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A Just Share: Justice and Fairness in Resource Allocation

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Each of us has some basic sense of what the words "fair" or "just" or "fairness" or "justice" mean. Each of us probably also has an idea of what is "fair" in health care. The attempt by the state of Oregon in the mid-1980s to quantify this notion made a previously private exercise a public one. This transition has been chronicled in the bioethics literature that focuses on resource allocation. These works examine both theories of justice and concepts of "health"; the fair distribution of health resources has been of continuing interest since the beginning of bioethics in the 1960s. Early writing on justice includes authors Tom L. Beauchamp, Robert H. Blank, James F. Childress, H. Tristram Engelhardt, Paul T. Menzel, Paul Ramsey, and Robert M. Veatch (VII).

During the 1980s, bioethicists such as Daniel Callahan and Norman Daniels proposed thinking of health care decisions not as moments of personal crisis but as choices that span a lifetime, possibly involving tradeoffs in other areas of one's life, e.g., education. The Oregon experience added another dimension to the discussion. The initial rank-ordering of health services by cost produced a skewed list—for example, surgery for life-threatening conditions ranked below minor, elective procedures. For the project to make sense, the ranking algorithm could not be based on cost alone, but rather on a combination of costs and benefits

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32

both to individuals and to the community—“concatenations of individual and group goods” (I, Jecker and Jonsen 1995). Various metaphors have been used in the literature to facilitate discussion of this shift from individual to individual/community trade-offs: medical services as a “commons” (I, Asch 1995, Jecker and Jonsen 1995, Michels 1994); resource allocation as a “lifeboat” (I, Campbell 1995; III, Kaveny 1994); medical care as “shares” in a community health (III, Nelson 1992, Ford and Kissick 1995; II, Anderson 1993); and rationing as traveling through the desert with one jug of water for two people (a story from the *Halachah* literature) (I, Zoloth-Dorfman 1995).

Such metaphors do not promote any one “theory of justice” but rather draw from the work of a number of bioethicists as well as from theological, sociological, economic, and business literature. The five major conceptions of justice that are referenced most frequently are: “(1) a libertarian conception, which takes liberty to be the ultimate political ideal; (2) a socialist conception, which takes equality to be the ultimate political ideal; (3) a welfare liberal conception, which takes contractual fairness or maximal utility to be the ultimate political ideal; (4) a communitarian conception, which takes the common good to be the ultimate political ideal; and (5) a feminist conception, which takes a gender-free society to be the ultimate political ideal” (I, Sterba 1995).

The use of new metaphors also draws on expanded concepts of “health.” “As health care is currently practiced, the most powerful symbols for public and professional alike are those that promise the defeat of time” (I, Campbell 1995). When medical care is perceived as an unrelated series of individual cures, the fact that health care resources are finite cannot be addressed.

“Reflections concerning the difficulties in limiting the use of health care resources have an ancient lineage and reveal a tight bond with the obsession to postpone death at all costs. Plato in Book 3 of the Republic recognizes the quandary of infinite expectations and finite resources that characterizes the challenge of health care choices.” (I, Engelhardt 1996)

The proliferation of expensive medical

technologies and the loss of autonomy by health care professionals further complicates perceptions of the crucial issues at hand. Some have said that Americans place too much emphasis on individualism to address these issues.

Daniels et al. believe that this is too pessimistic a view and that the American commitment to protecting equal opportunity for all provides a firm basis for developing a public consensus on what is fair in health care (III, Daniels, Light, and Caplan 1996). Finally, several authors suggest that the nature of all four principles of medical ethics, not justice alone, must be reformulated if we are to retain ethical values in a rationed health care (I, Purtilo 1994, Engelhardt and Wildes 1994, Frank 1996).

This bibliography contains annotations for recent discussions of fairness in health care as well as citations to early works on the topic. It is divided into seven categories:

- I. General Works on Justice and Resource Allocation
- II. Groups Affected by Rationing
- III. Applied Justice
- IV. International Perspectives
- V. Physicians as Gatekeepers
- VI. Organizational Statements
- VII. Early Works.

I. General Works on Justice and Resource Allocation

Asch, David A. **Basic Lessons in Resource Allocation: Sharing, Setting Limits, and Being Fair.** *Pharos* 58(2): 33-34, Spring 1995.

Asch compares the health care system to a commons upon which all graze, stating that a commons must be actively managed and regulated or everyone loses. He urges cooperative sharing where each must relinquish a part, setting reasonable limits that will always exclude some services, and thinking of health as more than something that medicine can provide. He states that the conflict between individual needs and social goals cannot be resolved and that fairness requires limits.

Baily, Mary Ann. **The Democracy Problem.** [Response to Norman Daniels, Meeting the

Challenges of Justice & Rationing.] *Hastings Center Report* 24(4): 39-42, July-August 1994.

Baily writes that “simple economics dictates that if Americans want to guarantee that they will always have access to something, they must give up the idea that they can have access to everything; they must recognize that because the cost of health care is shared communally, care priorities must also be determined communally. . . . This does mean working through the implications of alternative theories of justice, but it also means recognizing that compromise among competing moral visions is not only possible but essential, and it means looking for practical strategies to bring about such compromise.”

Broome, John. **Fairness versus Doing the Most Good.** [Response to Norman Daniels, Meeting the Challenge of Justice & Rationing.] *Hastings Center Report* 24(4): 36-39, July-August 1994.

In understanding fairness, Broome thinks it necessary to understand allocation as “claims.” “Fairness is about mediating the claims of different people.” He suggests that “fairness requires that each candidate’s claim should be satisfied in proportion to its strength” with equal claims sharing equally. Since this may not always be possible, a lottery may be the way to minimize unfairness.

Buchanan, Allen. **Equal Opportunity and Genetic Intervention.** *Social Philosophy and Policy* 12(2): 105-35, Summer 1995.

Buchanan asks what the prospect of genetically altering a human being implies for our “understanding of the requirements of justice, and of equal opportunity in particular?” The author proposes the “Resource Redress Principle”—i.e., that the fundamental equality of persons requires that those with “lower life-prospects” be compensated—wherein “all resources, natural and social, ought to be distributed equally.” He concludes that any attempt to base social resources on justice is unworkable, discussing four concepts of equal opportunity, and the complex issues of privacy and autonomy.

Buchanan, Allen. **Health-Care Delivery and**

Resource Allocation. In *Medical Ethics*, 2d edition, ed. Robert M. Veatch, pp.32 1-61. Sudbury, MA: Jones and Bartlett, 1997.

This comprehensive review of the issues involved in health care distribution includes sections on utilitarianism, libertarianism, cost-benefit and cost-effectiveness analyses, John Rawls’s and Norman Daniels’s accounts of the right to health care, as well as a discussion of a “decent minimum” level of medical services.

Callahan, Daniel. **Symbols, Rationality, and Justice: Rationing Health Care.** *American Journal of Law & Medicine* 18(1 & 2): 1-13, 1992.

Acceptance of the concept of rationing is the obligatory first step to any just and universal health insurance program according to Callahan, who says rationing and reform cannot be separated. He thinks that the “crucial issue is whether the baseline of care for the poor is set high enough to eliminate the most serious disparities between rich and poor.”

Campbell, Alastair V. **Health as Liberation: Medicine, Theology, and the Quest for Justice.** Cleveland, OH: Pilgrim Press, 1995. 151 p.

Campbell uses the image of a lifeboat when discussing the allocation of health care resources. Basing his analysis on an ecumenical reading of liberation theology texts as well as the writings of John Rawls and Norman Daniels, the author notes that it is only through “identification with the oppressed” that we can experience “[Kant’s] positive freedom of moral agency” and thus be able to “take risks for the other’s sake” when rationing health care.

Can Justice Endure Healthcare Reform? From Patient Care to Policy (and Back Again) [Special Section]. *Cambridge Quarterly of Healthcare Ethics* 5(4): 485-532, Fall 1996.

Engelhardt, H. Tristram. **Rights to Health Care, Social Justice, and Fairness in Health Care Allocation: Frustrations in the Face of Finitude.** In his *The Foundations of Bioethics*, 2d ed., pp. 375-410. New York: Oxford University Press, 1996.

Noting that de facto rationing exists but is unacknowledged in existing health care systems, Engelhardt holds that any government attempt to ensure equality of access by limiting medical treatment is immoral. He suggests that an “egalitarianism of altruism” (as opposed to one of envy) be used when “attempt[ing] to set some inequalities aside by using commonly owned resources.” He contrasts the work of John Rawls where “justice [is] primarily structural, a pattern of distributions that is amenable to rational disclosure” with that of Robert Nozick, who views “justice as primarily procedural, a matter of fair negotiation.”

Engelhardt, H. Tristram, and Wildes, Kevin William. **The Four Principles of Health Care Ethics and Post-modernity: Why a Libertarian Interpretation Is Unavoidable.** In *Principles of Health Care Ethics*, ed. Raanan Gillon, pp. 135-47. New York: John Wiley & Sons, 1994.

The authors state that since there is “no canonical secular understanding of the good . . . [or] distributive justice, health care welfare rights will need to be created out of common resources by democratic procedure”. Engelhardt and Wildes go on to caution that “after the government has created a web of health care welfare rights . . . private tiers of health care become morally unavoidable That the rich may purchase more health care than the poor, that the rich in this circumstance will not be equal to the poor will be fortunate for the rich, unfortunate for the poor, but not unfair.” Along with the other principles of autonomy, beneficence, and nonmaleficence, the authors view the concept of justice as functioning as one of the “middlemen who bring together diverse philosophical considerations in a way that can help organize the analysis of health care controversies.”

Evans, Donald. **The Limits of Health Care.** In *Philosophical Problems in Health Care*. ed. David Greaves and Hugh Upton, pp. 159-73. Aldershot, England: Avebury, 1996.

After discussing the maximization of benefit, cost-effectiveness analysis, and cost-benefit analysis as means of allocating health resources, Evans describes “the problem of

justice.” He says that justice is the most “prominent ethical challenge in maximisation theories” and the application of such theories “calls for modesty and sensitivity lest the interests of minorities be threatened and the preferences of self-appointed experts win the day in determining what health care provision people shall receive in ignorance of or in indifference to people’s perceptions of their own lives and interests.”

Frank, Arthur W. **A Common Health: Redrawing the Moral Map.** *Christian Century* 113(15): 486-90, 1 May 1996.

Using Alastair Campbell’s *Health as Liberation: Medicine, Theology, and the Quest for Justice* as a point of departure, Frank critiques contemporary discourse in medical ethics as taking a “radically individualist line” and celebrates Campbell’s “communal ethic” that fosters discussion of what we must sacrifice so that “all may have an adequate share of those resources that make health possible.”

Jecker, Nancy S., and Jonsen, Albert R. **Healthcare as a Commons.** *Cambridge Quarterly of Healthcare Ethics* 4(2): 207-16, Spring 1995.

Referring to the agricultural commons maintained by medieval villages, Jecker and Jonsen propose that we define health care as a community resource rather than as a private commodity. They provide a brief history of the commons system in Europe and its introduction as a health care concept in the mid-1970s. The authors also review the evolution of Oregon’s rationing plan from an exercise in utilitarian cost management to a communitarian balancing of individual and community values.

Kamm, Frances M. **To Whom?** [Response to Norman Daniels, Meeting the Challenges of Justice & Rationing.] *Hastings Center Report* 24(4): 29-32, July-August 1994.

Kamm discusses micro- and macrodistribution of health resources—whether to save a larger group of persons or the more urgently ill—and other ways that choices could be made. She concludes by saying “if the middle class gets

worse medical care than they used to because benefits have been extended to a larger population, this might be acceptable.”

Loughlin, Michael. **Critique: Dworkin, Rawls and Reality.** *Health Care Analysis* 3(1): 37-43, February 1995.

Loughlin thinks that philosophical writing must become more concerned with a “meaningful application of philosophy to ‘real life’ issues it purports to address.” He urges philosophers to consider their audience (academics, politicians, or the general public) with an aim of raising “the general level of thought and discussion in society.”

Lustig, B. Andrew. **The Common Good in a Secular Society: The Relevance of a Roman Catholic Notion to the Healthcare Allocation Debate.** *Journal of Medicine and Philosophy* 18(6): 569-87, December 1993.

Lustig analyzes Catholic teaching on the “right to health care and the legitimacy of healthcare rationing,” concluding with reflections on the “appropriate place for religious voices in the process of policy-making, as distinguished from its justification.” He describes policy discourse as tending to “work within the constraints of history and culture” and drawing upon “values already embedded in the choices we have made.”

Michels, Robert. **Defining Social Choices and Distributing Social Resources on the Health Care Commons.** *Annals of the New York Academy of Sciences* 729: 182-85, 4 December 1994.

Noting that “many pressing problems of the nation’s health are not primarily within the province of medicine,” Michels suggests that medical school curricula be modified to address public health issues heretofore ignored. If we “broaden the dialogue about factors and conditions that determine the pool of choices,” formulating standards for health care systems will take into account issues of housing, education, and poverty that “far more profoundly influence” the distribution of health care resources than a prioritized list of 700 conditions.

Nelson, James Lindemann. **Measured Fairness, Situated Justice: Feminist Reflections on Health Care Rationing.** *Kennedy Institute of Ethics Journal* 6(1): 53-68, March 1996.

Nelson seeks to bring “mainstream” treatments of justice in health care and feminist thought together in this discussion of new developments in the theory of rationing and the “emergence of a strong communitarian voice.” He points out that justice in the distribution of health care will mean different decisions for pluralistic communities, and he discusses various means to measure fairness as a way toward a theory of rationing. He describes “community health programs” (CHPs) of about 20,000 persons who could agree on health care decisions for members.

Nelson, James Lindemann. **Publicity and Pricelessness: Grassroots Decision Making and Justice In Rationing.** *Journal of Medicine and Philosophy* 19(4): 333-42, August 1994.

Nelson writes that in the absence of a convincing theory of justice in rationing, “democratic decisionmaking concerning priority setting emerges with a kind of inevitability. Yet there remain suspicions about this approach—most importantly, worries about the socially corrosive impact of explicit, public decisionmaking that in effect sets a price on the lives of persons.”

Payne, Jan. **Justice as the Goal of Medicine and Health Care.** *Bulletin of Medical Ethics* 110: 13-15, July-August 1995.

Payne thinks “health care hangs on the notion of justice and justice is the proper goal of medicine.” He says justice is not abstract, but rather a concrete concept that can be enhanced by ethics education for health care staff.

Post, Stephen G. **Justice, Community Dialogue, and Health Care.** *Journal of Social Philosophy* 23(3): 23-34, Winter 1992.

Reporting the efforts of a group of 30 Cleveland community leaders to identify moral values that could help in the development of public policy for health care distribution, Post indicates that they agreed that at some point rationing may need to be

introduced, informed by the values of just cause, participation, and common good. A basic insurance coverage with reasonable limits should be available, as well as some long term care plan that allows for patient choices. Concepts of caring are discussed as well as the needs of care givers.

Powers, Madison. **Efficiency, Autonomy, and Communal Values in Health Care.** *Yale Law & Policy Review* 10(2): 316-61, 1992.

Stating that “virtually every major proposal [for health care financing] assumes that universal access to health care is a value that public policy must promote, and opinion polls verify that this sentiment is widespread,” Powers describes the role of efficiency, market and non-market alternatives for health care allocation, individual autonomy and choice, and communal values and health care entitlement.

Purtilo, Ruth B. **Medicine in Transition—Emerging Ethical Issues in the Global Village.** *Annals of the Academy of Medicine, Singapore* 23(3): 437-40, May 1994.

Purtilo holds that two paradigm shifts in medicine are affecting traditional medical ethics and the principles of autonomy, beneficence, and justice: (1) medicine’s evolution from profession to business, particularly because physicians lost professional autonomy to be responsive to patient needs and satisfaction and (2) medicine’s dependence on expensive technology.

Rakowski, Eric. **The Aggregation Problem.** [Response to Norman Daniels, Meeting the Challenges of Justice & Rationing.] *Hastings Center Report* 24(4): 33-36, July-August 1994.

Rakowski states that health services should depend on “people’s informed preferences regarding possible treatments, given the risks they run and the efficacy of available procedures.” He realizes that this is difficult given “ill-informed and often incoherent preferences” but says that “justice requires redress for the uncourted ill luck and bad genes that mar some people lives, although disagreement abounds over what compensation is appropriate.” He continues:

“Each person, I have assumed, has an equal right to determine how the overall health care budget should be spent. Allowing each to decide which treatments, in which circumstances, her proportional share of the budget will buy her maximizes her authority while respecting everyone’s equality. The arrangement is fair.”

Reynolds, Curtis. **Responsibility and Justice. . . An Ethical Balance.** [Editorial] *Iowa Medicine* 84(8): 344-46, August 1994.

Saying that the appropriate use of resources is an obligation the institution assumes in return for public support, Reynolds writes that distributive justice applies to health care at many levels from federal budget planning to specific use of ICU beds or liver transplants. He thinks the common good calls for individuals to be held more responsible for choices causing ill health, but without moral judgment.

Rhodes, Robert P. **Health Care Politics, Policy and Distributive Justice: The Ironic Triumph.** Albany, NY: State University of New York Press, 1992. 339 p.

Rhodes places health policy issues in the context of American politics, pointing out conflicts between needs and evaluating solutions as he sees them. Saying that government finances more than 40 percent of the \$700 million total cost of health care, he discusses the distribution of power and influence in health care and concerns over who should receive more or less care. Describing medical and holistic models of health care, the author sees no easy solution to the complexities of “who has power, where justice lies, and what constitutes a prudent and just health policy.”

Roemer, John E. **Theories of Distributive Justice.** Cambridge, MA: Harvard University Press, 1996. 342 p.

Roemer presents the major philosophical theories of distributive justice and applies economic analysis of fairness of resource allocation to help in understanding the theories more fully.

Schwartz, Robert L. **Life Style, Health Status,**

and Distributive Justice. *Health Matrix: Journal of Law-Medicine* 3(1): 195-217, Spring 1993.

Calling the cost of health care and widespread lack of access to it a scandal, Schwartz says that making scapegoats of those with risky life styles allows society to avoid any obligation to reform health care. He discusses the individual's health from the viewpoint of personal responsibility, whether it involves voluntary or involuntary conduct, and the possible role of deterrence or punishment as a means to alter conduct. He urges that the public not "be drawn away from serious evaluation of the justice of our health care system by focusing on the life style of patients."

Self, Donnie J., and Olivarez, Margie. **The Influence of Gender on Conflicts of Interest in the Allocation of Limited Critical Care Resources: Justice Versus Care.** *Journal of Critical Care* 8(1): 64-74, March 1993.

Noting that the principle of autonomy is "inadequate for the resolution of many of the complex and difficult moral dilemmas involving conflicts of interest in the allocation of limited critical care resources," the authors analyze concepts of justice and care. From their data they think that men are more likely to use justice in the resolution of a moral dilemma, but that when women are required to use justice to solve a critical care problem, "they do a better job of it than men."

Sterba, James P. **Justice.** In *Encyclopedia of Bioethics*, Revised Edition, ed. Warren T. Reich, pp. 1308-15. New York: Simon & Schuster Macmillan, 1995.

After reviewing the five basic theories of justice, Sterba discusses John Rawls's position on justice and Norman Daniels's development of it for health care. Sterba thinks there are two options: (1) "to specify an optimal and affordable level of health care and then guarantee this level of health care to all legitimate claimants" or (2) "to specify a decent minimal level of health care and guarantee it for all legitimate claimants, but then allow higher levels of health care to be purchased by whoever has the income and desire to do so."

Upton, Hugh. **Justice and Health Care.** In *Philosophical Problems in Health Care*, ed. David Greaves and Hugh Upton, pp. 145-58. Aldershot, England: Avebury, 1996.

In general terms, Upton defines justice as a matter of people receiving what is due to them, which includes two subdivisions: the rectification of previous acts of injustice and the fair distribution of goods. Rights, entitlement, and desert are all seen to be connected to justice. He offers two views of the state's obligation: (1) health has status within welfare; causes of ill health should not be examined too closely since the state has a duty to help citizens in avoiding poor health and (2) the state has no obligation at all to provide health services. He presents theories developed by John Locke, Robert Nozick, and John Rawls to illustrate views of justice.

van der Wilt, Gert Jan. **Cost-Effectiveness Analysis of Health Care Services, and Concepts of Distributive Justice.** *Health Care Analysis* 2(4): 296-305, November 1994.

The author finds utilitarian and egalitarian approaches for health care allocation to be relevant but often overly theoretical and impractical in some respects. Instead, a "Rawlsian thought experiment" is suggested to reach a hypothetical agreement that could be impartial.

Veatch, Robert M. **Justice and Outcomes Research: The Ethical Limits.** *Journal of Clinical Ethics* 4(3): 258-61, Fall 1993.

Questioning the use of outcome predictors as a means to achieve fair distribution of health care resources, Veatch thinks that theories of justice do provide a basis for deciding whether marginal benefits can be excluded. Favoring calculation of well-being "over a lifetime," he thinks that "outcomes researchers need to face the question of what weight their outcomes measures should be given in comparison with considerations of justice, fidelity to promises, autonomy, and so forth. Justice may require that considerations other than the outcome be taken into account in deciding when to fund marginally beneficial, expensive services."

Zoloth-Dorfman, Laurie. **Community and**

Conscience: A Jewish Perspective on Justice and Health Care Reform. In *Health Care Crisis? The Search for Answers*, ed. Robert I. Misbin, Bruce Jennings, David Orentlicher, and Marvin Dewar, pp. 223-34. Frederick, MD: University Publishing Group, 1995.

Noting that “[in] the discourse of bioethics the language of Christianity has been critical—but the distinctive contribution of the Jewish tradition has been less widely expressed,” Zoloth-Dorfman describes three source texts from the *Halachah* (Jewish legal tradition) that bear directly on issues of justice and resource allocation: the text of the scarce resource, the text of siege, and the text of the Sanhedrin.

II. Groups Affected by Rationing

Anderson, Bo. **Distributing Social Goods Between Generations.** *Social Justice Research* 6(4): 343-55, December 1993.

Asking what a given generation owes to those who belong to younger or older generations, Anderson explains distributive justice in sociology and analytic philosophy. He looks at justice with a focus on what is “owed to the elderly” and suggests incentives whereby care givers’ time would be logged in a computer against the time when the care givers themselves need care.

Brock, Dan. **Justice and the ADA: Does Prioritizing and Rationing Health Care Discriminate Against the Disabled?** *Social Philosophy and Policy* 12(2): 159-85, Summer 1995.

Calling attention to the relevancy of function to justice (either in the prevention of disability or the restoration of function after disability), Brock says a principled basis is needed to weigh tradeoffs between maximized benefits and fair chances. He discusses the Oregon health plan, the Americans with Disabilities Act, and QALYs, concluding that “prioritization will force us to confront the issues . . . in order to clarify our moral responsibilities to disabled persons . . .”

Callahan, Daniel. **Controlling the Costs of Health Care for the Elderly—Fair Means and Foul.** *New England Journal of Medicine* 335(10);

744-46, 5 September 1996.

Continuing his long term interest in health resource allocation for the aged, Callahan says problems are apparent and growing. Physicians and hospitals are asked to take less money and the elderly are asked to pay a larger share of costs. He calls advance directives, futility treatment, covert age-based rationing, and physician-assisted suicide strategies to restrain cost. He concludes that open ended entitlement with regard to cost cannot remain but that “overt rationing based on age will be extremely distasteful politically” so that there is “more likely to be a slide toward rationing of the covert kind.”

DeVile, Kenneth. **Parties to the Social Contract? Justice, Proposition 187 and Health Care for Undocumented Immigrants.** *Trends in Health Care, Law & Ethics* 10(1/2); 113-18, Winter-Spring 1995.

Commenting on the California ballot initiative that denied most health services to illegal immigrants, DeVile thinks that “undocumented aliens’ significant participation in the U.S. economy . . . demands moral reciprocity and justifies some access to social benefits in the interest of distributive justice.” Saying that immigrants give as much as they receive, “social contractarianism, justice, utility and benevolence all demand that immigrants be granted reasonable access to social goods available to the rest of society.”

Dula, Annette, and Goering, Sara. **“It Just Ain’t Fair”: The Ethics of Health Care for African Americans.** Westport, CT: Praeger Publishers, 1994. 315 p.

This collection of essays grew out of a leadership development program for African-American medical ethicists held at the University of Chicago’s Center for Clinical Medical Ethics in the early 1990s. To stress the need for dialogue between bioethicists and African Americans, each essay consists of an article by a health care practitioner coupled with a commentary by an ethicist. “The common thread that runs through these [essays] is the issue of justice” along with a critical look at “the canon” of traditional bioethics that promotes a “best

interests' standard in a system that has discriminated against [African Americans] with impunity”

Harris, John. **Does Justice Require That We Be Ageist?** *Bioethics* 8(1): 74-83, January 1994.

Written in answer to Kappel and Sandoe's 1992 paper favoring automatic preference for the young in health care allocation, Harris thinks this concepts of justice are unacceptable. He writes that those who rely on these concepts will have to “accept the moral respectability of killing the innocent in order to maximise units of lifetime.” Saying that “money can be redistributed; life cannot,” Harris says that all people “matter morally despite these differences not because of them.”

Jecker, Nancy S., and Berg, Alfred O. **Allocating Medical Resources in Rural America: Alternative Perceptions of Justice.** *Social Science and Medicine* 34(5): 467-74, March 1992.

The authors claim that rural Americans are neglected in national debates about the allocation of medical resources. Based upon a study of 24 physicians in the rural northwest, they say the distribution of resources in rural areas occurs as a result of close personal relationships with patients and “calls upon the physician's skill at being simultaneously immersed in and distanced from others.” In conclusion, the authors say that “ethical debates about justice in health care cannot mark real progress without attending to how people reason and feel about justice in everyday clinical practice. . . . We need as well to fashion intermediate or bridge principles that take us from abstract and foundational principles to more specific and robust notions of just action.”

Kappel, Klemens, and Sandoe, Peter. **Saving the Young Before the Old - A Reply to John Harris.** *Bioethics* 8(1): 84-92, January 1994.

The authors hold that “for a distribution of health care resources to be fair, it should consider the consequences for the whole lives of the affected persons and not just how badly off they are at the present moment.” They write that since it worse to die young than die old, it is fair to give scarce health resources to

the young.

Orentlicher, David. **Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick.** *Harvard Civil Rights-Civil Liberties Law Review* 31(1): 49-87, Winter 1996.

Asking how health care can be distributed so that it “does not discriminate unfairly on the basis of sickness,” the author raises questions about biases “inherent in social structure.” Orentlicher describes various methods of health care rationing and urges that legal protections be in place to make certain that those persons with disabilities do not bear “more than their fair share of health cost containment.”

III. Applied Justice

Bayer, Ronald. **Justice and Health Care in an Era of Cost Containment: Allocating Scarce Medical Resources: A Perspective on Micro-Distributive Justice.** In *Social Responsibility: Journalism, Law, Medicine*, Volume LX, ed. Louis W. Hodges, pp. 3 7-52. Lexington, VA: Washington and Lee University, 1983.

In this early discussion of just health care allocation, Bayer lists five standards for health care distribution from most to least egalitarian: first come, first served; lottery; merit from past contributions to society; utility, i.e. future possible contributions to society; and ability to pay. He discusses inequality and inequity in the health care received by the poor and opines that the United States should be able to match health systems in Western Europe.

Brody, Baruch. **Public Goods and Fair Prices: Balancing Technological Innovation with Social Well-Being.** *Hastings Center Report* 26(2): 5-11, March-April 1996.

Brody points out that there were no bioethics comments included when the National Institutes of Health negated the “reasonable pricing clause” in the pricing of drugs and other technological innovations funded by public dollars. He holds that this raises profound moral and social questions, discussing several cases to provide

illustrations. Brody offers suggestions for fairer ways for government to fund research and cap prices.

Chadwick, Ruth. **Fairness Is at Issue.** *BMJ: British Medical Journal* 308(6933): 907, 2 April 1994.

Noting that the term “priority setting” has been deemed preferable to “rationing” even though priorities obviously give preference to some while others go without, Chadwick says a “procedural requirement of fairness is that like cases are treated alike.” She notes the difficult issues raised by “intrapersonal comparisons which of course affect most if not all criteria of allocation.”

Daniels, Norman. **Is the Oregon Rationing Plan Fair?** *Journal of the American Medical Association* 265(17): 2232-35, 1 May 1991.

Noting that the Oregon Basic Health Services Act mandates universal access to basic care, but includes rationing services to Medicaid recipients, Daniels writes that “whether the outcome seems fair depends on how much priority to the well-being of the poor we believe justice requires.” Praising Oregon’s willingness to “make rationing a subject of open, political debate,” Daniels concludes that any introduction of a comprehensive health care plan is a “complex issue.”

Daniels, Norman. **Meeting the Challenges of Justice & Rationing: Four Unsolved Rationing Problems: A Challenge.** *Hastings Center Report* 24(4): 27-29, July-August 1994. [See also Symposium replies by Mary Ann Baily, John Broome, Frances Kamm and Eric Rakowski, pp. 294-2.]

Speaking to the first congress of the International Association of Bioethics, Daniels presented four key problems in the provision of scarce health resources: how much should best outcomes be favored, what priority should the poor receive, whether modest benefits to many outweigh significant benefits to fewer people, and when should democratic processes determine fairness. Noting that democracy may be an impure and imperfect form of procedural justice, he suggests that this “can be corrected by appeal to some prior notion of what constitutes a fair

outcome of rationing” and urges working “harder at providing a theory of rationing.”

Daniels, Norman. **Seeking Fair Treatment: From the AIDS Epidemic to National Health Care Reform.** New York: Oxford University Press, 1995. 204 p.

Daniels thinks that HIV and AIDS patients have exposed weaknesses in the health care system—e.g., the loss of health insurance when it is most needed or remaining in jobs to keep health coverage, which are situations anyone may face. He looks at issues of justice and the lessons of AIDS to achieve fair health care reform, saying that access to health care is a requirement in a just society.

Daniels, Norman; Light, Donald W.; and Caplan, Ronald L. **Benchmarks of Fairness for Health Care Reform.** New York: Oxford University Press, 1996. 198 p.

Believing that health care reform proposals have floundered because Americans are confused about the issues involved rather than too individualistic and selfish to care, the authors propose that reform proposals be based on the central American value of “equal opportunity.” “Equal opportunity does not imply that . . . there is a right to healthcare, [but] rather . . . that we are obliged to meet health care needs because doing so is an important way of protecting our opportunities, and we are obliged to protect equality of opportunity.” The authors present a list of criteria to be used for evaluating fairness in health care proposals in order to foster clarity in public debate on these issues.

DeBruin, Debra A. **Justice and the Inclusion of Women in Clinical Studies: An Argument for Further Reform.** *Kennedy Institute of Ethics Journal* 4(2): 117-146, June 1994.

DeBruin proposes remedies raising both the quality and availability of care and of research for women. Noting that recent policies have helped, she urges the inclusion of more women in clinical studies to achieve a justice that is both distributive and nondistributive, acknowledging “the moral significance of both individuals and social groups.” She thinks that “justice requires that our society adopt a policy of preferential treatment in the

allocation of resources for research in order to remedy the injustices involved in its practices concerning the inclusion of women in clinical studies.”

Fleck, Leonard M. **Just Caring: Oregon, Health Care Rationing, and Informed Democratic Deliberation.** *Journal of Medicine and Philosophy* 19(4): 367-88. August 1994.

Saying that “the need for health care rationing is inescapable, that any rationing process must be public and visible, and that fair rationing protocols must be self-imposed through a process of rational democratic deliberation,” Fleck notes that while Oregon’s plan is flawed, it is a model with “worthy moral lessons,” the most significant being “democratic deliberation in articulating fair rationing protocols for a community.”

Ford, David E., and Kissick, Jon F. **Health Care Financing Reform in the United States: the Community Equity Model.** *Australian Health Review* 18(1): 61-81, 1995.

The authors describe a method of cost-sharing among community health providers and managed care plans that distributes local resources fairly without relying on capital investments from large health care corporations. Calling this model a form of “allocative justice,” Ford and Kissick see the community itself as the “fundholder” and its members as stakeholders accountable for the just delivery of health care within their community.

Garland, Michael J. **Justice, Politics and Community: Expanding Access and Rationing Health Services in Oregon.** *Law, Medicine & Health Care* 20(1 & 2): 67-81, Spring-Summer 1992.

Garland fully explains the steps taken by the state of Oregon to achieve its basic benefits health plan, which covers all citizens. Noting that a primary concern was to avoid unfairness to the poor, he presents various views of justice within the system, which relies on a prioritized list of health services.

Green, John A.; Williams, Christopher, Cribb, Alan; et al. **Fair and Effective Resource Allocation in Cancer Care: Uncharted**

Territory? *Health Care Analysis* 4(1): 19-44, February 1996.

Divided into five sections, the various authors suggest ways to achieve a just distribution of monies for cancer research and care. Noting that cancer affects one in three persons in Western societies, Green reviews the cost effectiveness of existing studies and concludes that unless new treatments provide real advances they should be restricted. Williams thinks there is a paucity of economic data concerning outcomes and that it is necessary to avoid over simplification of QALY tables. Cribb counters by inquiring if it is necessary to be “reasonable,” saying that it is unreasonable to allocate resources on the basis of specific diseases or specific interventions. Brecher comments on the morality of resource allocation, and Evans concludes the discussion by asking how treatment and research can be balanced, ranking present obligations over future obligations.

Hull, Robert. **Distributive Justice and the Minnesota Health Access Initiative.** *Journal of Medical Humanities* 16(2): 93-103, Summer 1995.

Hull thinks that it is the unusual character of health’s instrumental good rather than its intrinsic value that sets it apart from other goods, making it a social good that “society has an obligation to attempt to promote, above some minimum, for all its members. . . . Distributive justice requires that a level of services be defined as a minimum applicable to all and that access to that minimum be universal.”

Kaveny, M. Cathleen. **Distributive Justice in the Era of the Benefit Package: The Dispute Over the Oregon Basic Health Services Act.** In *Critical Choices and Critical Care: Catholic Perspectives on Allocating Resources in Intensive Care Medicine*, ed. Kevin Wm. Wildes, pp. 163-85. Dordrecht, The Netherlands: Kluwer, 1995.

Concerned that the “proponents and opponents [of the Oregon Basic Health Services Act] often seem to be talking past each other,” Kaveny proposes using a matrix of five interrelated factors to provide a broader context for resource allocation

debates. The author observes that the questions involving “values” at Oregon community meetings were inadequate and suggests that incorporating a more robust notion of care in medical programs is not only possible, but also profitable. She concludes with a description of an existing “innovative health care corporation which believes it is possible to combine clinical effectiveness, cost effectiveness and compassion. . .” in the delivery of health care.

Nelson, Robert M., and Drought, Theresa. **Justice and the Moral Acceptability of Rationing Medical Care: The Oregon Experiment.** *Journal of Medicine and Philosophy* 17(1): 97-117, February 1992.

The authors present an overview of Oregon’s health care provisions and say that the “moral acceptability of any rationing scheme” lies in whether the “resource scarcity is justified” and whether it has been “fairly distributed.”

Spielman, Bethany. **Bechtold and the Just Rationing of Experimental Procedures.** In *Health Care Crisis? The Search for Answers*, ed. Robert I. Misbin, Bruce Jennings, David Orentlicher, and Marvin Dewar, pp. 165-78. Frederick, MD: University Publishing Group, 1995.

Citing the works of various bioethicists on informed consent and rationing, the author describes the United States Court of Appeals for the Seventh Circuit’s decision in *Bechtold v. Physicians Health Plan of Northern Indiana, Inc.* wherein the court noted that “the prudent course of action” in allocating experimental procedures would be to have decisions made by “regional cooperative committees.” Spielman reviews the issues involved in having a public task force rule on rationing issues (commonly referred to as the “BECHTOLD proposal”) and suggests criteria by which such panels could be evaluated.

van der Wilt, Gert Jan. **Health Care and the Principle of Fair Equality of Opportunity.** *Bioethics* 8(4): 329-49, October 1994.

The author analyzes three medical cases from the point of view of the debate about their public funding in the Netherlands. He utilizes

Daniels’ fair equality of opportunity account of justice in health care to present moral concerns about public funding and argues for a casuistic use of the concept of fair equality of opportunity.

Veatch, Robert M. **Research on “Big Ticket” Items: Ethical Implications for Equitable Access.** *Journal of Law, Medicine & Ethics* 22(2): 148-51, Summer 1994.

“Justice, at least in its egalitarian form, is generally perceived as requiring the arrangement of social practices so that the benefits redound to the least well-off so to produce greater equality among members of the moral community.” In this article, Veatch concludes that a case can be made for expensive items since they may benefit future generations, particularly when the focus is on the least well off.

IV. International Perspectives

Blank, Robert H. **Rationing Strategies: Lessons from Abroad.** In *Health Care Crisis? The Search for Answers*, ed. Robert I. Misbin, Bruce Jennings, David Orentlicher, and Marvin Dewar, pp. 19 1-99. Frederick, MD: University Publishing Group, 1995.

Noting that all developed nations are facing spiraling medical costs no matter what kind of health care system they have, Blank describes the “core services” approach to cost control developed in New Zealand and the universal access/uniform fees structure found in Japan. The author suggests that the New Zealand model would be much better suited to the U.S. than a single-payer system and that the Japanese fee schedule would be preferable to a prioritized list of services.

Clayton, Matthew G., and Williams, Andrew D. **Subjective Health Assessment and Distributive Justice.** In *Measuring Health and Medical Outcomes*, ed. Crispin Jenkinson, pp. 160-75. London: University College London Press, 1994.

The authors ask how format questionnaires can best “inform judgements concerning the just distribution of scarce public medical resources.” Noting two considerations, that of subjective feeling of well-being and that of individual capability (physical and mental

condition obtained), they indicate their work deals only with the latter consideration. They discuss distributive justice, interpersonal comparison, and “expensive tastes” as indicated by information included in the health survey questionnaire popularly used in England. Clayton and Williams conclude that the objective standard of capability is preferable to that of welfare.

Daniel, Ann E. **Medicine, State and People: A Failure of Trust?** In *Just Health: Inequality in Illness, Care and Prevention*, ed. Charles Waddell and Alan R. Peterson, pp. 191-205. Melbourne: Churchill Livingstone, 1994.

Daniel describes the development of Australia’s national health system and the problems that arose between the professional medical societies and government managers of medical resources. She concludes that “. . . trust [between these two parties] is needed . . . [to ensure] a just and equitable health service adequate to the needs of everyone.”

Grubb, Andrew, and Mehlman, M. J., eds. **Justice and Health Care: Comparative Perspectives.** New York: John Wiley & Sons, 1995. 352 p. [Compilation of articles published in *Health Matrix: Journal of Law-Medicine* volumes 3-4, 1993-1994.]

Addressing a wide range of topics on the distribution of health resources both here and abroad, this collection includes topics such as racism in resource allocation, the rights of children to a greater proportion of health services, and Canadian and British rationing models.

Jecker, Nancy S., and Meslin, Eric M. **United States and Canadian Approaches to Justice in Health Care: A Comparative Analysis of Health Care Systems and Values.** *Theoretical Medicine* 15(2): 181-200, June 1994.

The authors state that the purpose of their study is “to compare and contrast basic ethical values underpinning national health policies in the United States and Canada. . . . In the U.S., standards of justice for health care are conceived as a voluntary agreement reached by self-interested parties. Canadians, by contrast, interpret the same justice tradition as placing greater emphasis on concern for

others and for the community.” Concluding that both countries’ traditions “encompass a rich enough diversity that no single and universal standard of justice can be gleaned,” Jecker and Meslin find a need to “draw creatively and critically upon diverse perspectives to fashion a just society” where basic values form an ethical commitment to health care reform.

McGuire, Alistair; Henderson, John; and Mooney, Gavin. **Distribution.** In their *The Economics of Health Care: An Introductory Text*, pp. 54-73. London: Routledge, 1988.

Citing studies from the National Health Service, the authors delineate the problems involved in democratically distributing medical services across all socioeconomic groups and discuss the justice theories of John Rawls and Norman Daniels as they apply to the formulas used to allocate health care.

O’Neill, Onora. **International Justice and Health Care.** *Bulletin of Medical Ethics* 94: 17-22, December 1993.

O’Neill urges international justice by making decisions to ration health care based on a global view instead of along national lines.

V. Physicians as Gatekeepers

Hall, Mark A. **The Problems with Rule-Based Rationing.** *Journal of Medicine and Philosophy* 19(4): 315-32, August 1994.

Hall thinks that rules are too imprecise for all the nuances in health care and the complexity of medical science. He cites interest group bias and inaccuracy as occurring in rule making and suggests that some combination of bedside judgment and rules would be most workable.

Pellegrino, Edmund D. **Interests, Obligations, and Justice: Some Notes Toward an Ethic of Managed Care.** *Journal of Clinical Ethics* 6(4): 312-17, Winter 1995.

Pellegrino addresses the proper ethical relationship between the obligations of physicians to their patients, with whom they have a covenant of trust, and the obligations physicians incur to a health plan or to society when they sign a contract as a participant. The

author holds that this is “part of the general question of the proper relationship between commutative and distributive justice when they are in conflict.” He concludes ethics and economics must have a “proper relationship” with each other, with ethics defining the right and good and economics the means to “achieve most effectively the ethical ends it [society] chooses.”

Redman, Barbara K. **Clinical Practice Guidelines as Tools of Public Policy: Conflicts of Purpose, Issues of Autonomy, and Justice.** *Journal of Clinical Ethics* 5(4): 303-9, Winter 1994.

The author comments on value-based medical decision making, using as her example women’s health issues and the disproportionate number of men used as subjects in biomedical research. She thinks that the development and use of definite clinical practice guidelines will result in “protection and promotion of the autonomy of patients and providers; and justice in the use of resources.”

Rhodes, Rosamond. **Love Thy Patient: Justice, Caring, and the Doctor-Patient Relationship.** *Cambridge Quarterly of Healthcare Ethics* 4(4): 434-47, Fall 1995.

Rhodes draws on particular cases to illustrate traditional moral theory in medical ethics, noting that justice can be endangered by bad faith. She concludes that both care and justice are “the requirements of conceptualization (i.e., principles and theoretical analysis) and feel that are morality. . . . [T]he justice-care perspective is a more satisfactory foundation for bioethics that the two or three separate alternative approaches that have previously been offered.”

Toon, Peter D. **Justice for Gatekeepers.** *Lancet* 343(8897): 585-87, 5 March 1994.

Under new fundholding practices in the United Kingdom, physicians must consider the morality of gatekeeping, according to Toon, who thinks that they will be unable to avoid being involved in the rationing of care. Toon says that such participation will ignore doctors’ duty to act justly and their need to cultivate the virtue of justice. “Health care

systems should encourage just action and not create temptations.”

VI. Organizational Statements

American Medical Association. Council on Ethical and Judicial Affairs. **Ethical Issues in Health Care System Reform: The Provision of Adequate Health Care.** *Journal of the American Medical Association* 272(13): 1056-62, 5 October 1994.

Taking basic themes from philosophers Beauchamp, Childress, and Daniels, “[i]n this report the Council discusses the ethical foundations of society’s obligation to ensure that none of its members is denied access to adequate health care because of an inability to pay for it. This obligation rests primarily on the belief that a just society affords its members reasonable protection from illness and disability to ensure that they have a fair opportunity to pursue their goals in life.” Saying that “fair procedures” should be followed in the “form of a basic package of benefits,” the Council states “financial restraints” indicate that not all “potentially beneficial health care services can be realistically included in a basic package, some prioritization of health care services must take place.” The report recommends criteria and procedural mechanisms for prioritization, but does not “actually prioritize services.”

Catholic Health Association of the United States. **With Justice for All? The Ethics of Healthcare Rationing.** St. Louis: The Catholic Health Association of the United States, 1991. 41 p.

This booklet lists eight criteria to be used when evaluating rationing proposals. Derived from Catholic social thought, these principles are based on “working for a common good; respect for human dignity; a ‘preferential option for the poor;’ and responsible stewardship of the resources necessary to sustain life.”

VII. Early Works

Beauchamp, Tom L., and Walters, LeRoy. **Contemporary Issues in Bioethics.** Belmont, CA: Wadsworth, 1978. 612 p.

Now in its fourth edition (1994), this

collection of essays contains a section on justice in the distribution of health care.

Beauchamp, Tom L., and Childress, James F. *Principles of Biomedical Ethics*. New York: Oxford University Press, 1979. 314 p.

The fourth edition (1994) of this textbook contains a section on theories of justice and resource allocation.

Blank, Robert H. *Rationing Medicine*. New York: Columbia University Press, 1988. 290 p.

Callahan, Daniel. *Setting Limits: Medical Goals in an Aging Society*. New York: Touchstone/Simon and Schuster, 1987. 256 p.

Churchill, Larry R. *Rationing Health Care in America: Perceptions and Principles of Justice*. Notre Dame, IN: University of Notre Dame Press, 1987. 180 p.

Daniels, Norman. *Just Health Care*. Cambridge: Cambridge University Press, 1985. 245 p.

Menzel, Paul T. *Strong Medicine: The Ethical Rationing of Health Care*. New York: Oxford University Press, 1988. 234 p.

Ramsey, Paul R. **Scarce Medical Resources**.

Notes. *Columbia Law Review* 69(6): 620-72, April 1969.

U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services*. Volume Two. Washington, Government Printing Office, 1983. 305 p.

Justice issues are discussed in the appendices of Volume Two (Sociocultural and Philosophical Studies) by Dan W. Brock, Allen Buchanan, Norman Daniels, and Daniel Wikler, among others.

Veatch, Robert M. *A Theory of Medical Ethics*. New York: Basic Books, 1981. 387 p.

Veatch, Robert M. *The Foundations of Justice: Why the Retarded and Rest of Us Have Claims to Equality*. New York: Oxford University Press, 1986. 210 p.

This Scope Note was prepared by Pat Milmoie McCarrick M.L.S., and Martina Darragh, M.L.S., Reference Librarians at the National Reference Center for Bioethics Literature.