SESSION 5: ETHICAL QUESTIONS IN THE REFORM OF HEALTH AND MEDICAL CARE: THE SIGNIFICANCE OF THE AMERICAN POLITICAL TRADITION

CHAIRMAN PELLEGRINO: This morning we return to a consideration of some of the ethical issues again associated with the various proposals that are coming forth on the question of medical and health care. As I explained to our two guests, we do not have long introductions. So I'll merely introduce them by name and their location.

The title today is "Ethical Questions in the Reform of Health Care," this time looking at it from the point of view of the American political tradition. And our first speaker is Andrew Busch, Dr. Andrew Busch of Claremont College. Dr. Busch?
PROF. BUSCH: Well, thank you very much. It's a real pleasure to be here. It's a real honor and privilege to be here, and thank you for inviting me.

Obviously health care and health care reform has had American policymakers befuddled for some time, and even public opinion is very ambivalent because Prof. Jacobs points out in one of his articles that's included in the booklet of materials, there are a variety of other polls that I could cite that show this, but suffice it to say, that Americans are ambivalent about this issue.

And so I think it's important for us to really give a serious consideration of what you might call "first principles," that is, how does this issue of health care relate to some fundamental principles of American politics and how that can perhaps guide us as we think about these issues going forward and provide maybe a more solid footing for thinking about some of these issues.

So what I'm going to do actually is think about this first in terms of the Declaration of Independence. And rather than include any essay of mine in the booklet, I just asked that a copy of the Declaration of Independence be inserted. We're all familiar with it. But I think it's always useful to take a fresh look at it and a look with an eye particularly to this issue of health care, and I think it's always a good place to start because I think the Declaration represents in a lot of ways the touchstone and perhaps the best, most concise summary of the fundamental political principles of the American republic.

So what are these fundamental principles that you can glean from the Declaration of Independence? There are really four main ones, I think, and maybe some subsidiary ones as well, but four main ones.

The first one is — and you can really see each, a clause or a phrase in the Declaration that relates to each of these. The first is equality. "We hold these truths to be self-evident that all men are created equal." Now it's fairly clear that the founders did not mean certain things by this. They did not mean this as a call necessarily to enforce material equality because obviously people aren't born materially equal or equal in wealth. And they pretty clearly did not mean that they thought that people were naturally equal in every respect in terms of propensity to hard work or intelligence or ambition or any of those things. So those things are not meant, but they did mean something pretty clear by this, and it's related to the second notion, which is that we have natural rights.

The very next clause, in fact, in the Declaration, that they're endowed, that is that all men are endowed by their creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness. So these are people's natural rights.

Well, what is a natural right? In the view of the founders, it's a right that people have by the mere fact of being born a human being. There are rights more specifically if you look to the Lockean tradition that people have in what you might call the state of nature, before there was any government at all. Right? What sort of rights would people have if there weren't any government yet at all? And they identify these as being life, liberty. Locke says property — at the time of the Revolution, most formulations of this property — though Jefferson folded that into the concept of the pursuit of happiness. Maybe you have freedom of conscience in the state of nature. Nobody can tell you what to think. You can live your life more or less as you would like with certain rules, certain limits, according to the laws of nature as Locke would have it, and you have the right to acquire property through your own labor. These are things that you have even if there is no government. So these are the key natural rights.

The third key principle that you can glean from the Declaration of Independence has to do with the purpose of government. And that is in the very next sentence it says that to secure these rights — that is these inalienable natural rights — governments are instituted among men. So in the view of the Declaration, and I think the founders more generally, the purpose of government is to protect natural rights.

And this is related to Locke's view and the view of others of people forming a sort of social contract, that people form governments for a particular purpose. In the state of nature, they might have a lot of rights, but these aren't always secure because people can come along and try to take your life. They can try to take your property. They can try to tell you what to do and boss you around. And there's no common judge. And so when every man is a judge in his own case, you wind up with a lot of problems.

And so people give up some of their natural rights, their right to be judged in their own case. They create a common authority. They give that power to the common authority, but only on the condition that the common authority uses its power to protect the rest of their natural rights and it actually succeeds in making those rights more secure than they would be in the state of nature.
Finally, the fourth point is consent of the governed. Right? The second clause of that sentence says that governments derive their just powers from the consent of the governed. This principle also flows from the notion of equality, that, in fact, you might be able to put a yoke on a pair of oxen and try to make them pull your plow around and so on. But when you're dealing with human beings who have equal and natural rights, you can't govern them without their consent precisely because they are equals.

There are some corollaries that are important that flow from these principles. One of them is when we're talking about natural rights, generally the founders are talking about individual liberty. They're not talking about collective rights. They're not talking about group rights. They're talking about individual liberty and individual responsibility that comes with that, and consequently you could say that there's a distinctly American notion of human dignity which is that human dignity is very much connected to the fact that people are free and that they have responsibility for the conduct of their own lives.

It is this liberty and responsibility that give people their dignity, not necessarily whatever material condition they find themselves in at that particular moment.

Limited government is pretty clearly a corollary of this. If the purpose of government is to protect natural rights, to protect life, liberty, and the pursuit of happiness, then it also isn't to do many other things. Right? The purpose of government is not in this view and the view of the Declaration or the founders in general to try to perfect society, to try to perfect individuals, to try to eliminate all social inequalities or things of that sort.

It's a distinctly non-utopian notion of the purpose of government which leads in the direction of a limited government that leads a large private sphere and a large sphere for civil society.

Another corollary is that, again, because of the principle of equality, government can use coercion. That's what governments do. They pass laws, and they try to make you obey them. Government can extract resources from society through taxes if there's consent. But it can only do these things for the common good, not for some individual's private gain.

Again, because people are equal, those who are in government or those who have access to the levers of government do not have a right to force other people to pay for their own private gain. There has to be some common purpose and some common benefit to the actions of government.

And, finally, the principle of natural equality or equality of natural rights in the state of nature also leads to a kind of political corollary of equality under the law, that once you do have government you have to have the rule of law and there has to be equality under the law.

These principles and corollaries produced a particular Constitutional structure, and it has at least a couple of major parts. One of them is that the Constitution does empower the federal government in certain respects. It creates a federal government that is more powerful than under the Articles of Confederation to be sure. And it empowers the federal government to conduct certain specified business, not, it should be pointed out, to do anything that it feels like, but to conduct a certain specified business delineated by the enumeration of powers for the common good.

At the same time, the Constitution aims very strongly to protect rights given that that is considered to be the first and foremost purpose of government. It does this explicitly through the Bill of Rights and also several provisions within the Constitution itself, but also it does this implicitly through the structure of government, particularly by trying to prevent an over-concentration of power both horizontally and vertically.

The horizontal version of this is what we would call "separation of powers," the fact that the federal government is divided between the three branches, none of which are considered to be supreme and which have the ability to check each other in certain ways. The vertical version of this is federalism, the fact that power is divided between the federal government and the state governments.

Now obviously these principles, these corollaries in the Constitutional provisions and structures that flowed out of them are subject to all sorts of debate. While Americans may generally agree in the principle of limited government, just exactly how limited is a matter of debate and there's no easy answer to that. But I think it's fair to say that in general these are, certainly if you start with the Declaration of Independence and the Constitution, the key principles of American politics.

So how does this translate to health care reform? Well, I think the place to start is by thinking about where health care and health care policy fits within the universe of the things the government does.
And the place to start there is by recognizing that at least within the framework of the Declaration of Independence or the founders’ conception of natural rights, health care is not a natural right. Certainly government provision of health care is not a natural right for the obvious reason that natural rights are things that people enjoy in the state of nature before there's a government. And so by definition, government provision of health care cannot be considered a natural right in those terms.

It may be the consequence of this is, when you think about the issue, that health care and health care reform might be very important issues. They might be areas where there ought to be policy departures either incremental or radical. It may be an area where greater public attention should be focused or a greater priority should be placed than is currently the case. But it cannot be considered something that should be approached with a kind of single-minded zealouness that supersedes the other fundamental principles of American government. It has to be balanced with fundamental principles or values.

To put this another way, I think Americans want a solution to or solutions to the problems that they see in health care, but that doesn’t mean that they necessarily want a solution that would do violence to fundamental principles of American political life. And so the question is, you know, how do some of these particular principles relate to health care? And there are a number of them, I think, that do.

For example, the principle of individual rights or individual choice can be related to a variety of health care issues. For example, whether or not to impose an individual insurance mandate on people: Is this consistent with individual rights or not? Perhaps or perhaps not. It depends on how you think about that issue. But certainly it has implications for individual rights that need to be taken into account.

At the biggest level, of course, there’s the question of how you finance this through taxation that might impact people’s property rights. And at the lowest level, the more sort of fine-grained level of health care reform, it would relate to all sorts of questions like, are people going to have a choice of health care provider? Are they going to have a choice of insurance companies? Are they going to have a choice of benefits plans? And I would argue that a health care reform that, all other things being equal, a health care reform that protects, that does a better job of protecting individual rights and individual choice is more in keeping with fundamental American principles than one that doesn’t.

In a related vein, individual responsibility comes into play. Certainly, I think — I wasn’t here yesterday. But having looked through the materials, I suspect that was discussed yesterday at some length.

This is also related to the question of an insurance mandate. It’s related to the question of whether you allow insurance, health insurance, rates to change depending on people’s health care choices and their personal behavior. And at the biggest level, there’s the question of whether you make people more dependent on government or whether they retain greater responsibility for themselves.

Again, I guess I would argue that a health care reform that protects individual responsibility or that promotes it would be more in keeping with fundamental American principles than one that reduces people’s individual responsibility in some important way.

I think that the principle of equality under the law comes into play, not because I think the founders would consider it a violation of equality under the law for some people to have insurance and other people not to on the face of it, but because I do think there is a certain arbitrary quality in the tax treatment of insurance with tax benefits going to employer-based insurance but not other insurance. I think that does raise a question of equality under the law that has to be grappled with.

There is, of course, a very big question of what the aggregate government cost is going to be and the aggregate level of government control is going to be, and this relates to the principle of limited government. Obviously, this is an issue that’s going to come into play if you think seriously about a single-payer program. There are a variety of other health care reforms that might bring this issue into play in a major way. And what we do with the existing health care entitlements, Medicaid and Medicare, relates to this issue as well. How do you provide the services that you want to provide without completely obliterating the principle of limited government?

By one estimate by 2050, if there's no change made, Medicare alone will take a considerably greater proportion of the gross domestic product than Medicare or Medicaid and Social Security combined do today. So that raises a real question about whether the United States can remain a society that's committed in any significant way to the principle of limited government and a significant private
sphere in civil society.

The principle of federalism comes into play, I think, in many of these issues in terms of how much leeway states are given to tailor health programs for their own particular needs and how much ability they have to experiment with different approaches. This would apply either to new programs or how to reform Medicaid which, as you know, is a program that states are deeply invested in and have a major role in.

There’s an issue that has to do with consent of the governed, I would argue, and that is that if the nation is considering some sort of major health care reform, I would argue that the principle of consent of the governed would dictate that such a policy needs to be at least somewhat reversible. It needs to be designed in such a way that you can imagine a way to step back from it. Otherwise, you have consent of the governed in this moment, but then every future generation is completely locked in or for all practical purposes is locked in.

In fact, I have to recall back in 1993 and 1994 when President Clinton was proposing his health care reform plan and he would always insert a phrase in his speeches promoting his plan that his hope was to produce a health care program that would give a right to health care that could never be taken away. And he meant this to be reassuring, but I actually found it rather chilling because what it meant to me was, no matter how inefficient this program may prove to be in practice, no matter how regimented it may become, no matter how expensive it may become, even if it becomes catastrophically unsustainable financially, even if it becomes a complete disaster in every respect, you could never get rid of it.

And I think we have to keep in mind that, no matter how hard we try, it’s very possible that any health care reform is not going to go as expected and that it’s going to be important for future generations to be able to back out of it in some way.

This would argue for either a more free-market approach, which is politically easier certainly to undo — government programs are much harder to undo than the lack thereof as we’ve seen over the last 70 years — or it might argue for an increased government role, but in an incremental way rather than a really gigantic way that would be much harder to back out of somehow if it doesn’t work very well.

And I think any health care reform has to plausibly be connected to the common good. That is, there has to be a plausible argument that can be made that there is a national benefit to this reform, whatever it is, and that it’s not simply sacrificing 85 percent for the private benefit of 15 percent because then it becomes more questionable about whether it really is the use of public power for the common good rather than just the private good of some Americans.

And I think there are a couple of — these are more substantive. I think there are a couple of process points that are related to American principles that are key as well. One of them is that clearly any health care reform plan needs to be approved through an open process with full public input. I think there were a lot of reasons that the Clinton health care reform did not wind up passing. One of them was because people calculated that it was not compatible with the principle of limited government. But part of it was because many Americans concluded that it was not compatible with the expectation of a policy being developed through an open process with full public input.

Also, I think this is something that isn’t considered as often, but I think ought to be. Whatever health care reform is adopted, I think if one is adopted, it needs to be implemented in a way that remains under the control of Congress rather than Congress delegating vast quantities of regulatory power to executive branch agencies. I think this is important for reasons of consent of the governed and accountability, public accountability, and I think it’s important because of separation of powers.

I think over the past century, we have gotten increasingly accustomed to Congress literally surrendering large parts of its law-making authority to executive branch agencies in ways that I think are detrimental to the fundamental principle of separation of powers. And so to whatever extent any new program could avoid that, I would think that it would be more consistent with key American principles.

I would just conclude by saying that, you know, obviously health care is a very, very important issue. It affects every American, and it has to be thought of in its own right. But it can’t just be thought of in its own right. It has to be thought of in terms of the broader stakes, and the broader stakes include the character of the American republic.

I think you could argue that we’ve developed a model in America of a free society that is unique and distinct from the social democratic or democratic socialist models of Europe with a greater emphasis
on individual liberty and responsibility. As I mentioned, a greater notion of human dignity is actually related to people's responsibility for themselves, a greater respect for property rights, and perhaps a greater emphasis on opportunity than on guaranteed economic results. And I think that America has for the most part benefited from this model, and I think the world has benefited from there being a major nation in the world that offers this alternative model of a free society, and I think any time we're talking about a major health care reform or a reform this significant size of a segment of the economy in a society, there is a danger that, in fact, that uniqueness could be lost if we get it wrong. And I think that the more that we take into account these fundamental principles, the more likely it is that we will be able to avoid that and retain our distinct and unique model of a free society.

Thank you.

(Applause.)

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Busch. Our next speaker is Lawrence Jacobs, the University of Minnesota.

PROF. JACOBS: Magically, my presentation is going to appear on the screen at any moment. I know that. Trusting that that is going to happen at any moment — yes? Do I have to hit something? Thank you very much.

Well, first, I want to thank you for the invitation to appear with you, and I want to praise your efforts and for the development of this commission's work.

In really thinking hard about, and searching for, and investigating and publicly deliberating about our identity as a nation, and the social union that holds us together as more than just individuals, I spend a lot of time going to conferences and reviewing papers and various publications, and these questions are often considered to be soft or kind of not really hard-headed.

A lot of the work that I see at least in the academic world and the kind of policy analysis world tends to focus on researching important but often narrow questions or trying to address more technocratic issues about how to better perfect or adjust already-existing programs. To step back and really ask larger questions about our shared values as a country and some of the ethical underpinnings of it is too often neglected, and I want to praise this commission's work and its evolution in addressing that.

Now I am not an ethicist. I'm not a philosopher. And so my focus and professional background is as a social scientist who studies public opinion, public values. For many years, twenty years, I've been doing research on health policy in politics, and that’s the background I come to you with today. And I tend to be someone who finds data to be important. I'm guided by it, and it leads me often to areas of the gray between more kind of essentialistic principles.

Now as I was listening to my colleague talk about America’s values, this is certainly an important element of American society. But I think the values that we find in America are quite pluralistic, and I'm going to provide some evidence of that briefly just by way of kind of sparking some discussion. But I think those values are long-standing. They're pluralistic, and they're dynamic. There's change over time in relation to changing circumstances and conditions in the country.

There is most definitely a Lockean tradition of limited government and respect and adulation of individual rights and liberty. America stands out in a whole variety of different kinds of survey measures with regards to our support for a private-enterprise system, our belief in rewarding work and accomplishment, and there's a lot of evidence of supporting this. I'm glad to share some of those.

But there's also another tradition in America that you could describe as a kind of civic republicanism — with a small "r" — or a kind of communitarian tradition. You see it discussed in the tremendous debate around the Constitution. I was delighted to see the Declaration of Independence. If you go back to that period, the Declaration and then the Federalist Papers which we all talk about were a very important part of a debate.

There was another side of that debate, and it tends not to get as much attention and is sometimes referred to as the Anti-Federalist or you kind of go into the writings of Alexis de Tocqueville, the famous French thinker who came to America, and he marvels at this complexity of America's moral bearings and culture.

Now I want to lay out a few themes and walk through some data that I think might illustrate some of these themes. And the basic point I would make is, if you're searching for a moral compass, don't think of it as one final resting point. I would say there are moral compasses and that they are
dynamic, as I said before.

Some of the multiple and competing strains in American public thought resonate and emanate from the specific policy issues. There are variations across different issues and certainly in health care, public beliefs, and also the policy debate. Public thinking does not go on as if it were public with some kind of cloistered jury. It’s a very dynamic sort of process.

Now let me kind of walk through what I see as some of the main strains and bring in some of these issues in public thinking today, and then hopefully this will be a kind of a prod to a certain kind of discussion.

This is one of my favorite movies. “We’ve got a problem.” And we don’t agree about a whole lot in health care, but I think we’re pretty close to a negative consensus that what we have is not doing very well. Now people will disagree on the degree of that breakdown, but there’s pretty wide agreement. And, indeed, we see this in terms of public opinion data. You’ll notice that top line, the big blue one. That represents the percent of Americans who say that the health care system needs fundamental change or needs to be completely rebuilt.

Now I was recently at a transportation seminar that Congressman Oberstar who chairs the Transportation Committee in Congress and, you know, they’re looking at transportation, and they were showing numbers that were about half this, and they were very impressed with that and talking to us. “Well, this is very impressive, Congressman, but let me tell you what’s going on in health care.” These numbers and this level of concern about the health care system is unlike anything I’ve seen in any other policy issue, and I work pretty broadly.

And what’s quite striking is some variation here, but it’s within a pretty narrow band and it’s pretty consistent. And I suspect if we went back before 1991 when this series begins, we could stretch it back a bit further.

And then the other, the lower line, is a series of questions that shows about 70 percent or so of Americans saying that the health care system has major problems or is in a state of crisis. The main point here is this is a remarkable degree of agreement that our health care system, to the extent that it is a system, is not working.

Now having said that, often there’s a kind of ergo moment when people roll our their proposal. And I want to urge you not to equate the negative consensus with any thought of a positive consensus. My view is that we don’t have a positive consensus. And, indeed, the deep agreement we have that the system is broken has become an invitation to stalemate and some very bitter polarization with very strong kinds of deeply principled views on what the right direction is.

I want to lay out four different reasons for being cautious in moving forward and thinking about how to proceed in dealing with this negative consensus. One is that there is a deep public ambivalence about what to do, and I’m going to show you a couple of different ways to think about this. I could give you some other ways.

And often, by the way, you’ll see the set of numbers I’m going to show you here in a second presented separately depending on which side of the divide you’re on. If you’re promoting kind of a maximal individual choice model, there’s one set of numbers people use. If you’re promoting a single-payer sort of model, there’s another set of numbers. I’m going to try to be as honest as humanly possible and present you both sets of numbers. There’s obviously other numbers.

But here’s the main point. When you ask Americans and try to tap their evaluations of the health care system — How is the country doing overall? How are other Americans doing? — you tend to find about over seven out of ten Americans expressing real concern about the nature of coverage and the cost of the system to other Americans of how the system is doing. When we turn and ask about what’s your personal, your personal experience or the experience of your own family with regard to coverage or cost, you find that the level of concern drops by at least half.

And when we go over to quality, you’ll notice right away that the level of dissatisfaction with quality is substantially lower than it is for coverage and cost. But even here, you see this bifurcation and a deep unhappiness with how the system is doing and a much different evaluation on how things are for individual Americans and their families.

In this case, we’ve got only 15 percent of Americans saying that they’re dissatisfied with the quality that they and their family receive for health care from their doctors and providers. That’s quite a statement. But there’s a split identity, and this gets tied up quite often in some of the debates and discussions.
There’s another important element of this kind of public ambivalence. In my view, there are two strains, and it falls from this Lockean tradition and from this more communitarian civic or public tradition that has really in some ways defined American culture.

We find consistently that when you ask about concrete government programs that address individual threats to citizens, there is substantial public support. You might think of this as a kind of operational liberalism; that is, in terms of the operation of our society and specific government programs to address what are seen as real problems facing individuals, there is an open embrace of government.

And here is just a couple of examples. Questions that ask Americans about their attitudes towards national health insurance financed by tax money that would pay for most health care services, we find consistently over 50 percent of Americans favoring that.

Here’s another kind of conundrum. Most of us who study health care will tell you that the costs are high and probably unsustainable moving into the future if their current rate of increase continues. And yet Americans have a very different attitude towards it and there are some that would say, “Well, this just reflects the fact that Americans, their knowledge and their expertise, is not very good and we shouldn’t be even looking to the general public for these sorts of issues.”

I think there’s another issue, which is that the lexicon, the language that we use, tend to be quite different. When we talk about costs, we mean usually system costs. When Americans think about cost, they mean price and they mean household budgets. And so we find over six out of ten Americans saying that they think other Americans spend too much on health care and that the government spends too little.

Now I have a whole presentation on this whole idea, and I’ve got to tell you it’s really hard to explain where Americans are coming from when they think government is spending too little, too little given the budget situations that we face. But there it is.

So we’ve got this one element that looks very much like support for a fairly liberal view. On the other hand, this Lockean tradition is very much alive. And there’s consistent suspicion and opposition to direct massive government involvement. And there’s a lot of different ways to talk about this. But maybe the simplest way is this nice, what we call “balanced brain” question that gives Americans a choice between maintaining the current system based mostly on private health insurance or adopting a government-run system. And what we find is that the current private health insurance system is favored pretty consistently by majorities or pluralities notable.

Now even among reform supporters, this ambivalence about the role of government is evident, and this is often forgotten. One series of questions asked Americans, "Do you prefer a government-run, tax-supported universal health insurance?" And we find that about 56 percent said yes. So then we followed it up and we asked that 56 percent, that is the reformers, "what if," and we gave them a series of possibilities: “What if this reform that brought in national health insurance would limit your access to some medical treatments that are currently covered?” Well, among that 56 percent, you now have 64 percent saying they would oppose it. And you bring in the possibility that your choice of doctors might be limited — 49 percent are opposed — or that there might be waiting lists for some non-emergency treatments — 40 percent oppose it — or that there might be an increase in health insurance premiums or taxes, and again you see an increase in substantial opposition and concern about that.

These are all issues in which people have strong debates about whether they would happen, the degree to which they would happen. They are clearly an important element of the debate. And the only point I would make here is that when you begin to probe, even among those who are most inclined to support government reform, that there’s a good deal of this uneasiness with government and the dislocation that could result from fairly comprehensive reform.

Okay. So that’s one element of what I think is an important discussion about American public thinking and it’s this deep public ambivalence.

I want to bring in another element, and it builds on this point that I made about being careful not think of the public as a cloistered jury that’s going to come out with a verdict and then policymakers somehow are going to fall on their knees and thank the gods for showing the direction. It doesn’t work that way, of course, and anyone here from Washington is not going to be surprised by this.

There are lots of different ways to measure the polarization of Washington. This is just one measure, and it simply shows the difference between the political parties in the House of Representatives and
in the Senate in Washington. And the main point here is you can see that in the 1930s into the 1950s, the kind of Eisenhower era and then even into the 1960s, the early 1970s, there was a good deal of bipartisanship. Now some of this was a kind of conservative coalition that came together on certain issues. On the other side, there was a kind of a tradition of moderate Republicans like Jacob Javits who helped to build the Medicare system and then others.

But the point is, there was a pretty large — maybe a third of the House and the Senate, maybe a bit more or a bit less that crossed the aisles. Wilbur Mills, Democrat from Arkansas who was chair of the Ways and Means Committee, pushed through some pretty significant tax-cut legislation. In any case, you get the point.

But what I want to focus on is what we see more recently as you move towards the right. This is our recent era, and you can see that we are at or above the historic levels that we’ve been able to track going back in American history in terms of the polarization in Washington. So when you look at the proportion of votes on the floor of the House and the Senate where 90 percent of Democrats line up against 90 percent of Republicans or you look at this sort of very nice measure of the distance between the parties, we are more divided in Congress today than perhaps in any point in American history.

Now does that affect the debate? Yes, it does. And I’m going to show you why in a second.

Now one of the big favorite stalking horses is media. The media is why we’re so divided. It really poisons the environment. And we went and analyzed media coverage — we do this pretty regularly — tracking the nature of press coverage and the issues that are picked up. And one of the themes that really comes out in our research is that the media largely represents, reflects, the policy issues that are being discussed in Washington and policy circles more broadly, not surprising, but also the tone and tenor of that discussion.

So when you see a high-level of polarization as we’re seeing in our era, it’s reflected in press coverage and it varies over time, and we’ve seen actually going back to the 1970s that the focus on conflict and political strategy and kind of insider got-you sort of coverage on health policy issues, on really detailed policy issues, has increased over time. Now having said that, the media also amplifies that disagreement and that conflict, but it’s a combination of both.

And I want to show you just a little snapshot of — and I know it’s going to be hard to read, but I’ll describe it to you — a little snapshot of how this sort of interaction of policy, highly polarized policy debates, public thinking, and media coverage come together.

Now the top line with the box — and I’m going near-sighted, so I apologize for those of you who can’t quite see this. But the line at the very top — and this is during the Clinton health reform era. I think we could find this during other periods, but it shows you the period between January of 1993 when the Clinton Administration is sworn in and inaugurated through September of 1994 when the Clinton health plan was basically pulled off the table.

Now that top line with the box represents public support for President Clinton’s health reform plan. And you can see that in September 1993, it was about 60 percent support for President Clinton’s plan, and then it drops to 40 percent. And at that point in July, it was about 60 percent who opposed the President’s plan, so it was kind of a flip.

Now what’s going on during this period? Well, you know the story well about the tremendous battles that went on in Congress. The President, this is one of his top items — perhaps the only issue after the budget and the economic stimulus plan — and he never got a vote in Congress the acrimony was so large.

The thing I want to focus us on is how the press covered this. Now you’ll see the other dark line that’s got the triangle, and it’s the one that kind of rises over the course of this period between January of ’93 and September of 1994. That reflects the proportion of attention by the press — in this case, Associated Press, so it’s pretty melba-toast-like — the focus of the press on the political story, the political bickering, the strategy focus, the gamesmanship of the policy discussion. It’s fairly — it’s often subordinate, but it’s below 40 percent, at times even around 20 percent of the press coverage through 1993. Beginning though in late 1993 and into 1994, it accelerates to the point where it’s the dominant, clearly the dominant, way in which the press is covering the debate on the Clinton plan.

Now what’s interesting is you back up and you look at what’s going on in 1993 in the spring and even into the fall of 1993, and there was a discussion for this brief period about the national consequences and the national issues, the national values tied up in health reform. And it’s during this period and particularly just following peaks in press coverage about these more national collective
considerations that we saw support for the President’s plan increase.

Now I don’t want to get into the strategies, and I frankly don’t care about who’s to blame and who’s not. The point I want to just make here and use this as an illustration is to show the way in which public thinking is endogenous to the larger public debate and the press coverage and the larger information environment, that the public is very much informed and impacted by the discussion and the nature of the discussion.

When it’s highly polarized and there is deep disagreement, the public gets uncertain and its sense of risk skyrockets and its support for any reform, whether it’s Bill Clinton’s health reform or frankly President Bush’s Social Security reform, it plummets. And I think that’s about as close to an iron rule of public opinion as we can get, and I can give you a lot of citations to support that.

Okay. We’ve had a long history of — I know the staff has been putting together some of that history on health insurance over the last century or more. Depending how you look at it, we’re about at Cycle 8 thinking that we’re now going into another one.

And I want to just kind of highlight — and hopefully this will feed into some of your thinking — some of the implications of this multiplicity of public views, and I’m just wrapping up.

When you look at proposals for tax credits, consumer-choice models, they certainly convey concern. I think the public generally sees that, but they are very vulnerable to Democratic counterattacks that these proposals do not address the larger systemic problems and dissatisfaction which I referred to earlier and that they do not lower the price that the consumer feels, and, you know, this is predictable. This is kind of Attack Politics 101. You don’t need to pay anyone a lot of money to come up with that.

Now when Democrats come forward to expand health insurance, expand the role of government, regulating insurers, or taking other steps, they will get credit for trying to do something about the price and trying to do something about the frustration with the health care system. But they are quite vulnerable to kind of the Lockean counterattack; namely, that this is more big government, that it’s going to increase uncertainty, dislocation, and will risk the personal health care that Americans value so highly.

Now it’s interesting when we go back to 1965 with Medicare Reform which is thought of by some as a golden era, perhaps by others as something quite different. But at that moment when Lyndon Johnson has just gotten a massive landslide victory and a mandate, only 46 percent supported Medicare when posed against a private health insurance model.

And I would say one of the key lessons here is that we focus too much on the public as the oracle for the direction we go and that we need, as a policy community, to really identify those basic principles and the basic approach for moving forward.

This is all by way of saying the work you’re doing is very important and that I hope it will feed into the discussion I think we’re heading into. Public opinion cannot unify a highly divided, polarized set of policymakers and policy analysts. That is something that the policy analysts and the policymakers need to do for themselves.

(Applause.)

CHAIRMAN PELLEGRINO: Thank you very much. Two excellent presentations, clear and to the point, and we appreciate it. Our plan is to — I think we can take a break now and return for Peter Lawler who will open the discussion, and then both of our speakers will serve as a panel responding to and working with Peter. So let’s take a break until five minutes after 10:00. We have an earlier adjournment than we usually have because of plane arrangements, so taking promptitude will be appreciated by everyone. Thank you.

SESSION 6: ETHICAL QUESTIONS IN THE REFORM OF HEALTH AND MEDICAL CARE: THE SIGNIFICANCE OF THE AMERICAN POLITICAL TRADITION, CONTINUED

CHAIRMAN PELLEGRINO: Thank you, thank you. Council members for being so prompt, taking your coffee with expedition and, I hope, delectation.

I will now ask Peter Lawler if he will introduce the discussion, and then the two speakers will act as a panel and the Council will be in position and be able to discuss the issue.
PROF. LAWLER: So I want to thank the two speakers for fine presentations. And what I’m going to say very briefly has to do with the speakers we’ve had over the last two days, so I won’t only be about you and so excuse me for that. And I’m supposed to talk about the ethical issues sort of abstracted out of the factual environment, which is tough to do.

The first issue raised by Alfonso yesterday is justice. He says, "Justice demands that we give everyone health care and that there be universal health care." And Alfonso talked about the positive right to health care. But according to Prof. Busch, a positive right is like jumbo shrimp or military intelligence. It’s an oxymoron. (Laughter.) There's no such thing as a positive right because in the state of nature, there’s no one to fulfill those positive rights for you.

I’m not so sure about that, but it’s a good issue. But if we have a positive right, what's the right to? Is it to basic health care or is it to the best possible health care? And some of our speakers from previous meetings seem to have said it’s a right to health itself and so it’s a right not to be poor because studies show being poor is bad for your health.

So exactly what the right that we have to health care? And the trouble I think in talking about health care in terms of rights as Prof. Busch pointed out, if you have a right, then it can’t be taken away even if it turns out the giving of the right was ill-considered like the Supreme Court says in Planned Parenthood vs. Casey, more or less. Even if Roe was wrongly decided, we can’t take it back on account of people got used to it. So there may be a danger in talking about health care in terms of rights instead of something that we can do given in our prosperous high-tech society so we should do, but it’s not a right as if we always have to do it independently of circumstances.

Another issue is money. Our friend Locke is all about the money. And so some people say with good reason, at least with reasons, that health care ought to be exempted from our system of money because money leads to commodification and that health care can’t have anything to do with commodification. So health care should always be nonprofit and co-pays are immoral because they involve money and so inequality. Deductibles are immoral because they involve money and some people are better able to pay them than others.

From the other point of view, money is an incentive to do a good job and people should be given money when they provide a service of real value, and so the problem with our current system is we’re giving people money for things that don’t have real value, and people who provide real value don’t get enough money. And so this is just a problem intrinsic to human nature. Right?

Socrates says, "The art of medicine in itself is selfless, always directed towards the patient." But doctors aren't selfless. Doctors have bodies. Doctors have got to eat like everyone else. So doctors also have to practice the wage-earner's art, so every real-life doctor is conflicted. He wants to be selfless. So Ben and Paul will provide procedures for free sometimes. But if they provided every procedure for free, their wives and kids would — wife and kids — you’ve only got one, right (Laughter) — would be somewhat upset if they every procedure for free. So they can’t be consistently selfless because they’re regular guys with bodies and they have to eat and they have to feed their kids and all that. So this seems to be a tension intrinsic into human nature that we can’t solve or can’t resolve. We have to, as they say, live the tension between the pure art of medicine and the wage-earner's art that even distinguished physicians have to practice.

Another principle is choice. America is all about the choice. So our health system should maximize individual choice, so the person is more responsible, so the person is more in control. We shouldn’t use the word “consumers.” That seems disgusting when it comes to health care. But we should treat people maybe as individuals or as persons.

But we also heard from Carl and others that informed choice in medicine sometimes is pretty close to an oxymoron, too. And from Dr. Pellegrino we've heard time and again it's hard to be pro-choice when you're on the gurney. So the principle of choice has some applicability to medicine, but it's hard to say how much.

Another principle is cost. High cost is immoral because people end up paying for it somehow and our present system is unsustainable over the long term because we can’t bring — as Ben pointed out and many others, we can't get costs under control. So when we think about cost, we think about unnecessary treatments and the chilling story about the oncologist who subjects people to chemo even though that type cancer won't respond to chemo. Why do some doctors do this, some health providers do this? Some say to get money. This can’t be good. There is a financial incentive to recommend unnecessary treatments. So from that point of view, if you took money out of the equation, there wouldn't be an incentive to recommend unnecessary treatments.
On the other hand, sometimes doctors might recommend unnecessary treatment and people might accept them because they're insulated from the real cost. So when people have to pay for treatments, they think about them and doctors are less likely to recommend them. So money might be the remedy to unnecessary treatments to some extent. It's hard to know. Should we take money out of it or should we put more money into it to reduce the number of unnecessary treatments?

We read in the article by Jim who presented to us about the prescription drug benefit. A lot of people think this was immoral because — a lot of conservatives think this was immoral because it was yet another entitlement. We can’t afford anymore entitlements. But if we read, we see that this turns out to have been a success, another success President Bush forgot to brag about. He has plenty of failures that people notice, but he forgets to brag about his successes.

Why was it a success? Well, it was a mixture of the Democrats and the Republicans. The Democrats like universal entitlements, and sometimes they're good I have to admit. I'm not against them all. But the universal entitlement was passed with the Republican input of the person who gets the entitlement shares in the cost. So the more the insurance costs, the more the person has to pay. That gives the providers the incentive to keep cost down, to negotiate with the pharmaceutical industry with respect to the cost of the drugs. So it's a combination of market, Republican, universal entitlement, Democrat, that produced a successful program that comes in under budget that people actually like. So is this moral, even though it's not moral according to any abstract principle? It provides people something we can provide them, something that's good for them, and in a cost-effective way.

There are other things that were mentioned in passing as immoral including the tax deduction given to employers and employees to pay for their insurance. This is a regressive tax. Do we have to get rid of this? Do we kind of like it because we benefit from it? And we used to be in favor, we liberals, in favor of mandates to employers, but it turns out that makes our employers too uncompetitive and they don't want to accept them. And so now we've changed to employee mandates. Are employee mandates moral, in fact? Can we command people to buy health insurance? Isn't that a violation of their individual rights?

We can command people to buy auto insurance because you can say, if you drive, you have to have it. But you have the freedom not to drive and, therefore, not to have auto insurance. And also you have auto insurance so you don't hurt other people. You have a responsibility that goes with the right to drive.

On the other hand, it's your own body. Should you have the right not to insure it? And that doesn't seem right because, if you get sick, we're going to treat you anyway, and we'll treat you anyway, for example. And if you say, "I will not accept the treatment if I get sick," you're pretty much bragging. When you're on the gurney (laughter) — when you're on the gurney, you're going to accept the treatment. Believe me. Many studies have shown that. But if we do mandate, then we have to mandate in a very responsible way with very low costs and a really good deal for the low costs. So mandates seem to require a really serious cost containment, so we can afford them.

And the last point I'm going to make is too much of this thinking is individual versus government. That is the error of European social democrats and American libertarians to think everything is individual versus government because in America, as Tocqueville and many of the other experts of the past have pointed out, America works because of the intermediary associations between the individual and government, like the family. You know, some huge percentage of care given in America is done voluntarily by women. We want them to keep doing it. They may not, but it would be good if they did. And so surely our health system should really do what it can to assist voluntary care-giving or the great principle Alfonso forgot to mention of subsidiarity as much as possible that should be done somewhere between above the individual or below government. This would seem to be a moral principle that would be indispensable for us.

And so it's precisely because employers used to be, as I said before, used to be kind of an intermediary association. But employer loyalty, careers and all that, they're a thing of the past. And so what employers used to do for us has gone to devolve to the individual or to government. But I hope this can happen in such a way that would be pro-family, pro-neighborhood, pro-voluntary care-giving that would facilitate the development of new intermediary associations.

That's all I have to say. It's up to you.

CHAIRMAN PELLEGRINO: Thank you very much, Peter, for that insatiable view of the topography of what we've been doing in the last two days.
Now I think I will open up the discussion with the members of the Council, either to the panel or to Peter. Who would like to speak first? Diana?

**DR. SCHAUB:** Thanks. Yeah, I had a question for Prof. Busch. I really appreciated your explication of the Declaration. It’s always the right place to start, it seems to me. But I’m wondering whether you moved too quickly to an assertion that health care is not a natural right.

Now I hadn’t been inclined to embrace the notion that health care was a natural right until I heard you assert that it wasn’t a natural right. So, I mean, my inclination was to go more in Peter’s direction, it’s not a natural right, but, you know, it’s a good thing and we should do it if we can do it. So I just wanted to try something out on you.

As you explained, the purpose of government is the protection of these natural rights. But in order to achieve that, there’s always a sort of translation from natural right to civil right as you move into a situation of civil society, and that seems to involve the creation or the assertion of new civil rights. So, for instance, there’s no voting in the state of nature. But voting and the right to vote are somehow essential to the operation of legitimate government.

So I’m wondering if we should maybe look more closely at this right to life. Now in the sort of Lockean situation, the right to life seems to be primarily about security against attack — right — the incursion of others, murderers and criminals. But I wonder whether in a more developed society that right to life and the protection of security couldn’t be seen as concerned with the incursions of nature itself: disease, and the way it assaults the body.

In other words, the status of the body is really fundamental in a Lockean society. Right? Government is not concerned with improving our souls or anything like that. It’s primarily concerned with the body and the protection of the body, so that society itself is sort of conceived as a mutual insurance scheme. Right? There’s a kind of pooling of risk in order to guarantee greater bodily security. So it seems to me you could argue that health care is a kind of logical extension of that.

And I might suggest a parallel with education. There’s no natural right to education. But remember that Jefferson at the time of the founding argued for public education and argued — and seemed to argue for it as kind of right. He argued that it was essential to the well-functioning of a democratic republic.

Now, you know, it was more than a hundred years before the United States began a system of public education. And even, you know, once we began public education, schooling remained a mixed system of public and private schools. But it is now and has been for some time mandatory. I mean, there is an individual mandate. Kids have to remain in school until they’re sixteen, and they can do that through either public schooling or private schooling.

So I wonder if we might think about universal health care in a similar way and whether that would provide a kind of argument for an individual mandate?

**PROF. BUSCH:** Certainly that was the mode of thinking of Franklin Roosevelt. For example, if you look at the Commonwealth Club address where he took basic rights from the Declaration of Independence and then tried to turn them into positive rights of government guarantees. And so certainly there’s a tradition of attempting to make those kind of linkages.

I think there are problems with it for a couple of reasons. One of them is that I think if you look at things like voting, you’re absolutely right. You have to translate some natural rights into positive rights or civil rights like voting because the principle of consent of the governed has to be operationalized somehow.

But it seems to me that it’s more of a leap to argue that the government has to provide health care in order for people to enjoy the right to life or for government to fulfill its duties in regard to protecting the right to life.

The problem in a sense is that, if government adopts this view in a broad sense in a broad way across the board, it really is a prescription for a completely unlimited government because there’s virtually no program that someone can’t claim is necessary for the enjoyment of natural rights. And so once you head down that path too far, I think any sort of barrier to unlimited government falls away.

The other aspect of this worth thinking about is that certainly if you try to think about this in the framework of the founding, property rights is a key element of natural rights, the right to acquire property and to be secure in that property. And the things that I think were put forward really as a general understanding of natural rights were able to be enjoyed without infringing on that, and it’s
unclear whether you can really say that people have a kind of fundamental right to property at a certain point if taxation becomes too confiscatory, which, in fact, could easily be resolved with a universal health care system.

People can enjoy freedom of speech without infringing on other people's natural rights. Even if that's written in some sort of positive right of law, they can enjoy the right to vote without infringing on other people's natural rights in some way. It's not clear that you can have a conception of health care that makes it a natural right above basically regular statutory rights without it infringing really seriously on property rights.

The one thing that I would say is that, while the founders had a clear appreciation of property rights as a key natural right, that didn't mean they were completely satisfied with just protecting the existing property. It was important to them to try to remove what they considered artificial barriers to people being able to acquire property, and so they changed inheritance laws, for example, so that the inheritance laws did not insist on only the eldest child, the eldest son, getting the inheritance because they considered that kind of leftover feudalism and it was necessary to try to change the law to try to protect people's ability to acquire property.

So I think if you apply that to health care you could say that people have a natural right to not have artificial barriers preventing them from getting health care. But the income by itself I wouldn't think would be considered one of those.

**PROF. JACOBS:** One question I think about often is these set of rights and ethical issues with regard to different parts of the population. A newborn that comes into the world, do they have a different set of rights? It's one thing to make an argument about individuals as they become adults and self-responsible. And it seems to me, that introduces a whole series of questions about the kind of creedal foundations of our society with regards to some very, I would say, conservative principles with regards to equal opportunity, liberty, and so forth.

If you've got a newborn coming into the world, we know categorically from lots of research now that their life chances are fundamentally affected by their circumstances and the health care they receive or fail to receive and the nature of that health care. So for me, I take a more situational, I guess, differentiated view with regards to some of these issues.

The second point I would make is simply that these rights, as eternal as they are in an abstract sense, evolve. And it seems to me the reality in America is we started off with a certain conception of rights, and that conception has changed.

And all you have to do is look at what's happened with our hospitals. They began often as religious institutions and voluntary hospitals, and they've now evolved into very substantial public institutions supported through many different levels of government. And that, I think, reflects the evolving sense of a positive right to certain sorts of health care and medical care, and I agree very much that what that constitutes is an issue in which there's a lot of disagreement and uncertainly.

**CHAIRMAN PELLEGRINO:** Thanks.

**PROF. BUSCH:** Can I just add something really quickly?

**CHAIRMAN PELLEGRINO:** Yes, quickly please.

**PROF. BUSCH:** Very quickly. I think the question of children actually relates very much to the point that Peter Lawler was making, that it's a mistake, I think, to consider everything in terms of individual versus government.

Obviously, if you're talking about a newborn, the first responsibility is not with the individual. But I think you could say reasonably that the first responsibility is with the family. And only if it's unable to meet that responsibility does government acquire some responsibility.

**CHAIRMAN PELLEGRINO:** Thank you very much. We have the following speakers lined up in the following order: Prof. Gómez-Lobo, Prof. Dresser, Prof. Meilaender, Prof. Carson, Prof. Schneider, Prof. Rawley. That's a significant list and — were you indicating a response also?

**DR. HURLBUT:** If you have time.

**CHAIRMAN PELLEGRINO:** And Dr. Hurlbut. So with that in mind, I would ask that we get to the point as quickly as we can, not to try to inhibit, but out of fairness to each speaker. Thank you. Peter, I didn't ask you if you wanted to comment first on what you've heard?
PROF. LAWLER: No, I don't.

CHAIRMAN PELLEGRINO: Okay, thank you. Prof. Gómez-Lobo?

PROF. GÓMEZ-LOBO: Yeah, more and the same. First, a tangential remark in reaction to Diana’s thesis. My own inclination would be to connect the right to access to health care to the third right, the pursuit of happiness, rather than to life. I feel very comfortable in keeping the right to life as a negative right, but I’m not an expert in that and I could revise it.

But the deeper problem I have is this. What bothers me, of course, is this reality of people in the United States in a very wealthy country who do not have access to health care because they do not have access to appropriate insurance, for instance. And that’s the reason why I thought it might be a good idea and a noble idea to keep that as a north pole as something marking the direction of any reform.

Now there I would differ a little bit with what Prof. Busch said. The fact that a positive right is granted and should not be taken away I think should not be equated with the system put in place to make that right effective. If it turns out to be ineffective, that is not a reason to say, “Oh, from now on not everyone has the right of access to health care.” I think we should uphold that right very, very firmly and for all.

Now my last remark — and this is really the question perhaps for both of you — have, say, European governments or has Canada become tyrannical because they have introduced a single-payer system? From what I heard yesterday, there were great advantages to having that, a system like that. Apparently, there might be more restrictions and choice imposed by insurance companies than in a broad system like that. And then the question of cost might be less if the information provided yesterday was correct.

So I don’t fear, to be honest with you, that we will have a tyrannical government just because we work towards giving access to health care to all Americans.

PROF. BUSCH: I’ll try to be brief. I went on a little too long the last time.

I guess in terms of the pursuit of happiness, I think we just have to remember that part of the pursuit of happiness is well considered to be the right to property. In fact, at the time of the founding, that was much more the common formulation of this. And it’s hard to imagine. To me at least, it’s hard to imagine how you would endow government with the right to insist on a wide range of social programs as a matter of right as a response to the pursuit of happiness without essentially undoing the enumeration of powers and giving the federal government carte blanche to do anything because the pursuit of happiness is, of course, a very broad notion and anyone can claim that they need a government program for helping them achieve that.

As far as Canada and Europe go, they certainly have much higher rates of taxation. That’s a limitation on freedom, I think, to some extent. There are other countries less democratic who have universal health care that actually can and has been used as a form of controlling the population. And I think that the broader issue isn’t so much what we call tyranny, but with Tocqueville we call it soft despotism, a sort of situation where people become so dependent on government that they really lose the capacity for self-government in some way. And I think that’s a much greater danger than creating a government that’s going to start putting people up against walls and shooting them or something.

PROF. GÓMEZ-LOBO: Well, I don’t think it’s everything or nothing. I think, of course, if we’re referring to health care access, that’s just one limited point in which I don’t see really a soft tyranny arising with it.

PROF. JACOBS: Just a quick point on this issue. And I think to my way of thinking, the more concrete, the better. It’s important to have principles. They guide our individual actions and they’re kind of a roadmap.

But just to take the issue of the Canadian system, which I think has been profoundly misrepresented often in some of these discussions, here’s a system in which much of the provision of care from doctors from private — it’s privately controlled. This is not about government provision of health care. That’s often misunderstood.

There’s a great deal of pluralism in terms of the provision system and even in terms of some of the payment schemes available. So even in the Canadian system, which some would see as kind of a compulsory system, I think there’s quite a bit more choice, and I think it’s a very important point
that you're making with regard to the locust of the compulsion; that is, it's one thing if you're being
told you have to go to this doctor and that's all that's available. It's another thing to be said, "Here's
your health insurance card to help you pay for something. You choose where you go." And that
seems to be to me the issue that is on the table.

I mean, I don't hear any — I mean, I don't hear a serious discussion about the nationalization of
provision of care or even I think people kind of learned their lesson, don't go near that. But it's more
about how you pay and enable, particularly for those that are finding the bar going too high. And I
think Americans are pretty clear that it goes too far and, even among those who are inclined to
support reform, they'll retract their support very quickly.

CHAIRMAN PELLEGRINO: Prof. Dresser?

PROF. DRESSER: This question is triggered by your slide, Prof. Jacobs, showing that support for a
government plan went down when you talked about, well, you can't choose your doctor and so forth.

We have so many of those constraints in the private system. Right? So how much of this — have
people looked at whether people say, "Well, if I have to be constrained in my choice of doctor or not
everything is covered," in a private system versus a public system, does it make a difference or is it
really the substance so that they don't want the constraints wherever they are?

PROF. JACOBS: Americans want free choice, and free choice from managed care. And, I think,
even to a real extent some of us have been through several cycles now on consumer-choice models.
This has been around for some time now. And I can't remember. I've lost count of which cycle it was.

But we're now in full retreat on managed care, and I would say the Alma moment in that was the
constraints put on choice and there's a lot of polling data showing that Americans over time,
particularly as managed care started to expand in the '90s really expand into the population. There
was a revolt, and now we've gone in another direction.

So I think your basic point is, there's a real concern about what's going on in the private sector. And
the polling data I was showing was the current system. So it may be a false choice, and I tried to
indicate that these are issues of debate about the extent to which lines would be longer and choice
would be less and so forth. But my main point was just to suggest that support for government
health insurance, even among those who are inclined in that direction, is quite susceptible to erosion
when these conditions are introduced.

I mean, I think we're in not a good situation because I frankly think our main two models that are on
the table right now are discredited. And it really raises the question for me of, what's the
responsibility of folks who study this and think about it and design policy to present some kind of
coherent alternative to it's the private or it's the government because I don't think that's where
Americans are right now. They've got concerns about both.

CHAIRMAN PELLEGRINO: Thank you very much. Dr. Meilaender?

PROF. MEILAENDER: There are a couple of things I want to hear Prof. Jacobs say a little more
about. But I just wanted to first make a quick comment about Diana's hypothesizing about sort of
extrapolating from the natural right to have one's life protected.

I mean, it's an interesting thought, but there would be something peculiar about it, wouldn't there, in
the sense that even though there are more homicides than we think there should be in our society,
government manages to protect most of us against death from death from homicide? But if the right
is to protect us against death from nature, it just loses a hundred percent of the time. So there's
something strange about the argument. I'd need to think about that more.

But there are a couple of things, Prof. Jacobs, I just would be interested to hear you say more about.
One is — and I don't know if this is true or not — but it just seems as if health care is one of those
things about which we always want more and better and so forth, and I wonder what effect that has
on your polling data about satisfaction and dissatisfaction. Do you know what I mean? I'd just like to
hear a little more about that.

And then the other thing, I would say — and I don't know whether you would agree with this or not,
but I'd be interested in your reaction — from a whole bunch of things that you pointed to in your
data from the degree of polarization to the — well, what you were just talking about in response to
Rebecca, the sort of soft nature of the support for a government system because people can peel
away quickly to the difference between judgments about the system as a whole and one's own
personal care and even what you've just said at the end about the major models for reform being
discredited. I mean, if you think all of those things, I would say this is an argument that, whatever we do, it should be done very incrementally and maybe experimentally in different ways and so forth. I'm just curious to know whether you draw the same conclusion or whether I just let my own predilections govern my reading of your data.

**PROF. JACOBS:** I strongly concur with your conclusion the way you read it. I think we are at a perilous moment yet again in health care where there's strong dissatisfaction with where we are and we've got two armies amassing on opposite mountain heads with quite different proposals, and it seems quite likely to me we're heading for another stalemate, more kind of deadlock and drift and a deepening of problems, problems that become more difficult to solve with each passing decade when you look. I mean, there's a real path dependency to some of these issues. And each year that goes by and each decade that goes by, I think the choices get harder.

I guess I'm more of a pragmatist. I don't see kind of divine answers in either model. I think it depends kind of on the set of questions you're asking. We just held a conference at the Humphrey Institute at the University of Minnesota on long-term care — and a fascinating topic because most definitely very, very wide support for choice. You want to decide where you're going to be cared for and your parents want to decide that and your children and so forth. But there are some very strong roles for government in terms of protection against fraud but also in terms of financing and helping to create insurance markets and so forth.

Those are the kind of choices that I think that we face in the real world, and I think these have to be choices that are done with great care with alertness to the potential for unintended consequences and for the most likely outcome, a stalemate, because of this highly polarized political process.

**CHAIRMAN PELLEGRINO:** Next, we have Dr. Carson.

**DR. CARSON:** Thank you for both for those concise presentations. I have a couple of questions. One should be a fairly easy one and that is, we've seen over the last couple of days a lot of satisfaction/dissatisfaction polling data. Do you have data from other countries just in terms of the kind of systems that they have and how satisfied their people are?

And, number two, this whole freedom issue is one that's somewhat disturbing. It goes against something in me to mandate to people that you must take a certain percentage of your money and you must spend it for this and that's all there is to it. It just doesn't seem quite American to me, and it seems to me like we're moving gradually toward a more totalitarian state, and that worries me. What we really need to do, I think — and I'd really like to hear your reaction to it — is get the price down to a reasonable level. And there are a number of ways obviously for that to be done, and I think it could be done through a combination of the federal government and private insurers by just making private insurers responsible for routine care and the government responsible for catastrophic care. That would dramatically drop the price, and it would also force us to begin to look at end-of-life care and some of the issues that lead to the incredible spiral in prices because, if we continue to ignore it, obviously we're not going to do anything about it.

And should, instead of us mandating that people buy it, we tell people that, if they get sick, they're going to be treated because we're not going to walk away from them? I mean, we're a moral society. We're not going to do it. So whether they have insurance or not, we're going to treat them. But if they don't have insurance, they're going to be charged for it and the charge will be higher than if they had insurance. It won't be the whole cost of the hospitalization, but there should be disincentive for not having insurance because otherwise people will say, "Well, I'll just wait until I get sick and I'll go in and then I'll pay it."

I'd like to know what you think about that kind of thinking.

**PROF. BUSCH:** Prof. Jacobs is probably able to talk about the public-opinion question better than I can in other countries.

I guess I would have to say I share the concerns that you have about an individual mandate both because I think it could wind up producing a really draconian enforcement mechanism. And there were a lot of things about Len Nichols' piece that I thought were very interesting and commendable. But I have to say I was troubled by what seemed to be the draconian nature of some of the enforcement mechanisms that he proposed for an insurance mandate.

The other problem with an insurance mandate is you can mandate it, but that still doesn't mean that anyone is going to do it. We mandate car insurance in all but three states and yet about fifteen percent of people don't have it. In the state of California, twenty-five percent of drivers do not carry
liability car insurance even though they’re required to by law. So I wouldn’t — for both reasons of liberty and just practical reasons, I would hesitate to put too much stock in that particular solution.

As far as the price question, there are classically, I guess, a couple ways of dealing with it. One is through government price controls. But that also has a liberty issue attached to it and a practical issue because those almost invariably lead to shortages. You wind up with a real distortion of the system that way, or you can try to use some sort of market mechanism and incentives to try to hold down the cost. It’s a more opaque method because you really can’t see it in operation in the same way as price controls, but it’s probably more effective and it has certainly less of a liberty problem.

I think it’s — certainly policymakers could take a look at this question of dividing things into kind of normal expenses versus catastrophic. One alternative that I’ve heard is perhaps having the health savings accounts that people would have for normal expenses and private insurance only for catastrophic occurrences which actually used to be much more common. I mean, I think that was kind of the original notion of health insurance was going to take care of you in catastrophic situation, and if you were taking your daughter to the doctor because she had a cold, you would sort of pay that out of your pocket usually. So that’s another possible way of looking at that. But I think from a policy standpoint I don’t see why you couldn’t take a look at those options.

**PROF. JACOBS:** So let me pick up the issue about satisfaction across countries. The most important thing here I think to appreciate is that evaluation of satisfaction is very much a function of the health care system available.

And in very broad strokes and with attention to time, here would be the generalization I would make. It’s very important to look historically at the sequencing of whether or not access to care was expanded before the more sophisticated supply of medical services became available.

In Europe and other countries, you see beginning the late 19th Century or early 20th Century expansion of access for a variety of different reasons far preceding the development of modern medical services. As those services became available, the prevailing systemic question across a whole number of countries was, could we afford the supply of this more technologically sophisticated services because it was available to everybody? And you see again and again a focus of government policy on restricting that supply. And so satisfaction on supply of services tends to be an area of concern.

On the other hand, there’s no real concern about price or about access. But if you look at the US and only the US, what we see is that the government is not really involved in expanding access until quite late historically speaking. But our involvement as a government was fairly significant, Hill-Burton and then NIH spending in terms of expanding and developing technologically sophisticated medical services. Then after this kind of development of a government involvement and subsidizing of a supply of more advanced services, we then get into access issues with Medicare and its various incarnations.

The result is that in the United States the questions have tended to be when we hear about national health insurance, can we afford to supply to an entire country these set of services. So the question is really about the access issues, and that tends to be the dissatisfaction about access, about price, coverage and so forth. We tend to get less concerned about the services themselves which, you know, you see in this data and I could present other data. But I think the key overwhelming kind of role here is satisfaction is a function of the existing system and its historic evolution of what it offers or what it doesn’t offer.

**CHAIRMAN PELLEGRINO:** Thank you. Carl Schneider?

**PROF. SCHNEIDER:** I would rather yield to Dr. Rowley’s question.

**CHAIRMAN PELLEGRINO:** Dr. Rowley?

**DR. ROWLEY:** Well, thank you, Carl. I’d like to make a series of comments and then have a question, and I just want to emphasize what Rebecca said, that the present system has very important limitations, more related to managed care than others. But I know for instance in the Hem-Onc system or related to that area that people will come to our hospital for evaluation and suggestion of treatment and then go back to their own physician who may or may not follow what is the best medical practice. So I think we shouldn’t sort of immediately assume that our own system presently for those who have access to it is so great and there are limitations.

I think that you’ve brought up Medicare and that’s an example of a government, not run — and that’s I think a very important system — but a government financed system, so we already have major
government involved in health care at the present time.

And I think that it’s also important. This group, as Carl has emphasized and Ed as well, our concern is not how it is done, but the ethical/moral principles that say or don’t say, depending on how we ultimately decide — and I suspect it’s going to be like all of our reports, a division — that whether it’s government, private, incremental, a major change, we’re actually going to leave to somebody else who knows much more than we do about this.

And so I think the details, and Prof. Busch’s emphasis on apparently that it’s the government who is going to run all of this in a somewhat tyrannical way is not necessarily true, and that’s not our problem. But it’s more to a discussion of is there an ethical moral issue in the whole question of what many of us think is inadequate health care in this country.

And so I want to make a plea that we did at the beginning of this Council back in 2002 make a statement on cloning and embryonic stem cells, which at least a number of people – and, I understand, people in Congress — paid attention to. I think if we really wrote a thoughtful, careful analysis of the moral ethical issues underpinning of this issue of access to health care that, as the morning’s speakers plus yesterday’s speaker said, we could really have an important impact, and I think that’s what many of us would like to see. So I think we should really put this as one of the top priorities in terms of the Council.

Now having made all of these preliminary remarks, I think, Prof. Busch, that you touched on equality and then sort of dismissed it as having much to do with health care or access, equal access of everybody to health care, and I don’t know that Alfonso would sort of agree that equality and justice have some commonality — and that’s not an issue I want to get into. But I would think that the principle of equality would extend to health care. I’d like to know what your comments are about that.

PROF. BUSCH: Well, first of all, clearly obviously Medicare is government financed. Medicaid is government financed. I remember reading a speech once from Lyndon Johnson in 1965 when he promised that people would not pay more than a dollar a month in Medicare tax, so that may be a cautionary note. There are things of value to be drawn from Medicare, but also some cautions to be drawn from it as well.

I think in terms generally of how health care reform is done, I think this is a critical question and I think it does have some very serious ethical and moral implications especially in terms of American principles. My argument was not in favor or opposed to any particular health care proposal, although I have concerns about some more than others. It was really a plea to think about what some of the key principles of American politics are and to think about how they might apply to this issue so that we don’t try to make policy without taking them into account. And I think a health care policy that’s compatible with those principles would be better than one that isn’t generally speaking.

In terms of the question of equality specifically, I think there are aspects and I think I’ve mentioned them in which equality does come into play and that is that I think there shouldn’t be artificial barriers to people getting health care. For the most part, there aren’t.

Certainly there are not legal restrictions on people buying insurance. The closest that we come is the differential tax treatment, which I do think is problem in terms of equality, and it has to do with equality under the law.

My point was simply that as the framers understood equality, they understood it as equality of natural rights and that means put in a practice of equality under the law, but it doesn’t necessarily mean kind of redistributive policies to attempt to equalize economic condition except in terms of equalizing opportunities.

So I do think equality is an issue in health care. I don’t think from the standpoint of the principle of the founding that equal levels of health care provision are a fundamental principle in the same way that liberty is.

CHAIRMAN PELLEGRINO: Dr. Hurlbut and Dr. Schaub.

DR. ROWLEY: Do you want to say anything?

PROF. JACOBS: There’s a time issue, so I’ll just very quickly respond to say, I think you’re right to focus on ethics and morals. I’ve said that before. In my view, you’ve got a tough choice because I don’t see black and white here. What I see is a very strong and evolving and developing sense of equality.
To me, it's just very difficult to read our history with regard to health care and not see that as kind of a guiding theme. Some people embrace it and wish it would go faster. Some people don't like it and want to dam it up. But it's evolving now.

There are all sorts of debates about right to what, and I don't know what that canvas has on it. On the other hand, I think there is a very strong enduring sense of liberty which we see in choice in the kind of deference to a private system in terms of provision. There are some who would like to see that grow. There are some that would like to see it fade away. But what I think would be very helpful for this committee would be to draw a tapestry and include those themes and don't get into the business of saying it's X or Y. I think we're spending too much time in that. We're just not really reflecting this country.

I'm just finishing a book which is coming out with the University of Chicago Press, not known as a liberal press. And what this book has done is it's looked very carefully at the attitudes of all Americans, and one of the main themes is that Republicans and high-income earners are as concerned as middle- and low-income earners and Democrats and Independents about many of these issues about equality and liberty. The kind of divide that we see in Washington I think is a mistake to kind of superimpose it on the rest of this country.

DR. ROWLEY: I want to make a comment to Prof. Busch’s last statement in terms of equating Medicare costs with — that was superimpose on our present system, which is fee-for-service and documenting every single test that a patient has and the justification thereof, which is why we have 30-plus percent overhead for this.

If we looked at some of these things, which are very much directly related to cost of things, and said, "What is it that we could reduce without changing necessarily the present system or" — I mean, you would have to change the present system, but the distribution, we could do a lot to bring down costs. And so I think that that's a very important issue is that we just superimposed Medicare on top of our inadequate system, and no wonder it's costing a lot.

CHAIRMAN PELLEGRINO: Dr. Hurlbut and Dr. Schaub, and then we will have the adjournment.

DR. HURLBUT: Dr. Jacobs, you've said that it appears that we're heading for another kind of low-grade Armageddon here with the two sides lining up in polarized position. And what I want to ask you about — but I want to make some comments as I ask the question.

What I want to ask you about is, if you think that is grounded in fundamental moral differences and moral opinions and moral matters or differences related to intuitive notions of how practical problems can be served?

Our role in this is obviously not to make a complete scheme for a solution. As was discussed yesterday, we don't have the time or expertise to adjudicate all of those difficult issues. But we perhaps do have some possibility of making a fundamental moral comment here. And so my overarching question here is, in what ways is this divide a fundamental difference in answer to moral issues?

Having said that, I want to reflect a little bit from both sides of the equation of some of what you have said, both of you have said. It's clear that by sociological analysis and just by an intuitive sense of things that there's a kind of a unique nature to our health care concerns that differs from a lot of what we would say about responsibilities and rights.

The ambivalence of attitude toward the system that you mentioned reminds me a little bit about the ambivalence of attitude that children have toward their parents. On the one hand, they have a kind of broadly critical view of their parents. On the other hand, when it comes to the personal delivery, they have largely a favorable disposition but also a strong sense of their entitlement, individual rights, a strange mix of individual responsibility and independence and a combination of ultimate dependence and sense of that somebody had better take care of them ultimately when they have great need.

The health care system seems to be a little bit like that. I mean, if we look back at our nation's history and we think of the times in our history we're most proud of ourselves unquestionably — the early settlements, the westward movement — we rarely think to ourselves, but were there a lot uninsured? I mean, we don't think in those categories. We somehow remember or rightly recognize that something was going on there that had — maybe we're romanticizing it. But I sense that we have the feeling, probably correctly, that the community was looking after itself and that threaded through that community were some assumptions about the nature of nature, the nature of community, and
the nature of what Diane has referred to as the natural corrosive power of physical process. We recognized the frailty and finitude of human existence and we collectively cooperated in addressing it as we could and sustaining one another in the midst of our inadequacies.

When I look at the modern situation and what changed, it seems to me that two things changed dramatically. One was the loss of close community and, therefore, the concern, collective concern and cooperative pooling of concern that takes place in communities, and the urbanization and anonymity, obviously, and the costly technologies that are now open-ended. I mean, obviously the future is unlimited in how we could extend into costly technologies. And here it comes back to what my initial question is. The relationship of basic moral dispositions and attitudes of what any parent thinks about their children: They should both be independent, but ultimately you want to care for them and love them.

Some people would say — and I've heard this in the hospitals. People come in for community-provided care. They come in in the most expensive kind of sneakers you could buy. They come in with tattoos all over their bodies. They're carrying a Coke and a pack of cigarettes in their pocket. And some people say, "Well, look. They should be able to pay for their care. Their priorities are wrong." Other people come in and they're so clearly stressed by the inability on a very decent and conscientious way to meet the needs of their basic lives. And usually and historically, I think that conflict would have been solved at the level of the community. People would have said, "Well, look. We're care for you, but you need to care for yourself, too."

And it seems to me there is part of the fundamental dilemma that is written large in our social attitudes, the sense that we somehow have to be careful not to enter into a situation or an arrangement that dispatches people from their fundamental responsibilities, their priorities. I mean, look at our savings rate in America. There's something reflected in that savings rate that bespeaks a society increasingly drawn into the imperatives of consumption versus a reserve for moments of ultimate need.

And so that's my question. Is there a fundamental attitude of moral disposition at issue in our conflict, or is it just differences in practical? Is there agreement on moral issues and a difference of practical implementation of solution?

CHAIRMAN PELLEGRINO: Thanks, Bill. Dr. Schaub, and then perhaps we can have a response from both panelists.

DR. SCHAUB: Yeah. I just wanted to make a quick reply to Gil and his response to me and this takes us back to Locke and the American tradition.

Gil pointed out that protection against the violent nature of others can work. You can deter murderers, but that protection against the violence of nature will always fail. In the end, we die. That's true. But I think it doesn't mean that the aspiration to master nature is not there, and this may just be an indication of how radical the aspirations of the modern project are.

I don't know whether Locke as much as Descartes looked forward to the indefinite prolongation of life, but it seems to me Locke certainly looked forward to increasing comfort and increasing security. Locke himself was a medical doctor, and his political philosophy which centers on care for the body I think is influenced by that.

Can I say one other thing about equality of opportunity —

CHAIRMAN PELLEGRINO: Yes. Go ahead.

DR. SCHAUB: — and Janet 's suggestion that we think more seriously about equality. Again, to go back to a kind of parallel between education and health care, we insist on access to education in order to equalize opportunity. And in doing that, I mean, we do actually put in place certain impediments to the right to acquire property at least temporarily.

I mean, children were taken off of farms and factories where they were very productive workers and required to go to school. Now, I mean, that's a temporary impediment and we do it with the long-term view that this will, in fact, contribute to a productive society, and it seems to me that you could make maybe a similar argument about health care, that the long-term effects of any kind of mandate would actually contribute to the greater productivity of society, but it does require looking to the long-term.

CHAIRMAN PELLEGRINO: Response?
PROF. JACOBS: Let me respond to this profound and important question about morals and pragmatism. In my view, we’re in an era of fading pragmatism and we suffer for it.

This was not the case in terms of in our community of kind of health-policy people or the larger kind of community of governance, both business and public. But that’s the era we’re in. I think the problems we face are fundamentally over divergent moral compasses, and I think, you know, you put your finger on one view which is about individual choice. Again, it’s just my inclination. I tend see that as a little more complicated. It’s individual choice, but it’s nested within an environment in which there are kind of social and economic choices.

And there’s a lot of quite interesting surveys that have been done on lower-income communities with high densities of folks who are pretty disadvantaged, and what we find is the availability of food, employment structure, and opportunities and so forth. It’s pretty dismal. So I tend to see an interaction between the individual choice and the collective situation.

But I think the problem we face today when I look at the dueling armies, it really is one of very fundamentally different moral compasses that are leading in different directions. The opportunity for compromises therefore are very, very difficult and fairly slight because compromise represents a selling-out, if you will, of fundamental precepts, and that’s always very difficult to move things along if you’re in that frame of mind.

PROF. BUSCH: I guess I would just add something in respect to the question of natural rights and education, the parallel with education. I think the way to look at what’s happened with education policy is that in some fundamental way it’s not a natural right. But that doesn’t mean the government can’t as a prudential matter conclude that it’s necessary for the well-being of society.

And I guess my view toward health care reform would be similar. That is to say, my only point is that once you begin considering a natural right, then prudential calculation largely is removed because then you have to provide it and people began arguing that you have provide it in a particular way, and then your freedom of action is gone and you stop balancing it against other fundamental questions.

And so I wouldn’t argue that in terms of fundamental principles government doesn’t have any right at all to involve itself. But my point is I think the founders frequently argued prudence is an important element to policy-making and you don’t want to foreclose that. You don’t want to foreclose careful thinking about it by arguing that it’s some sort of fundamental right. It’s beyond democratic consideration.

DR. SCHAUB: To clarify, I don’t think I ever said that it was a natural right, but that it could be understood as a civil right which was kind of logical extension or derivation from certain natural rights.

PROF. BUSCH: Right, okay.

CHAIRMAN PELLEGRINO: Yes.

DR. HURLBUT: Are you basically saying then that the problem is more fundamentally structural with regard to communities, not really a health care problem? That opportunity and social structure is essentially eroding the capacity for genuine personal responsibility and opportunity?

PROF. JACOBS: Well, I think that’s going on. I mean, I think there is a very profound historic transformation we’re somewhere in transit during and, you know, this is affecting and structuring the choices that individuals make.

But I think the health care system itself, you know, it interacts with that. These things get very sticky and it either enables or it exasperates or it’s hard for me to separate the two. I think there is interplay.

CHAIRMAN PELLEGRINO: Thank you very much. I’m sorry to have to be the timekeeper, but we’re over our time and one on my initial promises was to start on time and end on time. It may be too formalistic, but I think it does have some value. Thanks.

(Applause.)

SESSION 7: PUBLIC COMMENTS

There were no public comments offered.
Leon R. Kass

Edmund D. Pellegrino

Advising the President on ethical issues related to advances in biomedical science and technology.

The Charter of the President's Council on Bioethics expired on September 30, 2009.

"Among the most urgent of the Council's intellectual tasks is the need to provide an adequate moral and ethical lens through which to view particular developments in their proper scope and depth."

Dr. Kass served as chairman of the President's Council on Bioethics from 2001-2005.

"To advance human good and avoid harm, biotechnology must be used within ethical constraints. It is the task of bioethics to help society develop those constraints and bioethics, therefore, must be of concern to all of us."

Dr. Pellegrino served as chairman of the President's Council on Bioethics from 2005-2009.

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EDMUND D. PELLEGRINO, M.D.

COUNCIL CHAIRMAN

Dr. Pellegrino is Professor Emeritus of Medicine and Medical Ethics and Adjunct Professor of Philosophy at Georgetown University.

He has served as Director of the Center for Clinical Bioethics at Georgetown University; head of the Kennedy Institute of Ethics and director of the Center for the Advanced Study of Ethics at Georgetown; President of Catholic University; President and Chairman of the Yale-New Haven Medical Center; Chancellor and Vice President of Health Affairs at the University of Tennessee; founding Chairman of the Department of Medicine at the University of Kentucky; and Founding Director and Vice President of the Health Sciences Center, State University of New York, Stony Brook, where he oversaw six schools of health sciences and the hospital, and served as Health Affairs Dean of the School of Medicine.

He has authored or co-authored 24 books and more than 550 published articles; is founding editor of the *Journal of Medicine and Philosophy*; a Master of the American College of Physicians; Fellow of the American Association for the Advancement of Science; member of the Institute of Medicine of the National Academy of Sciences; recipient of a number of honorary doctorates; and a recipient of the Benjamin Rush Award from the American Medical Association, and the Abraham Flexner Award of the Association of American Medical Colleges.

In 2004, Pellegrino was named to the International Bioethics Committee of the United Nations Education, Scientific and Cultural Organization (UNESCO), which is the only advisory body within the United Nations system to engage in reflection on the ethical implications of advances in life sciences.

Throughout his career, Dr. Pellegrino has continued seeing patients in clinical consults, teaching medical students, interns and residents, and doing research. Since his retirement in 2000, Dr. Pellegrino has remained at Georgetown, continuing to write, teach medicine and bioethics, and participate in regular clinical attending services.
FLOYD E. BLOOM, M.D.

COUNCIL MEMBER

Floyd E. Bloom was until March 2005, Chairman of the Department of Neuropharmacology at the Scripps Research Institute. He is currently professor emeritus in the Molecular and Integrative Neuroscience Department at TSRI, and the founding CEO and board chairman of Neurome, Inc. He previously was Director of Behavioral Neurobiology at the Salk Institute and Chief of the Laboratory of Neuropharmacology of NIMH.

He has received numerous awards, including the Pasarow Award in Neuropsychiatry and the Hermann van Helmholtz Award, the Sarnat Award for Mental Health Research, as well as a number of honorary degrees from major universities. He was the editor-in-chief of Science magazine from 1995 to 2000.

Dr. Bloom was born in Minneapolis, Minn., in 1936. He attended Southern Methodist University in Dallas, Texas, where he received an AB degree cum laude and then an MD degree, cum laude from Washington University in St. Louis, Mo.

He is a member of the National Academy of Science (1977), The Institute of Medicine (1982), The American Philosophical Society (1989) and the Royal Swedish Academy of Science (1989).

Dr. Bloom has authored or co-authored a total of 32 books and monographs, 415 original research articles, 256 solicited articles and reviews, 59 editorials, and more than 300 abstracts.
REBECCA DRESSER, J.D., M.S.

COUNCIL MEMBER


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ALFONSO GÓMEZ-LOBO,
DR. PHIL.

COUNCIL MEMBER

Alfonso Gómez-Lobo, Dr. phil. Ryan Family Professor of Metaphysics and Moral Philosophy, Georgetown University. Professor Gómez-Lobo specializes in Greek philosophy, Greek historiography, the history of ethics, and contemporary natural law theory. He is the recipient of several awards, including a research fellowship from the Guggenheim Foundation. His latest book, *Morality and the Human Goods*, was published by Georgetown University Press in 2002.
WILLIAM B. HURLBUT, M.D.

COUNCIL MEMBER

William B. Hurlbut, M.D. Consulting Professor, Department of Neurology and Neurological Sciences, Stanford Medical Center, Stanford University. Dr. Hurlbut's main areas of interest involve the ethical issues associated with advancing biotechnology and neuroscience, the evolutionary origins of spiritual and moral awareness, and the integration of philosophy of biology with theology. He has worked with the Center for International Security and Cooperation on a project formulating policy on Chemical and Biological Warfare and with NASA on projects in astrobiology. He is the author of "Altered Nuclear Transfer," a technological proposal to our nation's impasse over stem cell research.

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Peter Augustine Lawler is Dana Professor and Chair of the Department of Government and International Studies at Berry College. He teaches courses in political philosophy and American politics and has won several awards from Berry for doing so.

He is executive editor of the acclaimed quarterly journal, *Perspectives on Political Science*, and has been chair of the politics and literature section of the American Political Science Association. He also serves on the editorial board of the new bilingual critical edition of Alexis de Tocqueville’s *Democracy in America* and on the editorial boards of several journals. He is a member of the Society of Scholars at the Madison Center at Princeton University, the George Washington Professor on the American founding for the Society of Cincinnati for the state of Georgia, and he is a member of President Bush’s Council on Bioethics.

He has written or edited ten books. His newest book, *Aliens in America: The Strange Truth about Our Souls* is a starred, featured selection in *Booklist*, the journal of the American Library Association. Another recent book, *Postmodernism Rightly Understood*, was also widely reviewed and praised. His very long introduction to a new edition of Orestes Brownson’s *The American Republic* is now available.

His *American Political Rhetoric* (edited with Robert Schaefer) is used in introductory American government courses at a sizeable number of colleges and universities. The fifth edition was just published.


Some of the topics of his recent articles and chapters include Shakespeare’s *The Tempest*, William Alexander Percy, Walker Percy, Alexis de Tocqueville, biotechnology, bourgeois bohemian virtue, religion and conservatism, compassionate conservatism, conservatism, the filmmaker Whit Stillman on nature and grace, disco and democracy, *Casablanca* and the American dream, the future of human nature, the utopian eugenics of our time, the rise and fall of sociobiology, Richard Rorty, grade inflation and the Ivy League, Harvey Mansfield and Carey McWilliams, caregiving and the American individual, Christopher Lasch, virtue voters, culture wars, Flannery O’Connor and nihilism, Orestes Brownson, and postmodernism rightly understood.

Lawler has given invited lectures at more than 50 colleges and universities. He has received a large number of grants from both the Liberty Fund and the Earhart Foundation, as well as numerous other foundations.

Dr. Lawler recently edited a book on Tocqueville and American political life today and the fifth edition of *American Political Rhetoric*. He wrote an introduction to the new Sheed and Ward edition of John Courtney Murray’s *We Hold These Truths*, and book chapters on religion and the American founding, Locke and American greatness, Flannery O’Connor, and *Casablanca*. 
PAUL McHUGH, M.D.

COUNCIL MEMBER

Paul R. McHugh, M.D. is the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine. He was the Henry Phipps Professor of Psychiatry, Director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine, and psychiatrist-in-chief at the Johns Hopkins Hospital from 1975-2001. He is the author of 4 books and more than 150 papers.
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Diana J. Schaub is a professor and chairwoman of the department of political science at Loyola College in Maryland. From 1994 to 1995 she was the postdoctoral fellow of the Program on Constitutional Government at Harvard University. In 2001, she was the recipient of the Richard M. Weaver Prize for Scholarly Letters. Ms. Schaub has taught at the University of Michigan at Dearborn and served as assistant editor of the National Interest. She has her A.B. from Kenyon College, where she was elected to Phi Beta Kappa, and an M.A. and Ph.D. from the University of Chicago. She is the author of Erotic Liberalism: Women and Revolution in Montesquieu’s "Persian Letters" (1995), along with a number of book chapters and articles in the fields of political philosophy and American political thought. Ms. Schaub’s work also appears in the New Criterion, the Public Interest, and The American Enterprise.