BIOETHICS WITH LIBERTY AND JUSTICE

Themes in the Work of Joseph M. Boyle

Edited by
CHRISTOPHER TOLLEFSEN
University of South Carolina, Columbia, SC, USA

12: HEALTH CARE TECHNOLOGY AND JUSTICE

Germain Grisez

221–239

2011

Springer

Health Care Technology and Justice

Germain Grisez

12.1 The Need for Health Care

The title of this paper refers to a subject matter that is already being dealt with by many able scholars, for some of whom it is a central preoccupation. The issue of justice in health care has also been an abiding concern of Joseph Boyle (see, e.g., Boyle, 1977, 1996, 2001). In essays ranging over some 30 years, he has defended a right to health care in developed nations, and has addressed some of the difficulties that arise in a context of finite resources and moral pluralism. In this essay I shall only propose some ideas that I hope will be helpful to Boyle and others who wish to contribute to the ongoing debate on these matters.

Health care here does not refer to contraception, abortion, in vitro fertilization, freezing embryos and corpses, sex change surgery, cosmetic surgery, assisted suicide, euthanasia, or drugs or procedures meant to enhance an already-healthful somatic or psychic function or to reduce the discomfort of healthful somatic and psychic states, such as fatigue and grief.

In health care, the physician-patient and nurse-patient relationships are central, but, in addition to physicians and nurses, many others help meet health care needs: dentists, optometrists, pharmacists, hospitals, community clinics, pharmaceutical companies, phlebotomists, respiratory therapists, x-ray technicians, critical care paramedics, nurse practitioners, and so on and so forth. When referring in general to those who help meet health care needs, I call them "providers," and I call those whose needs they meet "clients." In using these general expressions, I do not mean to reduce providers and clients to their roles in the relationship of supplying and obtaining things that cost money, nor do I mean to disparage the dignity of any kind of provider.

The justice of existing laws and present practices regarding many matters, including taxation and immigration, is questionable and vigorously debated, and reforms in any of these fields would affect all the others. But in what follows I focus on

---

G. Grisez (✉)
Mount St. Mary's University, Emmitsburg, MD, USA
e-mail: grisez@msmary.edu

C. Tollefsen (ed.), *Bioethics with Liberty and Justice*, Philosophy and Medicine 110,
DOI 10.1007/978-90-481-9791-0_12,

justice in health care and prescind from other matters. So, my statements about what justice requires for citizens and lawful residents should not be read as saying anything about what it requires for illegal immigrants, and my remarks about taxes should not be read as endorsing existing tax laws and their enforcement or any proposal to change them.

All knowledge about how to care for one's own and others' health can be called *health care technology* in a broad sense. In this sense, the people of every society acquire by experience and hand on a health care technology—a body of knowledge about how to identify what is safe to eat and drink, how to protect themselves against environmental challenges, how to help birthing mothers, how to care for babies and the incapacitated, how to avoid getting and spreading diseases, how to avoid injuries, how to deal with illnesses and injuries, and how to function despite them, and despite handicaps and declining capacities. Without such practical knowledge, people could not survive. Their common moral responsibilities with regard to this technology are to seek that practical knowledge, share it with others, and cooperate in acting on it.

During modern times, health care technology greatly increased wherever the means of communication improved, formal education became widespread, and systematic inquiry was conducted in biology, chemistry, and health-related statistics. As people in industrialized societies also grew wealthier, they became more able to act on their increasing knowledge—for example, by providing clean water, sewage disposal, a better balanced and more adequate diet, and more adequate clothing and shelter for themselves and their families. As people's ability to live healthily increased, infant mortality declined, the spread of communicable diseases slowed, and life expectancy rose.

In most if not all societies, certain people with special responsibilities for providing health care have possessed and handed on specialized technology. With the modern development of health care technology, such people acquired many new tools and behaviors: drugs, devices, and procedures for use in prevention, diagnosis, and treatment of diseases and injuries. With the increasing variety of skills required to use burgeoning technology, health care professions—or jobs—multiplied and were diversified. Businesses were founded to develop, manufacture, and market drugs and devices; and hospitals, which previously offered nursing care to poor people, became places designed and equipped to apply a broad range of the ever-expanding health care technology. Health care thus became a complex industry, and *health care technology* now is generally used in a narrow sense to refer to the set of goods and services that industry provides.

In industrialized nations during the past two centuries, technological innovation in many fields has been increasingly rapid, and there also has been rapid innovation in the fine arts, literature, and various forms of play. Because of human creativity and the unquenchable human desire for new goods and services, no limit to such technological and cultural innovation is or even can be in prospect. Nevertheless, most natural desires could be satisfied adequately without further innovation. For example, most people could have an adequate diet without taking advantage of innovation in processing and marketing foods and drinks, and in preparing and presenting meals. Moreover, frugal people generally delay or even entirely forgo taking advantage of innovations that themselves generate desires for new products and services rather than respond to some antecedently perceived need.

In contrast, with such adventitious desires and even with other natural desires, the desire to preserve life and bodily integrity, and to maintain and promote healthful functioning, generates demands for innovative technology. For while it can be easily satisfied by most people during part of their lives, almost everyone sooner or later urgently needs up-to-date products and/or services of the health care industry; and many people would benefit even more from anticipated technological innovations.

Sometimes health care technology decisively wins a battle, as when systematic vaccination eradicated small pox. But many elements of health care technology have unwanted side effects and/or limited effectiveness. Then improvements are desired. Moreover, as life expectancy has increased, additional, treatable physical and psychological pathologies have been identified. Currently, the study of genes, molecular biology, and cell biology promise breakthroughs in the diagnosis and treatment of many diseases, and in the growing of replacement tissues and organs. If the human life span is naturally limited, as some maintain, to about 120 years, present health care technology still has a long way to go before that limit is approached by the life expectancy of people whose lives are not shortened by violence or injuries. Moreover, there seems to be no end to the possibilities for dealing more effectively with the damage to bodily integrity and functioning caused by injuries. Therefore, although, as in other fields, no end is or can be in prospect to innovation in health care technology, innovation in this field is peculiar in being driven by an urgent natural desire that at times in most people's lives cannot be fully satisfied.

Due to ever-expanding technology and the unpredictability of the need for health care, that need, unlike others that are clearer and more definite, is indeterminate and always growing. This peculiarity of health care technology significantly contributes to the difficulty of questions about moral responsibilities in its regard. Although there are other questions, I will focus on those about providing and paying for health care.

With various exceptions, including many drugs, people have never been able to shop for health care technology as they do for most other goods and services. Very often, people with incipient health problems do not know what care they need. Diagnoses often are uncertain, and alternative plans of treatment often are incommensurable with respect to their prospective benefits and burdens, including their prospects of success and risks of bad side effects. Providers often must motivate the demand for the goods and/or services they will supply. Clients often are more or less committed to a provider before he or she makes a diagnosis or proposes a plan of treatment, which usually is tentative, sometimes must be worked out step by step, and seldom is sure to succeed. Reliable information that would be needed to compare potential providers is often unavailable, and nonmonetary factors often impede or prevent clients from changing providers. Consequently, providers seldom compete by offering at different prices health care of similar quality to meet the same need in the same way. Thus, there never has been and never will be a market for health care technology comparable to the markets for groceries, automobile servicing, and hotel rooms. In fact, many providers have no effective competitors, because there is no alternative provider reasonably available to their clients. Realizing how matters stand, providers are likely to be tempted to set exorbitant prices for their goods and services.

Until the twentieth century, however, physicians and nurses mainly offered advice, moral support, nursing care, and the alleviation of symptoms. Most people seldom urgently needed such professional care, and many went through life without ever receiving it. When a form of care that would affect survival or functioning was clearly needed and urgently desired, its cost was seldom burdensome for the wealthy and influential. Some people who could not afford clearly needed care obtained it from charitable institutions or providers who waived part or all of their fees, because of their professional commitment to serve and their acquaintance with community members who needed their service. Of course, some poor people died due to lack of professional health care, but their deaths were regarded as part of the normal course of events just as were others' deaths due to lack of an adequate diet.

As the health care industry took shape during the twentieth century, technology regarded as effective by most clients proliferated, and people with health problems increasingly desired that technology. At the same time, health care grew more and more expensive, causing many clients to fear they would be unable to pay for it when they or their dependents clearly needed it.

Never able to care for all poor people, charitable institutions could not begin to meet the growing needs of an even larger part of society. As the cost of other elements of care grew, the willingness of a provider to reduce or waive fees fell increasingly short of solving the problem of a client who could not afford needed care. Moreover, some providers no longer had the professional commitment common in earlier times, and increasing mobility together with the differentiation of health care jobs often meant that providers had no direct relationship at all, or only a transient one, with their clients.

12.2 Schemes for Meeting the Need

As a result of these complex developments, by the mid-1930s many people in industrialized nations were anxious about how to meet their own and their dependents' needs for health care. By then, too, there was a large middle class with social and political influence in all these countries. Many people were therefore ready to welcome and able to promote arrangements to avoid incurring fees for health care at the time it was needed—fees that might well be beyond their means, exorbitant, or both. At the same time, many providers were open to ways of ensuring timely payment for their products or services, without limiting their clientele to those who could pay for what they needed when they needed it. Thus, beginning in the 1930s and continuing through subsequent decades, many schemes developed for providing and paying for health care.

All those schemes can be understood as variations on two basic models: insurance and prepayment. In the former, for the payment of a premium, the insurer agrees to pay or reimburse providers for a more or less extensive set of health care products and/or services when they are needed. The latter takes two forms. In one, a provider or set of providers of health care products and/or services undertake to meet, more or less, the needs of a specified person or set of persons. In the other, an organization undertakes to meet the needs of a specified set of persons by employing providers and providing facilities.

With either basic model, the payer can be the covered individual (or family), a government for all or some of its citizens, another entity (such as an employer), or some combination of these.

Until Section 12.5 below, I will not deal with insurance schemes that undertake only to pay or reimburse for certain sets of costly products and services that most covered persons will never need, nor will I deal with prepayment schemes that guarantee only to deliver specified products or services at specified times. I will deal with those that undertake, subject to various conditions, to provide or pay for a broad variety and unspecified quantity of forms of care.

Most schemes have involved some sort of mixture of the two basic models. For example, an insurance scheme may specify certain products and services, such as inoculations and checkups, to be supplied to any covered person who wants them, and a prepayment scheme may promise reimbursement within limits for products or services obtained from third parties.

Most schemes limit and some designate the providers who will be available, and all employ managers to ensure that providers and clients meet conditions set by the scheme for delivering what it promises. No scheme undertakes to meet every clear need with a free choice among all the products and services that health care technology as a whole makes available.

Regardless of differences among schemes, the possibility of obtaining care without incurring any—or any additional—expense makes it easier to seek that care. Consequently, clients will count on obtaining care they otherwise would not expect, and clients are likely to obtain care they otherwise would not obtain. Clients thus have a sense of entitlement to care.

In some cases, that effect on clients' motivation is all to the good, for example, when it leads them to get appropriate inoculations and check-ups they otherwise would neglect. In other cases, it is all to the bad, for example, when it leads nervous people to obtain risky care they do not need or leads people who otherwise would maintain a healthful lifestyle to overeat, use tobacco, abuse alcohol, carelessly risk transmitting or contracting diseases, and/or neglect hygienic practices, such as washing hands.

Probably far more often, the possibility of obtaining care without incurring any (additional) cost leads people with a reason to desire some form of care to obtain it even though their need for it is not clear and, if they had to pay directly for it, they would delay seeking it or prefer a less expensive alternative. For example, if new drugs are covered, many clients will prefer them to generics; if heart scans are covered, many healthy clients will prefer them to stress tests; if MRI examinations and spinal surgery are covered, many clients who would otherwise deal conservatively with back pain will prefer an MRI for diagnosing a ruptured disk and surgery for treating it.

More generally, coverage by any scheme will motivate many clients to see their primary care physician or go to an emergency room before symptoms are intense or definite enough to make clear the need for care; and a primary care or emergency room physician's diagnosis of the onset of a chronic condition will more quickly lead many clients to a specialist for a complete work up, a plan of treatment, and regular return visits. Thus, more clients with sore throats are quickly checked for streptococcus despite the lack of other symptoms; more clients receive eye examinations by ophthalmologists rather than optometrists; and more clients with digestive problems soon see gastroenterologists, receive complete examinations, and return for regular check ups. Such accelerated choices to seek and extend treatment occasionally prevent disasters and seldom lead to serious regrets.

Since choosing to obtain care without incurring any, or any additional, cost seems reasonable and is not obviously harmful to others, most people who make such choices will not ask themselves whether that is fair to whoever must ultimately pay for this care that they would not obtain if they had to pay for it themselves. Conscientious people who do ask themselves that question reasonably judge that, since others covered by the scheme take full advantage of what it offers, they are not duty bound to deny themselves any available benefit as long as they proceed honestly within the scheme's rules.

Clients' sense of entitlement motivates most individual providers to supply more products and/or services than they otherwise would, partly because most want to be accommodating and partly because they do not want to be blamed for the occasional bad result of not supplying what a client wanted. Moreover, under any scheme, some providers are tempted to supply or to say they are supplying more goods and/or services than clients desire or need, in order either to meet performance standards set by managers of prepayment schemes or to increase their income in insurance schemes.

Consequently, no matter how a scheme is structured, its costs tend to exceed the amount that those ultimately paying are prepared to pay, and the scheme's designers and managers must limit what and how much it supplies or pays for. Since many of the items delivered or paid for are individually small in cost, managers cannot bring about the needed limitations by closely monitoring each and every transaction, but they can and do try in other ways to put the lid on.

12.3 The Shortcomings of Existing Schemes

Every sort of scheme can try to limit how much it will provide by requiring a manager's or management-designated agent's prior approval (or preauthorization) for the use of certain elements of health care technology. That requirement promotes the common good and harms no one insofar as it reduces waste due to some clients' unreasonable desires and/or some providers' excessive deference, bad judgment, or greed. However, when people without first-hand knowledge of clients and their needs are responsible for setting limits, they are likely to be tempted to do that without adequate consideration and due regard for clients' best interests. A client's failure to obtain required prior approval, due to forgetfulness or temporary non-competence, also can result in a serious loss. At the same time, providers and clients are likely to be tempted to exaggerate—that is, to lie about—the seriousness and urgency of needs so as to increase the likelihood of obtaining approval or authorization for care they consider necessary.

By promises and/or threats—usually implicit rather than clearly articulated—a scheme's managers also can try to motivate providers to choose to omit some examinations and treatments, to refuse to write some prescriptions, and/or to avoid making some referrals. This also promotes the common good and harms no one insofar as it reduces waste. But even without a provider's being aware of it, this pressure from managers can color his or her views of what is in clients' best interests and thus lead to judgments at odds with them. And insofar as promises and/or threats lead competent providers to make choices contrary to their judgment about what is in a client's true interests, they are led to betray their professional responsibility and deprive the client of the loyal service to which he or she is entitled. Clients who are less aggressive and less able to look after their own interests are of course more likely to suffer in this way.

How much a scheme provides can also be limited by charging copayments—specified amounts that clients must pay towards various products or services. Insurance schemes also can specify both deductibles (amounts that must be paid before coverage or some elements of it begin) and limits on the total coverage or some of its elements. Just to the extent that clients desiring care encounter such limits, the scheme does not benefit them; yet participation in the scheme remains more or less constraining to them as well as to potential providers.

The common interest in keeping health care affordable may seem to require copayments, deductibles, and limits of coverage. However, the more someone can afford to spend, the less effective these disincentives are; so, the less likely they are to prevent choices at odds with the common good. The less someone can afford, however, the greater are the disincentives of such costs and limits to obtaining even clearly needed care; and the more likely they are to lead to choices at odds with the best interests of those making them and/or of their dependents. So, such methods of limiting what a scheme undertakes are unfair, because they mainly limit what poorer participants get out of it, and may well deter them from obtaining care they clearly need.

Managers of a scheme involving the insurance model can limit payments in several ways besides those already mentioned. Long and complicated contracts not made available to individual policyholders can make it virtually impossible for them to know what they are entitled to. The process of filing claims can be made complex and inconvenient for providers, those covered, or both. Managers can use technicalities to generate plausible excuses for refusing, reducing, or delaying payments; they can require precise and even repeated submission of evidence to support claims. Subordinates can be given subtle incentives to misplace or lose paperwork. Due to the use of such tactics, some legitimate claims are never filed, some that are filed never meet technical requirements for approval, and some that meet the requirements are abandoned in frustration and despair of ever being paid. At the same time, such tactics waste policyholders' and providers' time and require the latter to hire people or pay agencies to file insurance claims and handle problems with them.

Managers of a scheme involving the prepayment model directly limit the goods and services it makes available by supplying what their limited budget can buy while managing access so that participants receive a more or less fair share of the limited quantity of products and services. The more necessary it is to restrict access to the promised benefits, the more likely participants are to experience the unavailability of some elements of health care technology, delays in receiving goods and services, overcrowding in facilities, and other inconveniences and discomforts.

Managing access necessarily involves scheduling care on the basis of a judgment about whose needs and/or which needs deserve priority. While it may be said that the judgment is made by considering which need is more serious, more urgent, and more likely to be met effectively by prompt care, it is likely to be influenced by other factors. Other things being equal, for instance, participants whose prospects for recovery make their lives seem more worth saving or whose needs can be met quickly and easily may be given priority. In any case, the result of such scheduling is that those without priority will receive care later rather than sooner, if they receive it at all. For example, cataract or hip-replacement surgery might be forthcoming only after a long wait.

Managing access also means limiting care for chronic conditions and accepting some risks of failing to adjust treatment when appropriate or to respond in timely fashion to new symptoms calling for a radical change in the plan of care.

Finally, managing access can mean refusing to provide a means of care despite its foreseen benefits if the benefits are judged inadequate to justify the burdens, including the impact the care's cost will have on the scheme. As clients' life expectancy and chances for recovery lessen, the prospective benefits of providing care for them decrease and its costs often increase. Those managing access to care may thus decide not to supply costly examinations and treatments to participants who are old, gravely debilitated, or both. Such participants may receive only less costly treatments and medications, perhaps only palliative care.

Because delays and limits increase participants' risks and suffering, they—and any allies they may have among providers—are likely to be tempted to conceal relevant information and to lie in order to obtain more care or obtain care sooner than competing claimants. At the same time, because judgments prioritizing needs involve many incommensurable variables, the rationality of such judgments often is unclear, and those making them may well be unfair. The unfairness might be due to some factor which is not even consciously considered (for example, personal experience with similar problems), or due to rationalization (for example, admiration for a client's courage and cheerfulness). Or it may be a deliberate and admitted unfairness—for example, due to a personal relationship, or a bribe or threat.

The managers of some schemes structured on the prepayment model identify the minimum payment sufficient to obtain from some potential providers each product and service the scheme promises to those covered. The managers then offer payments only slightly above that minimum, but do not obtain commitments from or otherwise motivate any group of potential providers to supply or serve all those covered at the specified prices. When those covered can find no provider ready to supply what was promised at the payment offered, this tactic unfairly breaks the promise. It also may tempt providers to bill for more than they provide, accept side payments (bribes) from those needing care, and/or reduce the quantity and/or quality of what they provide.

Despite the proliferation of schemes, most clients obtain at least some of their health care by paying directly for it. People not involved in any scheme must do so or do without the health care they need, unless they can obtain it without charge. Because no scheme undertakes to meet every clear need with a free choice among all the products and services that health care technology as a whole makes available, most clients covered by a scheme also must pay directly for some health care. The wealthy sometimes pay for what they regard as better and/or more convenient care, and even those who are not wealthy sometimes do this in order to obtain some urgently desired element of care more quickly and/or from a preferred provider.

12.4 Injustices Peculiar to the United States

In the United States, many people are not covered by any health care scheme—some because no scheme will cover them, some because they cannot afford coverage, some because they opt out of an affordable private scheme or fail to apply to a governmental scheme for which they are eligible. The schemes are quite diverse, and most do not remain unchanged for long. Despite the efforts of designers and managers to limit what and how much schemes provide or pay for, the ultimate payers are constantly pressed to pay more. Yet because of efforts to limit costs, most providers as well as many clients consider themselves to be involved in an arrangement unsatisfactory not only in what it does for them but also, and even more, in what it imposes on them and requires of them.

By allowing employers and self-employed individuals to pay with pretax dollars for coverage by health care schemes and to deposit pretax dollars in health care reimbursement accounts, the U.S. government motivates many people to maintain coverage by such schemes and/or to set up such accounts, and thus subsidizes the health care of all who consequently pay less tax than they otherwise would. This subsidy is greater for those whose income is higher, because they pay taxes at a higher marginal rate and generally have more costly health care schemes and/or larger reimbursement accounts. Covered people whose income is so low that they owe no tax on it do not receive any subsidy on this basis, nor do employees whose employers neither provide a health care scheme nor offer health care reimbursement accounts.

Currently (2008), U.S. citizens and permanent residents become eligible for health care coverage by Medicare at age 65 if they or their spouses have had at least forty quarters of employment covered by Social Security. Most do not pay for Medicare part A (hospital insurance). But for Medicare part B (medical insurance) there is a charge, ranging from $192.80 per month (for a married couple whose household income is under $164,000 per year) to $476.80 per month (for a couple whose household income exceeds $410,000 per year). This scheme also covers certain other people under various conditions—a couple without any covered employment can obtain Medicare parts A and B for $1,038.80 per month.

Besides the payment required to obtain it, Medicare has many gaps, which participants can more or less fill by buying one or another of a standard set of medigap policies from a commercial insurance company. So, Medicare is far less adequate for those who cannot afford a medigap policy than for those who can, most of whom also spend a smaller percentage of their greater incomes on the basic Medicare coverage.

In the United States, citizens and permanent residents who are very poor, regardless of age, are eligible for coverage by Medicaid. Thus, many very poor elderly people in the U.S. are eligible for coverage by both Medicare and Medicaid. However, some people who are ineligible for Medicaid—because, though far from wealthy, their earnings or assets exceed the eligibility limits—have no other coverage, and can afford neither to purchase basic coverage (or a medigap policy, if covered by Medicare) nor to pay directly for health care they clearly need. Consequently, in the U.S., some people who work hard but earn little never in their lives receive governmental help to obtain health care they clearly need but cannot afford, while most people who are better off receive at least some help during part of their lives. Those who generally receive the most governmental help during their lives as a whole are those who need it least: people who have high earnings during their working years and substantial household income in retirement. (Although the small proportion of couples whose household retirement income exceeds $164,000 per year must pay more than the minimum for Medicare, that payment still is far less than the cost to the government of their Medicare benefits, and their higher payment for Medicare often is more than offset by the greater tax savings they enjoyed on nontaxable coverage during their working years.)

Medicaid, funded partly by the federal government and partly but variably by each state, generally pays less than Medicare or private coverage schemes pay for similar services. One consequence is that fewer physicians accept Medicaid, and those covered by it sometimes cannot find individual providers willing to care for them. However, federal law requires any hospital that accepts Medicare and operates an emergency room to examine anyone who comes to that facility and to care for such people until their condition is stabilized. So, poor people who have Medicaid coverage and people without any sort of health care coverage often seek care from hospital emergency rooms. Since there is no governmental payment for people without coverage and since Medicaid payments generally are less than the marginal costs of emergency room service, most hospitals incur substantial losses on their emergency rooms, which often are overcrowded with people who must wait many hours for evaluation and care.

Hospitals compelled by the law to provide emergency room care without charge, as well as other providers of health care products and services covered by Medicaid and Medicare, usually set or negotiate higher prices for the same things when providing them to someone covered by a nongovernmental scheme. But providers often set the highest prices for clients who, having no coverage, incur the obligation to pay for anything they or their dependents get as they get it.

Such cost shifting especially burdens the latter group. The burden falls on them not because they are well suited to bear it but simply because imposing it on them is possible and their need compels them to pay what is demanded. The burdened group includes the working poor who have no coverage, and who consequently sometimes forgo clearly needed care they would get if they were either wealthier or less honest and industrious. Insofar as the burden of cost shifting is deliberately imposed by governmental policies and actions, it is morally equivalent to an unjust tax; insofar as it is deliberately imposed by hospitals and other providers, it is morally equivalent to theft.

12.5 Towards a Just Health Care Scheme

Since all existing health care schemes are not only unsatisfactory in other respects but morally problematic, and since much of what the U.S. government does about health care is blatantly unjust, U.S. citizens and governmental officials share a grave moral responsibility to seek and promote justice in providing and paying for health care.

I doubt that there is a single, just resolution to this problem. There are likely to be several morally acceptable resolutions, each with incommensurable advantages and disadvantages of its own. Moreover, only groups including experts in health care, economics, law, and politics are likely to be able to work out practicable resolutions to the problem. But some requirements for establishing justice in health care can be formulated, and I hope my attempted formulations may help guide efforts to develop morally acceptable and practicable resolutions.

First, governments must be involved not only in setting and enforcing standards for health care, and regulating its provision and payment for it, but in paying for health care for certain groups of people, including those engaged in public service whose health is essential for their service (for example, military personnel) and those whose well being as a whole is the responsibility of public authorities, such as prisoners and incompetent persons for whom no one else is responsible.

The proliferation of health care technology and the social and economic structure of the health care industry make it no longer reasonable to expect providers regularly to reduce or waive their charges for care supplied to poor people. Insofar as providers are compelled to provide care without charge, they are induced to shift costs indiscriminately, and therefore unfairly, to those who can pay for care. The health care needs of poor people also far outstrip the resources available to nongovernmental institutions, such as churches and charitable organizations. Therefore, governments ought to see to it that hospitals and individual providers who care for poor citizens and lawful residents receive fair compensation.

How much and what sort of health care of poor people should governments pay for? Other things being equal, a government capable of it surely ought to spend at least as much on the health care of poor people as on the health care of people for whose care as a whole it is responsible. But how much governments should pay and for what can only be discerned by considering available resources and competing needs, and applying the Golden Rule. In doing so, two things should be borne in mind: first, that the need of poor people for health care is not less real or important than that of people who are wealthy; second, that meeting that need and certain other needs of poor people, such as their need for education, would enable many to escape from poverty and use their gifts to contribute to the common good.

Second, governments must set the prices they will pay health care providers for the goods and services they deliver to poor people, who at times need almost all the products and services provided by the health care industry. Governments already set prices for most—for example, the U.S. government sets prices for everything covered by Medicare. Of course, the prices may not be fair, and setting fair prices would be a complex and costly undertaking. However, to fulfill their responsibility to citizens and to avoid injustice, governments must set fair prices for every product and service provided by the health care industry. For, if governments pay too much for those products and services, the common good is injured; if they pay too little for any of them, providers and/or those to whom providers shift costs are cheated.

Often the fair price will be more than the minimum most providers would accept for caring for poor people. Most providers of health care products and services will at times deliver them for a payment covering slightly more than their marginal cost, since that seems profitable inasmuch as it is assumed that other payers have covered or will cover other costs. However, if a government in setting prices on the health care products and services supplied to poor people takes advantage of that tendency of providers, it unfairly shifts to other payers some of the capital cost of health care facilities, the training of health care personnel, providers' business overhead, and so on.

At the same time, the fair price often will be less than the price a provider would otherwise charge and could obtain. After all, monopolies can and often do charge exorbitant prices for things people urgently need, and, in an economic even if not in a legal sense, some providers have a monopoly on elements of health care technology: those who hold a patent on a drug or device and those who alone can provide a service needed here and now. Moreover, as already explained (in Sect. 12.2 above), many providers have no effective competitors. Fair governmental price setting for elements of health care thus will require a procedure similar to setting the rates charged by public utility monopolies: the full costs of each item must be determined and allocated, and a reasonable margin of profit allowed.

If governments set and pay fair prices for health care products and services, and providers charge other payers more for the very same things, the excess charge will be unnecessary and unfair. So, no provider that sometimes accepts a payment or subsidy from the government for a product or service should be permitted to charge anyone more than the fixed price for that product or service.

Third, considerations already set out (in Sect. 12.3 above) show that there are serious problems with schemes that undertake to cover a broad variety and unspecified quantity of forms of care that many of those covered will be more likely to obtain because they are covered. By requiring that managers attempt to limit what is delivered, such schemes tempt everyone involved, including the managers themselves, to act immorally; and, even so, do not achieve satisfactory limitations. It therefore seems to me that such schemes cannot contribute to a just solution to the problem of providing and paying for health care. If I am right, in the United States justice requires not merely change in health care financing but the termination of Medicare, Medicaid, and virtually all the private schemes currently in operation.

Nevertheless, both insurance and prepayment schemes can and must be parts of a just system.

Insurance can soundly cover any set of elements of health care technology that is quite costly and constitutes care known to be both necessary and effective for a condition that will not become much more likely if it is covered by insurance—for example, the elements of care needed by someone who suffers a stroke, perhaps beginning with an ambulance ride to the emergency room and ending with a final visit to a physical therapist. Some chronic conditions also meet the standard for insurance coverage—for example, those resulting from genetic and other congenital defects—but it cannot be met by chronic conditions that different lifestyle choices would very likely forestall.

Because health care technology develops and is subject to revision, it will be an ongoing task to specify the conditions and sets of elements to be covered, as well as the criteria for a diagnosis and prognosis that must be met for appropriately initiating and carrying on the course of care. Besides being inherently difficult, specifying the objects and conditions of coverage also will be controversial, and the stakes will be high for all parties. So, the task might best be assigned to an entity with some insulation from the political process, similar to that enjoyed by the U.S. Federal Reserve Bank.

Insurance also can cover one set of elements of health care technology that is quite costly and constitutes appropriate health care for a condition likely to become more common if it is covered—the one that typically begins with a pregnancy test and ends with a final postnatal checkup. This coverage is warranted because it subsidizes the care of new members of society and those who give birth to them.

Automobile insurance companies need to be able to tell when they must pay on a claim, make sure that the work they are paying for is done properly, and prevent errors and fraud. So, if soundly managed, they obtain accurate information about accidents and check out damaged vehicles and the work of body shops. For similar reasons, health care insurance requires that those who make payments have access to the care process, all parties to it, and all relevant information. To ensure that the conditions that warrant providing care have been met, preauthorization generally will be required. Those who handle claims will need enough education and experience to deserve the respect of health care providers and to know when to require further evidence and/or second opinions.

Handling claims properly will be time consuming. Those who handle them, being well qualified, will have to be well paid. So, managing the insurance scheme will be costly. Still, the work of good claim handlers will be not only necessary for sound health care insurance but beneficial: it will motivate providers to adhere to sound practices and, in general, be more careful than they otherwise would.

Prepayment can cover a package of elements of health care technology that every covered person will receive because everyone, or every member of one sex or the other, should receive them at certain ages or stages of life, or at certain intervals during at least part of their lives. Most health care providers believe it would be good to do certain things for every person, even those with no symptoms or injuries. Not all providers of a certain kind of service are likely to agree entirely about what all clients need, but surely providers can reach a consensus about some things that will benefit everyone and when those things should be done. Elements can be covered by prepayment if there is both a consensus among providers that they are needed and supporting evidence that they are worthwhile. The package might include various inoculations, some medical screening and testing, and a periodic session with a primary care physician; a periodic dental examination and cleaning; and a periodic eye examination.

Although the worth of annual checkups has been questioned, a periodic consultation with a primary care physician could be cost effective. The interval between consultations might vary at different stages of life. The purpose would be to receive appropriate inoculations, discuss the results of screening and testing, review and record any care received since the last checkup and its results, plan additional care if needed, and deal with matters such as diet, exercise, and the use of nonprescription medications.

Much effective preventive health care consists in supplying information and advice. Effective information and advice must take into account an individual's peculiar condition, needs, and limitations. Well-constructed computerized data bases can supply precise answers to adequately specified queries formatted in a standardized way. Suppose that all the information gathered during the course of someone's receiving health care—including the examinations and tests covered by prepayment, and information about care already received and its results—were kept in an electronic file with a standardized format. That file could be used along with a well-constructed, preventive-care data base to generate personalized advice for presentation by a primary care giver to each client along with appropriate explanations and in as persuasive a manner as possible.

Fourth, everyone clearly needs at least insurance and prepayment coverage of the sorts just described. Poor people cannot pay for that coverage, and nobody except governments can reasonably be expected to pay for it on their behalf. So, if governments can pay at least for that coverage for poor people, they should do so.

If the United States government supplied that insurance and prepayment coverage to poor people, they could obtain more easily much of the care Medicaid now delivers, and that care would be better. (As I shall explain under "Fifth" below, poor people also would need a subsidy to pay directly for care that cannot be covered by insurance and prepayment.) If the U.S. government supplied the same insurance and prepayment coverage, without copayments and deductibles, to the near poor—most of whom now have no coverage at all or only inadequate coverage—most of them would be able to pay directly for other care they need. So would most of the elderly, if the government supplied the same coverage for them, without any copayments and deductibles, in place of Medicare.

If people earning an adequate living had the same insurance and prepayment coverage—again without copayments and deductibles—it would, to a great extent, replace the coverage most of them currently have under various insurance and/or prepayment schemes—coverage mostly paid for by those people and/or their employers with pretax dollars, and in that way, as explained in Sect. 12.4 above, unjustly subsidized by the government. Two questions arise: Who should pay for an insurance and prepayment package, along the lines I propose, for people earning an adequate living? Can the U.S. government justly subsidize it, and, if so, how?

Someone might respond that such people should pay for all of their health care, just as they pay for the food they eat, with post-tax dollars, and that the government should subsidize them with a tax credit inversely proportional to their income. In that case, however, health insurance no longer would be nearly as attractive an employment benefit as it now is. Its only advantage would be that a group of employees can be insured more easily and cheaply than they can as individuals. However, employers either would stop offering health insurance or would offer it as an option that many healthy employees would reject. Affordable insurance would then become unavailable to unhealthy people. Groups without their healthier members would pay dearly for coverage; unhealthy individuals would pay even more dearly or simply be refused coverage.

Some think that such problems could be prevented by governmental mandates. But how can it be just to compel healthy individuals to buy health insurance that they do not think they need? And how can it be just to compel insurance companies to insure those whose claims predictably will exceed what they pay in premiums? Moreover, governmental mandates may well be impossible to enact or be unconstitutional.

Still, except for some very wealthy people, everyone needs health insurance, since most people will eventually need, for themselves or their dependents, care that they will not then be able to afford. Denying it to them would be cruel; compelling providers to supply it without payment would be unjust; and using public resources to supply it would unfairly burden those who had foreseen such needs and prepared to meet them. Thus, the common good requires that people have some fair way of paying for that care. The only fair way anyone has suggested is for the government to make the health coverage of those earning an adequate living a public benefit, and paying for that benefit by increasing everyone's income taxes—a method of payment that also has the advantage of automatically subsidizing those whose income is less. Consequently, it seems to me that the U.S. government and any government that can afford the health care insurance and prepayment coverage that everyone needs should pay from general revenues for the same coverage for all citizens and lawful residents.

In the United States, and perhaps elsewhere, insurance schemes, such as drivers' liability insurance and workers' compensation insurance, have covered health care in certain cases. Most people regard those arrangements as reasonable and just. So, I do not think governments should accept responsibility to cover the health care required to deal with injuries or illnesses that occur in such cases.

Fifth, insofar as possible, clients ought to pay from their own resources for any health care that cannot be covered by insurance or prepayment and that they or their dependents need. In this way, clients themselves, rather than managers or officials who do not know them well, will judge, with the advice of caregivers, what is in their own interests and will make the hard choices between health care and other goods they need and want. Moreover, the prospect of having to pay for health care from their own resources will motivate most people to avoid many illnesses and injuries.

Poor people must be helped to meet their need for health care as well as their other needs. But poor people either can judge what is in their own interests or not. If they can, they should not be given separate subsidies for food, shelter, and health care. Rather, they should be given a reasonable periodic payment and allowed to decide how to use it. If poor people cannot judge what is in their own interests, appropriate guardians or caregivers should be assigned responsibility for receiving such people's payments and making the necessary judgments on their behalf.

With governmental price fixing, the care for which clients will have to pay will be more affordable than it otherwise would be. Then too, fair governmental payments for the products and services covered by insurance and prepayment will help health care schools and charitable organizations operate community clinics in which fees for other elements of health care will be reduced or waived, and will enable generous individual providers to negotiate appropriate financial arrangements with clients in financial straits. Governments also might subsidize some elements of health care technology—for example, very effective drugs not covered by insurance or prepayment whose fair price is too high for many clients. Some providers could also be subsidized—for example, those serving in poor and thinly populated areas. Governments should never subsidize health care in ways that benefit the wealthy more than poor people.

Governments should pay each provider fairly for health care they legally require that provider to supply to someone who cannot pay.

Sixth, elements of health care technology that are unsafe or ineffective or both are gravely dangerous and often wasteful. The responsibility for judging and certifying safety and effectiveness cannot reasonably be entrusted only to potential providers, and clients or private organizations seldom have information and resources to do the job. Therefore, governments that can evaluate the safety and effectiveness of health care technology should not allow anything to become or remain generally available unless shown beyond reasonable doubt to be safe and effective, and if they directly or indirectly pay for or subsidize health care, they should allow in that care the use of nothing whose safety and effectiveness have not similarly been shown.

Before new drugs, biologics, and devices are approved to be made generally available in the United States, the U.S. Food and Drug Administration (FDA) requires a review process to determine that they are safe and effective when used as directed. Here, *safety* does not mean no bad side effects, but that such side effects can be reasonably accepted or recognized in time to discontinue use and avoid unacceptable results; *effective* does not mean using the item will always have the hoped for good effect, but that using it is likely to have the effect in a specified percentage of cases—or, in the case of certain items approved for use because there is no better alternative, that there is sufficient reason to hope for benefit to make it reasonable to use them.

The FDA's performance in fulfilling its responsibility has been criticized and surely could be improved. But more relevant here is that the FDA's authority is limited: some old drugs and devices were never approved; herbal medications and dietary supplements are not subject to review; many approved drugs are prescribed for off-label uses in which their safety, effectiveness, or both are reasonably doubtful; the FDA does not test a proposed new product but reviews the results of tests arranged by the product's proponent; once a product has been approved, the FDA obtains limited information about bad side effects and even less information about effectiveness. Moreover, neither the FDA nor any other U.S. governmental agency engages in a similar effort to evaluate the safety and effectiveness of new, much less of old, health care procedures and treatments, and to prevent those not shown to be safe and effective from being generally available.

If a government undertakes to prevent the general use in health care of any drug, device, procedure, or treatment whose safety and effectiveness have not been shown beyond reasonable doubt, it will have to assume, pending the review of elements of care already in use, that they are safe and effective if their use conforms to existing standards of practice. However, ongoing review of all the elements of health care technology and appropriate governmental regulation will gradually bring standards of practice into conformity with judgments based on available evidence, gathered and weighed by generally accepted scientific methods. If, moreover, the government allows nothing to be used in any health care it pays for or subsidizes unless using it has been shown beyond reasonable doubt to be both safe and effective, everyone will receive the quality of care that everyone deserves and wants, without being burdened by waste.

Some will object that in undertaking such extensive regulation of health care, a government would subject providers to a large and costly bureaucracy far more responsive to political appointees above it than to the interests of clients who need care by providers they know and trust. In democratic nations, it is of course true that politicians and political appointees exercise ultimate authority over all governmental activities; but the civil servants who regulated the health care industry would have to be competent providers themselves or experts respected by competent providers. Regulatory efforts would succeed only if they had the cooperation of competent providers. Ideally, each professional group regulates itself and disciplines its own members, and that ideal, which is never perfectly realized, ought to shape governmental regulation and be more fully realized by it. With such regulation, providers would be more trustworthy, and people needing care would more likely be able to obtain it from a provider they trusted.

The same government employees who saw to the safety and effectiveness of all elements of the technology used in providing health care could also manage the provision of care covered by insurance and prepayment at government expense.

Thus, not two costly bureaucracies but only one would be needed. The information about the health care each person received, gathered during his or her periodic consultation with a primary care provider, could be the data for ongoing studies of safety and effectiveness. Before being covered at government expense, newly approved elements of health care technology also could be tested more fully for safety and effectiveness by considering the results of using them in the care of those able and willing to pay for them with their own resources.

Those government employees might well also be charged with the tasks of screening the data gathered about the health care people receive and its results, identifying unexplained bad outcomes, systematically investigating them, detecting and deterring deviations from sound practice, and promoting safer alternatives to accepted practices found to lead to avoidable errors.

A century ago, when health care was far less costly than now, avoidable errors by providers and providers' frequent use of elements of technology that were either unsafe or ineffective or both often had tragic results. Today, the tragedy is on a far greater scale, and the colossal waste it involves is intolerable. Governments of wealthy nations could greatly reduce the tragedy and the waste, and they owe it to their citizens to do so. In fulfilling that responsibility, they also will justly benefit poor people all over the world.

Seventh, some health care facilities and individual providers will want to deliver, and some clients will want to receive and be able to pay for, what I shall call "premium care"—elements of health care technology that they regard as better and/or more convenient than "standard care," that is, similar elements of health care technology available at the prices a government sets for whatever is covered by its insurance and prepayment scheme, or partly paid for by its subsidies. The parties interested in premium care cannot be justly forbidden to cooperate in receiving and supplying it, unless that adversely affects standard care or some other aspect of the common good. Of course, in providing premium care, providers ought to conform to just governmental regulations meant to ensure safety and effectiveness.

Some parties interested in premium care will argue that they are entitled to at least part of the governmental payment or subsidy that would go to provide care for them if they settled for standard care. However, giving them even part of that payment or subsidy would promote the proliferation of premium services that would more or less severely limit the availability of standard care and more or less defeat the purpose of fixed prices. Moreover, standard care will meet people's needs, and those who seek premium care can afford it. So, governments justly can, and it seems to me should, refrain from giving those interested in premium care any part of the payment or subsidy enjoyed by those who settle for standard care.

Some health care facilities and individual providers will wish to offer simultaneously both standard care and premium care, as airlines offer coach and first class on the same flights. However, those flying first class subsidize those flying coach, whereas premium care clients would not subsidize standard care clients; and providers offering both sorts very likely would inconvenience standard care clients, at least in scheduling premium care. More important, by billing separately for premium features, providers offering both services could offer premium care at low prices, and thus circumvent the ban on subsidizing it. It therefore seems to me that governments should not cover or subsidize any care whatever supplied by a provider that simultaneously supplies premium care (and by *simultaneously* I mean during a definite period of time such as a calendar year).

Of course, every client should be free to obtain some elements of care from standard providers and others, for which he or she is willing to pay, from premium providers. And standard care providers should remain free to serve a client, such as a foreign tourist, not covered by government schemes, provided they charge no more than the fixed prices for products and services.

Finally, premium care providers should be required to meet the same standard requirements for recording and reporting information about clients, to facilitate enforcement of the regulations meant to promote the safety and effectiveness of procedures and treatments, and the safety of practices. Analysis of the comparative results of premium and standard care also would enable managers to identify superior features of premium care valuable enough to warrant their use in standard care, including technological innovations not yet approved for general availability.

References

Boyle, J.M. Jr. 1977. The concept of health and the right to health care. *Social Thought* 3:5–17.

Boyle, J. 1996. Catholic social justice and health care entitlement packages. *Christian Bioethics* 2:280–292.

Boyle, J. 2001. Fairness in holdings: A natural law account of property and welfare rights. *Social Philosophy and Policy* 18:206–226.