essential premise is reversed—"the most seriously wounded are rushed in [for treatment] and the merely mutilated must wait." Albert R. Jonsen, *The Good Samaritan as Gatekeeper*, in *THE NEW MEDICINE AND THE OLD ETHICS* 45, 45-46 (1990). See Felicity Barringer & Donald G. McNeil, Jr., *Grim Triage for Ailing and Dying at a Makeshift Airport Hospital*, *N.Y. TIMES*, Sept. 3, 2005, at A4.

<sup>198</sup> See generally Louis Kaplow, *Discounting Dollars, Discounting Lives: Intergenerational Distributive Justice and Efficiency*, 74 *CHI. L. REV.* 79 (2007); RICHARD A. POSNER, *CATASTROPHE: RISK AND RESPONSE* 165-71 (Oxford U.P. 2004).

<sup>199</sup> See generally Kaplow, *supra* note 198; Posner, *supra* note 198 at 165-71.

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> Menzel, *supra* note 66, at 38; see also Roy W. Perrett, *Valuing Lives*, 6 *BIOETHICS* 185 (1992); see also Kaplow, *supra* note 198; POSNER, *supra* note 198 at 165-71.

<sup>203</sup> See generally Kaplow, *supra* note 198; POSNER *supra* note 198 at 165-71.

<sup>204</sup> John J. Fialka, *Balancing Act: Lives vs.*, *WALL ST. J.*, May 30, 2003, at A4; see generally John D. Graham, *Valuing the Future: OMB's Refined Positions*, 74 *U. CHI. L. REV.* 51 (2007).

for example, priced a life at \$6 million while the Department of Transportation set \$3 million as appropriate.<sup>205</sup> The Food and Drug Administration chose to use a sliding scale based on the number of additional years a new regulation could be expected to allow each person to live.<sup>206</sup>

Subsequently, in preparing evaluations of President George Bush's proposed Clear Skies Act, aimed at reducing power plant pollution which would have the effect of benefitting mainly those older people with breathing disorders, the EPA sought to discount the lives of those over age seventy by thirty-seven percent by using this second model of willingness to pay.<sup>207</sup> Because of a loud and sustained uproar by senior citizens groups, this formula was stopped.<sup>208</sup> Nonetheless, the OMB stated its conviction "to weigh each person's life expectancy in cost-benefit analyses of legislation and regulations."<sup>209</sup>

### A. Measuring Quality of Life

A controversial, albeit growing, view in health economics is that the goal of all service should be to create as many years of healthy life as possible for as many as possible. The underlying basis for this view is, quite simply, the "assumption that for all alike a year of healthy life is equally valuable."<sup>210</sup> The productivity of healthcare, then, is measured in terms of years of healthy life or quality-adjusted life years (QALYs). Thus, when consideration of the cost of receptive treatments is combined with the length of lives extended and the quality of life they enhance, interesting examples can be posited that force striking conclusions.<sup>211</sup> For example, because hip replacements

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<sup>205</sup> *Id.*

<sup>206</sup> Fialka, *supra* note 204, at A4. Professor W. K. Viscusi of Harvard University conducted research which places a \$7 million value on human life. *Id.* See Cass R. Sunstein & Arden Rowell, *On Discounting Regulatory Benefits: Risk, Money, and Intergenerational Equity*, 74 U. Chi. L. Rev. 171, 183 (2007) (discussing the EPA's position).

<sup>207</sup> Fialka, *supra* note 204, at A4.

<sup>208</sup> *Id.*

<sup>209</sup> *Id.*

<sup>210</sup> Andereck, *supra* note 86, at 79; POSNER, *supra* note 198, at 165.

<sup>211</sup> Robert Hahn & Scott Wallsten, *Whose Life is Worth More? (And Why Is It Horrible to Ask?)*,

produce QALYs at approximately one-twentieth the cost of renal hemodialysis, the conclusion is obvious: more replacements should be done. Using the same principle, there should also probably be more coronary bypass surgeries for individuals with severe angina and left main vessel disease and more screening and follow-up treatment for mild hypertension because of the qualitative results that follow these procedures.<sup>212</sup>

The aged are disadvantaged significantly by QALYs—this, because QALYs measure only treatment endpoints without taking into consideration either the proportional loss or gain in the quality of one's life. Thus, the major moral criticism of QALYs is that they set no value on life *per se*.<sup>213</sup>

An alternative to QALYs has been suggested in what is termed “the saved young life equivalent.”<sup>214</sup> Although arguably still reducing individuals to numbers, this approach seeks a unit of measurement in which saving a young person's life and restoring him to full health is the controlling paradigm. This position is justified because, simply, a majority of people would view this very goal, ideally, as a positive step toward achieving “the maximum benefit” any individual could achieve.<sup>215</sup> An assessment of comparative treatment values is thus made “in terms of how many expected outcomes of each treatment would be equivalent to SAVE.”<sup>216</sup>

Instead of trying to structure a model that seeks to incorporate a defensible method of pricing life and health, QALYs are thought to be a more feasible means of prioritizing healthcare services. The goal of trying to obtain the most QALYs from a healthcare system does not force a search for an answer to the central question: namely, what amount of money should be spent per QALY. Thus, QALYs will be of considerable use in those contexts in which the question of the

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WASH. POST, June 1, 2003, at B3.

<sup>212</sup> Menzel, *supra* note 66, at 80.

<sup>213</sup> MASON ET AL., *supra* note 8, at 433; *see also* Lee, *supra* note 160 (regarding health insurance caps).

<sup>214</sup> MASON ET AL., *supra* note 8, at 382.

<sup>215</sup> *Id.*

<sup>216</sup> *Id.*

amount of resources to spend on healthcare has presumably been answered; that is, when there is a health budget to stay within such as in the British National Health Service, an American prepaid plan, or in a rational Medicare plan operating in the twenty-first century.<sup>217</sup> Indeed, some speculate that soon within this century, QALYs will be accepted totally and used in planning and organizing health services.<sup>218</sup>

### **B. Risk-Benefit or Cost-Benefit Analysis**

Perhaps the fairest idea for limiting or rationing care is to be found in risk-benefit analysis, which shows the risk and potential benefit of a medical procedure.<sup>219</sup> In developing risk-benefit uses, although age might always be expected to weigh against an older person likely to have fewer years of vigorous life left, it would not be necessarily conclusive.<sup>220</sup>

If, for example, a very elderly man with an aneurysm, failing kidneys, and other complications were presented for surgical evaluation, under a cost-benefit analysis, a decision regarding the merits of surgery would be simply tied to cost. Under risk-benefit analysis, if the likelihood of the patient surviving surgery were practically zero, whereas the likelihood of his living very long even if he did survive the surgery was very low, then surgery to repair the aneurysm would probably not be found to be cost-effective.<sup>221</sup>

## **IX. STRUCTURING A DECISIONAL FRAMEWORK?**

Establishing fair procedures for the distribution of health care resources is a crucial goal for contemporary society to set and,

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<sup>217</sup> MARY R. ANDERLIK, *THE ETHICS OF MANAGED CARE: A PRAGMATIC APPROACH* 55 (2001).

<sup>218</sup> AARON & SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* 80, 81 (1984); see Matthew Adler, *QALYs and Policy Evaluation: A New Perspective*, 6 *YALE J. HEALTH POL'Y L. & ETHICS* 1 (2006).

<sup>219</sup> Kilner, *supra* note 12, at 1073.

<sup>220</sup> Andrew H. Smith & John Rother, *Older Americans and the Rationing of Health Care*, 140 *U. PA. L. REV.* 1847, 1850 (1992).

<sup>221</sup> Eric Rich, *Official Suggests Risk-Benefit Rationing*, *WASH. POST HEALTH MAG.*, Jan. 23, 1990 at 25.

hopefully, to achieve. Accordingly, fairness is to be defined and shaped by four conditions: (1) public accessibility to “limit-setting decisions” and their policies and rationales; (2) clarity in policy rationales which explain how “value for money” is met in distributing healthcare resources within a society where there are reasonable resource constraints on the resources themselves; (3) a framework for principled decision making which provides a means for resolution of disputes; and (4) a regulatory process which not only assures public access to the initial “limit-setting decisions” but also provides an equitable mechanism for challenging the reasonableness of contested healthcare distribution decisions.<sup>222</sup>

### A. Restoring Trust

Sadly, as a direct consequence of the multiple and conflicting roles a physician is cast in or forced to choose between, because of either the particular managed care program he is practicing under or the professional ethic he espouses, medicine is no longer being seen as caring for people. Indeed, the very acceptance of medicine as a moral value, whose end is the healing of a vulnerable person’s life and whose paramount essence is codified in the virtue of benevolence, is thus challenged to its very core.<sup>223</sup>

The politics of economic self-interest compromise—if not extinguish—the sacred trust patients once placed in their physicians. Stated otherwise, the present system promotes the use of expensive, invasive, and at-risk treatments and places little effort in patient care. It has been suggested that a new ethic needs to be recognized and embraced by physicians—one that shifts from using medicine if it might assist to one that promotes use only when it will.<sup>224</sup>

### B. Balancing Needs Within The Democratic Process

The ineluctable conclusion to be drawn from this analysis is that in formulating healthcare policies, the principle of distributive justice

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<sup>222</sup> ANDERLIK, *supra* note 217, at 134.

<sup>223</sup> David Thomasma, *Virtue Theory, Social Practice, and Professional Responsibility in Medicine*, in 4 CRITICAL REFLECTION ON MEDICAL ETHICS 321, 321-38 (M. Evans ed., 1998).

<sup>224</sup> ANDERLIK, *supra* note 217, at 5.

demands decisions such as allocating and rationing healthcare be made fairly within the political process. Further, it demands that broad grants of discretion (which in turn often promote managerial indecision) to administrative decisionmakers in the HMOs, who themselves have varying systems of values and limited discretion, to bedside medical gatekeepers be limited. Only through deliberate debate within a democracy can assumptions about aging, the value of life for the aged, and intergenerational responsibilities of assisting the elderly in their care be set, tested or—as the case may be—rejected.<sup>225</sup>

“Most people,” it has been said, “are ignorant about most matters.”<sup>226</sup> This is true, particularly with regard to the healthcare market, where consumers are found to be lacking in basic information about not only the quality but also the price of medical services. This ignorance, in turn, means consumers lack the expertise to evaluate the professional qualifications of healthcare providers as well as evaluate necessary information regarding the range of alternative treatments available to them. Even when price information is available, healthcare consumers have difficulty assessing and, indeed, comprehending what the data means and how it impacts their access to healthcare.<sup>227</sup>

Because the efficient use of medical resources dictates that both consumers and healthcare providers weigh the costs and benefits of alternative medical treatments, the failure to access healthcare information regarding these options means—essentially—that physician preferences for particular medical procedures trump the ideal of informed patient consent.<sup>228</sup> And, this in turn, means that the physician solidifies his position of power as the primary gatekeeper to healthcare resources.

In the final analysis, what is called for is fair democratic procedures designed to allow average citizens to be sufficiently informed and knowledgeable in order to make choices among just

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<sup>225</sup> George P. Smith, II, *Judicial Decision Making in the Age of Biotechnology*, 13 NOTRE DAME J.L. ETHICS & PUB. POL'Y 93, 102 (1999).

<sup>226</sup> RICHARD A. POSNER, *THE PROBLEMS OF JURISPRUDENCE* 112 (1990).

<sup>227</sup> GEORGE J. ANNAS, *THE RIGHTS OF PATIENTS* ch. 3 (3<sup>rd</sup> ed. 2004).

<sup>228</sup> *Id.* at 479.

alternatives for healthcare resource allocations.<sup>229</sup> Supported by traditional tests for cost-benefit analysis, together with policies that promote cost-effectiveness, tied – as such – to those discernible values ranked clearly as beneficial and those regarded as costly, such a process can in fact work.<sup>230</sup>

Granted, a public dialogue to reach a consensus on how medical resources ought to be distributed is unlikely.<sup>231</sup> Yet, a “public conversation” on these issues of the type the state of Oregon undertook several years ago is available. No matter within what policy forum the healthcare resource debate occurs—local, state, or national—a fundamental balancing test will, of necessity, be employed; one that weighs, in an equitable and reasonable manner, individual needs with larger societal standards of economic efficiency.<sup>232</sup> By seeking to integrate moral and ethical reasoning with quantitative or economic formulations of needs and resources, the opportunities for a stronger and more contemporary standard of distributive justice will be both enhanced and stabilized.<sup>233</sup>

The ultimate moral issue seen in this debate is not—rather surprisingly—whether too much or too little treatment is offered; but rather how to seek an optimum level of reasonable or appropriate treatment based on the medical condition of each patient. Failing to deal with the inherent difficulty of allocative decisions here foredooms the total decision making process to a continued state of lethargy where inaction becomes the tragic hallmark of health care management.

If agreement could be reached for setting principles of distributive justice which, in turn, would establish a mechanism for determining how to set fair limits to healthcare, societies would then be empowered to check all social decisions and practices against the principles in order to determine whether these decisions conformed

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<sup>229</sup> CHILDRESS, *supra* note 1, at 254.

<sup>230</sup> *Id.*

<sup>231</sup> BLANK, *supra* note 121, at 98; *see generally* PETER L. BERGER & RICHARD J. NEUHAUS, *EMPOWER PEOPLE: FROM STATE TO CIVIL SOCIETY* (Michael Novak ed., 1996).

<sup>232</sup> ANDERLIK, *supra* note 217, at 130.

<sup>233</sup> EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE: TOWARD A PHILOSOPHY AND ETHIC OF THE HEALING PROFESSIONS* 170-191 (1981).

to the principles. In cases where decisions, policies, and practices failed to conform, they would be held unjust and subsequent actions then taken to change them. When disagreements arose over interpretation of principles or facts, legal procedures for resolving such disputes would be sought.<sup>234</sup>

Ideally, the establishment of a national minimum standard of healthcare that delineates what an adequate level of care should be for managed care organizations, the managers within it, and the physicians who are practicing under it would be a positive step toward resolving present inadequacies in the system. Once such a standard is in place, some level of competition will be expected to “take place not on establishing the leanest rationing strategy the market will bear (however ethically problematic it may be), but on delivering the agreed minimum standard efficiently.”<sup>235</sup> This standard demands of the physician an ethical obligation to his individual patients “to interpret it in the light of the patient’s circumstances and make certain it was offered to them.”<sup>236</sup>

Realistically, designing a satisfactory mechanism for defining a morally acceptable threshold standard of care is problematic.<sup>237</sup> Reaching a political consensus on this challenge is even more daunting given the public’s level of “understanding” – and, indeed, lethargy.

## X. CONCLUSIONS

In the final analysis, it is quite possible (and probable) that society has come to view healthcare as little more than a commodity—a service. Like other commodities in a market economy, specific and harsh rationing decisions are imposed on physicians. The direct consequence of this societal re-direction means the foundational principles of professional medical ethics—

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<sup>234</sup> Daniels, *supra* note 64, at 14.

<sup>235</sup> Mary A. Bailey, *Managed Care Organizations and the Rationing Problem*, 33 HASTINGS CTR. REP. 34, 40 (Jan.–Feb. 2003).

<sup>236</sup> *Id.*

<sup>237</sup> *Id.* at 41; see generally George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care or Health Protection?*, 39 VAND. J. TRANSNAT'L L. 1295 (2005).

autonomy, beneficence, and justice—will yield to “social good and economic need.”<sup>238</sup> The whole art of healing, once seen as a partnership between the healer and nature, itself, is also thus recast as an effort to redesign nature—improving upon it, and aiming it in new startling directions heretofore not found in its history.<sup>239</sup>

The choice implied in the rationing of medical goods and services, “will reveal more about the kind of people we are, and wish to be, than it would about the ideas we profess.”<sup>240</sup> Indeed, there is a growing national belief in, and acceptance of, the inevitability of rationing and an awareness of the attendant ethical issues and dilemmas deriving therefrom within the patient-physician relationship<sup>241</sup>—issues arising inescapably from the very nature of managed care which, itself, challenges the foundational basis of relationship centered care.<sup>242</sup>

From a transnational perspective, perhaps it is more realistic—when considering the extent to which there should be a governmental obligation to guarantee a citizen’s good health—to refer to a right to health protection—with this including a right to access healthcare together with a right to live under healthy conditions.<sup>243</sup> Ideally, guaranteeing access to healthcare resources is the foundation upon which all other assertions of healthcare “rights” and their permutations are built. Lacking a strong, determinative framework for both identifying and analyzing the essential societal factors representing the conditions under which people can access health care makes acknowledgement of an absolute right to health care unrealistic and impractical.<sup>244</sup> International legislative templates

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<sup>238</sup> PELLEGRINO & THOMASMA, FOR THE PATIENT’S GOOD, *supra* note 91, at 189.

<sup>239</sup> David C. Thomasma, *The Principle of Dimension*, in THE HEALTH CARE PROFESSIONAL AS FRIEND AND HEALER, *supra* note 23, at 133-47; *see generally* Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583 (2008).

<sup>240</sup> PELLEGRINO & THOMASMA, *supra* note 90, at 185.

<sup>241</sup> *Id.*

<sup>242</sup> David C. Thomasma, *The Ethics of Managed Care: Challenges to the Principles of Relationship Centered Care*, 25 J. ALLIED HEALTH 233 (1996); *see generally* Nan Hunter, *Managed Process, Due Care: Structures of Accountability in Healthcare*, 6 YALE J. HEALTH POL’Y L. & ETHICS 93 (2006).

<sup>243</sup> GEORGE P. SMITH, II, HUMAN RIGHTS AND BIOMEDICINE 16 (2000).

<sup>244</sup> *Id.*

go only so far in shaping a response to this issue. Rather, the dynamics of gatekeeping ethics and the centrality of the medical healing partnership between patient and physician must be seen as the paramount elements in assuring distributive justice both in the national and transnational health care delivery system.<sup>245</sup>

Parts of this article derive from my book, *DISTRIBUTIVE JUSTICE AND THE NEW MEDICINE* (2008).

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<sup>245</sup> See generally PELLEGRINO & THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE*, *supra* note 233, at 170-191.