JUSTICE AND RIGHTS TO HEALTH CARE

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We are facing a health-care crisis; in 1988, U.S. health-care expenditures amounted to $496.6 billion, or 11.2% of GNP. Further studies suggest that, if current trends continue unabated, U.S. health-care expenditures will consume an even larger percentage of GNP by the year 2000, $1.6 trillion or 16.4%.[1] Another figure mentioned is that health-care costs will "consume 17% of GNP by the year 2000—more than the current shares of education, defense, and recreation combined."[2]

In the face of this crisis, the debate over entitlements to health care continues. In this paper I want to consider one contribution to the debate, Norman Daniels's fair equality of opportunity argument for justice in health care. Daniels has argued that people have "rights and entitlements [to health care that are] defined within a set of basic institutions governed by the fair equality of opportunity principle."[3] I shall briefly explicate and criticize Daniels's argument, identifying where it fails. In addition, I shall advance an argument for a right to a just minimum of health care; this right, I will argue, can be derived from David Gauthier's theory of justice as articulated in his *Morals by Agreement* .

Norman Daniels attempts to argue for the aforementioned rights and entitlements by extending the Rawlsian principle of fair equality of opportunity so that health-care institutions would be included among the basic institutions falling under the principle. He argues, first, that health care is a "*special* social good" (Daniels, 56) because of its limited role in maintaining species-typical normal functioning. He then argues that impairment of such functioning has an adverse impact on one's normal opportunity range,

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where a normal opportunity range is defined as "the array of life plans reasonable persons in [a society] are likely to construct for themselves" (Daniels, 33). Because disease and illness are like lack of talent and/or skill, in that they adversely affect the range of opportunities one may have in a modern liberal-democratic society, one should not be denied access to the full scope of one's normal opportunity range simply on the basis of the "natural disadvantages induced by disease" (Daniels, 46). Finally, assuming that justice requires guaranteeing fair equality of opportunity, Daniels concludes that health-care institutions should be among those basic institutions which are governed by a principle that will guarantee fair equality of opportunity. He says:

> I urge the fair equality of opportunity principle as an appropriate principle to govern macro decisions about the design of our health-care system. Such a principle defines, from the perspective of justice, what the moral *function* of the health-care system must be—to help guarantee fair equality of opportunity. This is the fundamental insight underlying the approach developed here. (Daniels, 41)

Daniels buttresses this part of his argument with the argument that, in order to generate the conclusion that health care is a special social good, we need a theory of health-care needs. Health-care needs, he tells us, are "those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning" (Daniels, 32). The theory of health-care needs on which Daniels relies is Christopher Boorse's biomedical model.[4]

Daniels-cum-Boorse's account of the biomedical model is that "health is the absence of disease, and diseases (I include deformities and disabilities that result from trauma) are *deviations from the natural functional organization of a typical member of a species*" (Daniels, 28; italics in original). The list of needs Daniels includes under health-care needs is substantial: (1) adequate nutrition, shelter; (2) sanitary, safe, unpolluted living and working conditions; (3) exercise, rest, and some other features of life style; (4) preventive, curative, and rehabilitative personal medical services; (5) nonmedical personal and social support services (Daniels, 32). These needs can be met, Daniels argues, by a four-tier system of health-care delivery which he goes on to describe.

While Daniels's argument does not guarantee a universal individual right to health care, it does guarantee that we would have those "rights and entitlements [to health care that are] defined within a set of basic institutions governed by the fair equality of opportunity principle" (Daniels, 54). These basic institutions—essentially Daniels's four-tier system—are, on his account, necessary to provide what a theory of justice in health care

requires if our general theory of distributive justice guarantees that we are to have fair equality of opportunity.

While Daniels's argument may be related to that of Rawls, there are important differences, especially concerning the fair equality of opportunity principle. Rawls argues extensively for his fair equality of opportunity principle: it is a principle of distributive justice that would be chosen by free, rational, equal, and mutually disinterested agents behind a veil of ignorance. On Daniels's account, the fair equality of opportunity principle is assumed at the outset. Thus, it is worth noting that Daniels's argument is a conditional argument. This is important for at least two reasons. First, alternative theories of justice—for example, those advanced by Nozick and Gauthier—may not include fair equality of opportunity as a principle of justice. And second, Daniels's reliance on the principle of fair equality of opportunity is deeply problematic, for, as I shall argue shortly, health care does not necessarily lead to an increase in one's normal opportunity range.

Another difference between Rawls's and Daniels's accounts of fair equality of opportunity is that the scope of opportunity Rawls had in mind is much narrower than the scope Daniels has in mind. Rawls's conception of fair equality of opportunity relates to the likelihood one has in a just society of securing one of the better positions that society has to offer. Daniels's conception is much broader in the sense that it relates to the likelihood one has in a just society of actualizing any one of the "array of life plans reasonable persons are likely to construct for themselves" (Daniels, 33). Given that Daniels's conception is much broader than Rawls's, then, as Lawrence Stern notes and Allen Buchanan reiterates,[5] "Daniels' FEO [fair equality of opportunity] requires promoting equality in more areas of life than Rawlsian FEO."[6] The promotion of equality in more areas of life is problematic, for, if it cannot be constrained, society may find itself attempting to meet all health-care needs in the name of fair equality of opportunity. Any such attempt would place us on the edge of a "bottomless pit" that has the potential to consume not only our health-care budget but all of society's resources.

There are, however, more substantial objections that can be raised against Daniels's argument. The most compelling objection is that, *pace* Daniels, his argument results in a narrowing of the range of opportunity that people would otherwise have. Presumably, on his account, the money for funding health care would be raised through taxation. Either the money raised through taxation would be sufficient to meet annual health-care expenditures or it would not. If it was sufficient, then people would have less money to spend on their other non-health-care preferences. This assumes, of course, that people have limited resources such that they cannot satisfy all their preferences. If people have less money to spend on their other non-health-care preferences, then they will be unable to satisfy those preferences. And if one's opportunity range is related to these non-

health-care preferences, then, to the extent that one cannot satisfy one's preferences, one's opportunity range has been restricted.

If the money raised through taxation was insufficient to meet the annual health-care budget, then, presumably, the remaining funds would be raised through deficit financing, or raising the national debt. If this were the case, then, while the opportunity range of the present generation might not be narrowed, the opportunity range of some future generation or generations would be narrowed (on the assumption that deficit financing cannot be continued indefinitely). Thus, on either account, we would end up with a narrowing of opportunity ranges, either the ranges of the present generation or the ranges of some future generation or generations.

Daniels defines the concept of a normal opportunity range as "the array of life plans reasonable persons in [a society] are likely to construct for themselves" (Daniels, 33). My preceding argument rests on this same definition. The life plans reasonable persons in a society are likely to construct for themselves are just those plans that people make with respect to educating themselves, choosing a career, having a family, providing for their children's education, and providing for their retirement. If the amount that people are taxed to fund health care is greater than the amount that they would have voluntarily spent on health care (e.g., by purchasing insurance), then they will have less money to spend on these other areas, and hence will have a narrower range of opportunities.

The next objection to Daniels's argument is that his reason for tying health care to the principle of fair equality of opportunity is arbitrary and unsubstantiated. Daniels first argues that health-care needs reflect dissimilarities in natural differences, not social differences. He then argues that the notion of species-typical normal functioning, in conjunction with access to health care, can be used to solve the problem of these natural differences and thus leave everyone equal with respect to their normal opportunity range. But the different exceptional talents that people are born with are also the result of natural differences and not social differences; that is, they are deviations from the norm of species-typical normal functioning. If deviations from this norm are the baseline for determining if positive measures ought to be taken with respect to guaranteeing access to one's normal opportunity range, then the same should apply to differences in natural talents. But Daniels does not attempt to rectify the inequality that exists between people with different exceptional talents. He says, on the one hand: "But if it is important to use resources to counter the advantages in opportunity some get in the natural lottery, it is equally important to use resources to counter the natural disadvantages induced by disease"; and, on the other hand, that "this does not mean that we are committed to the futile goal of eliminating or 'levelling' all natural differences between persons" (Daniels, 46). Since he offers no reason to explain why the disadvantages one has from disease are more important than the disadvantages one

has from not having been born with exceptional talents, his reason for tying health care to the principle of fair equality of opportunity is purely arbitrary and therefore unsubstantiated.

The third objection to Daniels's argument is also related to the notion of deviations from species-typical normal functioning. While it is true that some of the differences between people with respect to their health-care needs are natural differences, not all of them are. For some differences in health-care needs are self-inflicted. Thus, Daniels must either exclude those health-care needs which are self-inflicted from being covered under his fair equality of opportunity argument, or allow some people to free-ride on their more health-conscious neighbors. Daniels notes that there is "nothing in [his] view [that] makes health protection *so* overriding a concern that we may deny individuals the autonomy to take risks that endanger life, liver, and lungs" (Daniels, 153). Therefore, while he may not endorse high-risk activity, he permits it, as he should; but the people who engage in such activities are not made to pay the costs that result. The problem is not simply that people engage in high-risk activities, thereby increasing the costs all must pay, although this is important. Rather, the problem is that there is no means available to Daniels's theory that could limit the number of people engaging in such high-risk activities.

I now want to consider an alternative approach to guaranteeing a universal right to a just minimum of health care. This approach will rest on certain key concepts of David Gauthier's theory of justice: the notion that society is a cooperative venture for mutual advantage; Gauthier's interpretation of Locke's proviso; the right to compensation if one's rights have been unjustifiably violated and/or if one's liberties have been unjustifiably restricted; and Gauthier's principle of distributive justice, minimax relative concession. I will begin by briefly explicating each of these concepts and then show how they can be used to derive a universal right to a just minimum of health care.

As a contractarian, Gauthier, like Rawls, endorses the idea that society is a "cooperative venture for mutual advantage among persons conceived as not taking an interest in one another's interests."[7] The rationale for agreeing to enter such a society is straightforward; a society, "analyzed as a set of institutions, practices, and relationships" (Gauthier, 11), that can guarantee that each of its members will benefit from entering it, as compared to what each could expect from remaining in a Hobbesian state of nature, is one that is sure to have the voluntary support of its members. If such a society is possible, then there must be a set of conditions under which each person would voluntarily agree to enter into it.

In Gauthier's case, the agreement to enter such a society is a hypothetical agreement, not an actual agreement. Furthermore, the set of individuals who are parties to this hypothetical agreement does not include everyone. Gauthier explicitly excludes animals and those who cannot

contribute to the cooperative enterprise (Gauthier, 268). The people who are parties to the hypothetical agreement are highly idealized agents; that is, they are conceived to be rational in the sense that they are concerned to maximize their expected utility, and they are fully informed with respect to each other's utility function. In addition, Gauthier assumes that bargaining is cost free.

Once armed with these assumptions, Gauthier's task is fivefold. (1) He must tell us what it is that people would agree to. (2) He must demonstrate why these highly idealized agents would agree as he says they would. (3) He must demonstrate why it would be rational for people so conceived to keep their agreement. For while it may be rational to make an agreement, it may not be rational to comply with it once the conditions under which the original agreement was made change. A simple example will illustrate the nature of this problem—typically referred to as the compliance problem. Suppose we each find it rational to help each other harvest our crops at the end of the season and agree to do so. However, while it may be rational to agree to help you harvest your crop after we have harvested mine, once my crop is harvested my expected utility will be maximized if I now defect rather than keep the agreement. (4) Gauthier must supply a principle for governing the distribution of the cooperative surplus, or the benefits of cooperation. If people cannot reach agreement on such a principle, then they will not cooperate. However, prior to reaching agreement concerning a principle of distribution, Gauthier must first specify the initial bargaining position; he must specify what assets the bargainers are allowed to bring to the bargaining table. Unless people reach agreement on this issue, either there will be no other agreement or any agreement reached will be unstable.

With respect to (1), Gauthier argues that these highly idealized agents would agree to impartial constraints on the pursuit of individual utility-maximizing behavior. With respect to (2) and (3), he argues that they would agree to such self-imposed constraints and keep their agreements because doing so would maximize each person's expected utility. With respect to (4), he argues that rational agents would agree to the principle of minimax relative concession to govern the distribution of the cooperative surplus; that is, when bargaining over distribution, each agent would agree to make a concession no larger than the concession any other agent would make. In other words, rational agents would agree to minimize their maximum relative concession. Finally, Gauthier's solution to the problem of defining the initial bargaining position is the noncooperative outcome constrained by Gauthier's interpretation of Locke's proviso; that is, each agent brings to the table those assets he would have in the absence of the others.

Locke originally conceived of the proviso as one of the conditions that must be satisfied in the state of nature if one is to acquire a claim right to private property. He argued that one could acquire such a right

provided, among other things, that there was "enough, and as good left" in common for others.[8] Robert Nozick, like Locke, was concerned to provide an argument for the original acquisition of property and thus substantiate his entitlement theory of justice. He interpreted Locke's proviso to mean that "the situation of others is not worsened."[9]

Given that Gauthier is concerned to provide an argument not merely for a claim right to property but also for the claim right to one's original factor endowments—that is, the natural assets one is born with—he finds Nozick's interpretation of Locke's proviso to be too demanding. He argues that Nozick's interpretation may require one to worsen one's own situation so as to avoid worsening the situation of others. Locke held, and Gauthier agrees, that preserving one's own life is more important than preserving the life of another. Hence, Gauthier modifies Nozick's interpretation to allow one to preserve one's own life. Gauthier interprets Locke's proviso so that it "prohibits bettering one's situation through interaction that worsens the situation of another" (Gauthier, 205).

An example will help illustrate this. Imagine that someone is drowning in a lake. Suppose further that his being in the lake came about in one of two ways: I could have pushed him in, or he could have accidentally fallen in. If I pushed him in and then fail to rescue him, I have worsened his situation, for he would have been better off had I been absent. If he accidentally fell in and if I should happen to pass by and ignore his cries for assistance, then, while I may have failed to better his situation, I have not worsened it. For the outcome he could expect, by my passing by and not saving him, is the same outcome he could expect if I had not come along. Thus, on Gauthier's account, the base point for determining whether one is made better or worse off is determined by the outcome one could expect in the absence of another.

Rational agents, Gauthier argues, would only consider approaching the bargaining table if they knew that what each initially brought to the table had been acquired fairly—that is, if they knew that neither of the players would have been placed at a strategic disadvantage by the coercive efforts of the other. If an initial acquisition were unfair, then the bargaining situation itself would be contaminated such that any outcome would be unfair. This would lead to problems with compliance and hence to social instability. But if the prebargaining baseline is the noncooperative outcome constrained by Gauthier's proviso, then, since no one would have bettered his situation through interaction that worsened the situation of the other, each party could bring to the bargaining table what he could make use of "in the absence of his fellows" (Gauthier, 209). In the absence of his fellows, each person could only make use of his natural factor endowments, his physical and mental capacities. In the drowning example, where the person accidentally fell into the water, in the absence of all others, he could expect to drown. Thus, the first step in Gauthier's derivation of claim rights

to one's own person is that the noncooperative outcome, constrained by his proviso, "gives each person [an] exclusive [claim] right to the use of his body and its powers, his physical and mental capacities" (Gauthier, 210).

There are three other steps in Gauthier's derivation of rights and liberties, but for my purposes I need not explicate them here. What is important for my purposes is that people have rights and liberties and that there are certain consequences which follow if these are unjustifiably violated or restricted. If a person's liberties are restricted and if the justification for restricting them fails to satisfy Gauthier's proviso, then the liberty-restriction is unjustified. If the liberty-restriction does not violate Gauthier's proviso, then it is justified. Under Gauthier's theory of justice, people who have their liberty unjustifiably restricted are owed compensation (Gauthier, 212-16).

While several justifications have been advanced to justify the restriction of people's liberty—the offense principle, the principles of weak and strong paternalism, the principle of legal moralism, and the social-welfare principle[10]—Mill's harm principle is the only one that does not violate Gauthier's proviso. Mill argued that we may justifiably allow the restriction of a person's liberties in order to prevent him from harming another.[11] Harming someone is worsening his situation and therefore is in direct violation of Gauthier's proviso. Since restricting someone's liberty in order to prevent him from harming another is not in violation of Gauthier's proviso, no compensation need be paid to the person whose liberty is thus restricted.

However, suppose we restrict someone's liberty, not to prevent him from harming someone, but rather so that some other person will benefit. Would such a restriction violate Gauthier's proviso? If so, then compensation must be paid to the person whose liberty is restricted. If not, then compensation is unnecessary. For example, consider the social-welfare principle, which says that we are justified in restricting someone's liberty in order to benefit others. If my liberty is restricted so that others may benefit, then I am worse off than I would be in the absence of these others; therefore, Gauthier's proviso is violated, and, in order to rectify the injustice, I deserve to be compensated.

Under Gauthier's theory, unjustifiable rights-violations or liberty-restrictions call for market compensation, rather than full compensation, since full compensation may be less than what one could have obtained through voluntary exchange. If a rights-violator paid only full compensation, when full compensation was less than market compensation, then Gauthier's proviso would be violated; that is, the rights-violator would have benefited himself by worsening the situation of the person whose rights were violated. However, if full compensation is greater than market compensation, as it sometimes is, then full compensation must be paid, for otherwise, again, the malefactor would be benefiting himself by worsening the other's situa-

tion.

For example, suppose you restrict my liberty to engage in voluntary cooperation with another and, further, that you do so with the intention of compensating me for my loss. If you gave me only full compensation for my loss, and this was less than what I could have received by engaging in voluntary cooperation with someone else, then I have been made worse off than I would have been in the absence of your restricting my liberty. You would have violated Gauthier's proviso. However, if you paid me market compensation—that is, what I would have received had I cooperated with the other person—then I would be as well off as I could have been had my liberty not been restricted. In other words, if you do not pay me market compensation, then I am precluded from receiving any part of the benefits you obtained from restricting my liberty.

That people have rights and liberties, and that unjustifiable violation/restriction of these requires market compensation, is important in determining what constitutes justice in health care. But justice in health care need not, at least according to Gauthier's theory, guarantee a right to health care—though it may in fact do so. Prior to determining how such a right might be guaranteed, we must first consider what Gauthier's conception of essential justice demands with respect to people having the liberty to engage in fully voluntary cooperation.

A society operating within the conceptual and normative framework of Gauthier's theory is, to use his term, an "essentially just society." Such a society, Gauthier argues,

> affords its members the opportunity to enjoy the intrinsic value of participation. But it does this, not by imposing any participatory structures, but by freeing persons from the barriers to fully voluntary cooperative interaction. We have indeed claimed that rational persons would accept the perfectly competitive market where conditions make perfect competition, or a near approximation thereto, feasible. But an essentially just society does not impose the market on its members; it does, however, remove what might be barriers to it, both in enforcing the proviso and punishing force and fraud, and in rejecting compulsory social practices and institutions that embody any substantive goal. An essentially just society can neither ban nor require capitalist acts among consenting adults. (Gauthier, 341)

Under Gauthier's theory, people have a claim right to their person and property; that is, they are morally entitled to their initial factor endowments and whatever property they obtain without violating his proviso. Moreover, people are entitled to the full exercise of their liberty insofar as they are not under a duty to refrain from performing some particular

action; that is, they are entitled to engage in any action not prohibited by his proviso. If people are entitled to exercise their liberty, then they are entitled to care for their own health to the best of their knowledge and ability, so long as they do not violate the proviso. They are also entitled—again, short of violating the proviso—to seek out others to assist them in caring for their own health.

As things now stand in both Canada and the United States, people's liberty to meet their own health-care needs is restricted, for the medical professions of both countries have a monopoly on the practice of medicine. This monopoly, since it deviates from what would take place in a free market, is either justified or unjustified.

Kenneth Arrow has argued that the medical profession's monopoly is justified owing to the uncertainty associated with the incidence of disease and the efficacy of treatment.[12] I will not concern myself here with whether Arrow's argument is successful.[13] For, as I shall argue, people will be entitled to a just minimum of health care whether the medical profession's monopoly is justified or not.

Let us assume, for the sake of argument, that the medical profession's monopoly on the delivery of medical care is indeed justified. If it is, then that is to say that this nonmarket system is Pareto-superior to a free market system—there are benefits obtained from the medical profession having a monopoly that are not obtainable from a free market system. If there are such benefits to be obtained, then—since each person's liberty to care for her own medical needs has been justifiably restricted—each is entitled to her fair share of the benefits that arise from the monopoly. Under Gauthier's theory of justice, each person's fair share of these benefits is determined by the principle of minimax relative concession. Since each person's liberty has been equally restricted, each is entitled to an equal share of the benefits. The share that each person is entitled to is a just minimum of health care.

Let us now assume that the medical profession's monopoly is not justified. If it is not, then people's liberty to provide for their own health-care needs has been unjustifiably restricted. Under Gauthier's theory, if people's liberties have been unjustifiably restricted, in violation of his proviso, then they are owed market compensation. The compensation that people are owed as a result of this unjustified restriction of their liberty is also a just minimum of health care.

The argument for compensation is not an argument for being compensated for past unjustified restrictions of one's liberty, but rather an argument for the present injustice of unjustifiably having one's liberty restricted. This assumes, of course, that the medical profession's monopoly is indeed an unjustified restriction of liberty. Be that as it may, this will not detract from the overall conclusion which I am arguing for. That is, the medical profession's monopoly is either justified or not. If it is, then people

are entitled to their fair share of the benefits that result from it. If it is not, then people are entitled to market compensation for the unjustified restriction of their liberty. In either case, people are entitled to some medical care, and whatever it amounts to, it is a just minimum to which everyone is entitled.

I now want to explore a third alternative which would also guarantee a just minimum of health care. Let us imagine that the medical profession did not have a monopoly on the practice of medicine. If this were the case, then people would have three options available to them: they could attempt to meet their own health-care needs to the best of their ability and knowledge; they could seek out other nonphysician practitioners to assist them in meeting their health-care needs; or they could seek out physicians to assist them in meeting their health-care needs. Since their liberty has not been restricted, they would be entitled to that amount of health care they could obtain by exercising any one of these three options. The amount of health care they did obtain from exercising any of these options would also be a just minimum of health care to which all would be entitled.

The importance of having the liberty to meet one's health-care needs by using one's own knowledge and abilities and/or seeking out other nonphysician practitioners of medical care should not be underestimated. Not only would such an exercise of liberty not be in violation of Gauthier's proviso, but also, as some have argued, "90% of patient contacts with the health care system are for the management of chronic conditions."[14] Since the treatment of chronic conditions requires less physician contact than the treatment of acute ones, this suggests that physicians are not nearly as necessary for the delivery of health care as we once might have thought.

Moreover, several recent studies in the United States have demonstrated that some nonphysician health professionals, specifically nurse practitioners and physician assistants, can make significant contributions to providing care. In analyzing seventeen studies conducted in the United States from the mid-1960s to 1980, Jane Cassel Record et al. found that 80% of office visits for adult care and 90% of office visits for pediatric care could safely be delegated to nurse practitioners and/or physician assistants.[15] The quality of care actually provided by these nonphysician health professionals was found to be "at least as high as the care rendered by physicians," and patients were just as satisfied with the care received from nurse practitioners and physician assistants as they were with physicians' care.[16]

In addition, as noted in a recent *JAMA* editorial, "there seems to be little relationship between the percentage of gross national product spent on medical and health care and the extent of improvements in expected life span."[17] In graphs comparing life expectancy with the percentage of GNP spent on health care in the United States, George D. Lundberg observes that the major gains in life expectancy occurred when health-care expenditures were at their lowest. According to Lundberg's graphs, average life

expectancy in the U.S. has risen from 49 in 1900 to 77 in 1990. But the major part of that increase (from 49 to 72) occurred before 1960, during a period when the portion of GNP spent on health care was between 3% and 5.5%. That is to say, the major part of the increase in life expectancy came *before* the sharp increases in health-care expenditures that began in the 1960s. Between 1960 and 1990, as the portion of GNP spent on health care rose from 5.5% to 12.5%, life expectancy rose only from 72 to 77.[18]

In a study that sought to determine the impact of medical services on health status, using data for 1963 and 1970, Benham and Benham concluded that "positive increments in nonobstetric medical services for adult population groups from 1963 to 1970 did not lead to improvements of health."[19] This study is important not only for the conclusion drawn, but also because part of the data comes from the mid-sixties, a period after Medicaid and Medicare (a kind of decent-minimum project) were implemented in the United States.

There is further evidence that current and past expenditures on health care in this country, and in others, has had little impact on mortality. In making this claim, one must, of course, draw a clear distinction between "clinical practice on the one hand and the larger responsibilities of medicine as an institution on the other."[20] Thomas McKeown, after studying the decline in mortality rates in several countries since the end of the seventeenth century, concluded that the decline was "due predominantly to a reduction of deaths from infectious diseases" (McKeown, 45).

With respect to noninfectious diseases as a cause of death in the eighteenth, nineteenth, and twentieth centuries, McKeown concluded that "the contribution of clinical medicine to the prevention of death and increase in expectation of life in the past three centuries was smaller than that of the other influences" (McKeown, 91). He judges improvements in nutrition as being the most important, and also states that improvements in public hygiene accounted for at least one-fifth of the reduction of the death rate between the mid-nineteenth and mid-twentieth centuries. Vaccinations—with the exception of the smallpox vaccine, "whose contribution was small" (McKeown, 78)—and medicines made little contribution until sulfonamides were introduced in the mid-1930s. Changes in reproductive practices were also very significant, McKeown argues, for they "ensured that the improvement in health brought about by other means was not reversed by rising numbers" (McKeown, 78). In a later study, McKeown reached basically the same conclusion: "[I]t is most unlikely that personal medical care had a significant effect on the trend of mortality in the eighteenth and nineteenth centuries."[21]

In another recent study of the decline in mortality in the United States since 1900, it was found that the vast majority of the decline occurred before the mid-sixties explosion of health-care expenditures, or in the words of the authors of the study: "*It is evident that the beginning of*

the precipitate and still unrestrained rise in medical care expenditures began when nearly all (92 percent) of the modern decline in mortality this century had already occurred" (see Figure 1).[22] Markowitz et al. argue that the general decline in mortality in the late nineteenth century, which was due to "various sanitary reforms, antitoxins, protective sera and increased education," was responsible in part for the medical reform movement of the era, for physicians were worried that "the actual need for the physician would decline."[23]

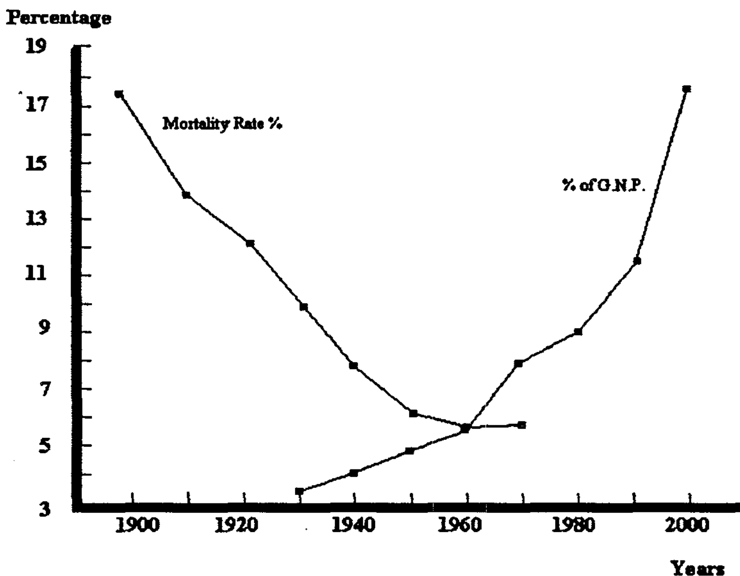

Figure 1: *Percentage Decline in Age & Sex Adjusted Mortality Rates Compared with Percentage of U.S. GNP Spent on Health Care*

Three additional studies concluded basically the same thing: "For most of history, medical care has been irrelevant in the determination of aggregate social indices whatever comfort it may have brought to particular individuals";[24] and "indeed, from a historical standpoint, nutritional improvement, establishment of sanitary control and the spread of educational achievement in industrialized nations have been clearly more significant for improving the health of nations (particularly in the reduction or postponement of mortality) than medical delivery has been";[25] and "the marginal contribution of medical care to life expectancy, holding the state of the art constant, is also very small. Improvements in medical science (primarily new drugs), however, have had significant effects during the period 1930-

60."[26] In addition to these general observations, the leading causes of death in the United States and Canada are causes for which the physician can offer only palliative care. In both the U.S. and Canada, the four leading causes of death, in order, are heart disease, cancer, cerebrovascular diseases (principally strokes), and accidents.

A recent study on the impact of medical care on mortality in Canada, despite almost all of the provinces having had some degree of national health insurance throughout the course of the study, from 1958 to 1988, and despite "spectacular gains in utilization"[27] during the years studied, could only conclude that "medical care *probably* had an important impact on changes in mortality rates from amenable diseases."[28]

The evidence presented, while perhaps not conclusive, certainly does give one cause to be skeptical about the overall contribution of the institution of medicine to life expectancy and the decline in mortality rates, especially given the physicians' monopoly on the practice of medicine. Furthermore, if the aforementioned studies withstand critical scrutiny and if, as I have argued, people are indeed entitled to a just minimum of health care, then the minimum they are entitled to should be sufficient to meet most of their health-care needs. On the other hand, even if further investigations did reveal that medicine's overall contribution to increases in life expectancy and decreases in mortality were more than the aforementioned studies suggest, the burden of proof for demonstrating that people have a right to more than a just minimum now lies on the shoulders of others.

1. Sally T. Sonnefeld et al., "Projections of National Health Expenditures through the Year 2000," *Health Care Financing Review,* vol. 13, no. 1 (Fall 1991), p. 1.

2. Lee Smith, "A Cure for What Ails Medical Care," *Fortune,* July 1, 1991, pp. 44-49.

3. Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985), p. 54; subsequent page references will be given parenthetically in the text.

4. Cf. Christopher Boorse, "On the Distinction Between Disease and Illness," in *Medicine and Moral Philosophy: A Philosophy & Public Affairs Reader* , ed. M. Cohen, T. Nagel, and T. Scanlon (Princeton: Princeton University Press, 1981), pp. 3-22.

5. Allen E. Buchanan, "The Right to a Decent Minimum of Health Care," *Philosophy & Public Affairs*, vol. 13, no. 1 (Winter 1984), pp. 63-64.

6. Lawrence Stern, "Opportunity and Health Care: Criticisms and Suggestions," *Journal of Medicine and Philosophy*, vol. 8, no. 4 (Nov. 1983), p. 340. For Daniels's response to Stern, see Daniels, "A Reply to Some Stern Criticisms and a Remark on Health Care Rights," *Journal of Medicine and Philosophy*, vol. 8, no. 4 (Nov. 1983), pp. 363-71.

7. Cf. David Gauthier, *Morals by Agreement* (Oxford: Clarendon Press, 1986), p. 10; see also John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971), pp. 4, 13; subsequent references to these books will be given parenthetically in the text.

8. John Locke, *Two Treatises of Government* , ed. P. Laslett (Cambridge: Cambridge University Press, 1965), ch. 5, par. 33.

9. Robert Nozick, *Anarchy, State, and Utopia* (New York: Basic Books, 1974), p. 175.
10. Cf. Joel Feinberg, *Harm to Self* (Oxford: Oxford University Press, 1986), ch. 19.
11. John Stuart Mill, *On Liberty and Other Essays*, ed. J. Gray (Oxford: Oxford University Press, 1992), p. 14.
12. Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* , vol. 53, no. 5 (Dec. 1963), pp. 941-73. For a response to Arrow, see Dennis S. Lees and Robert G. Rice, "Uncertainty and the Welfare Economics of Medical Care: A Comment," *American Economic Review* , vol. 55, no. 1 (March 1965), pp. 140-54. See also Arrow's response to Lees and Rice: Arrow, "Uncertainty and the Welfare Economics of Medical Care: Reply (The Implications of Transaction Cost and Adjustment Lags)," *American Economic Review* , vol. 55, no. 1 (March 1965), pp. 154-58.
13. See my "A Just Minimum of Health Care," Ph.D. Dissertation, Bowling Green State University, 1993, ch. 6.
14. William Barnhill, "Canadian Health Care: Would It Work Here?" *Arthritis Today*, November/December, 1992, p. 43. In addition, one should note that this 90% figure is in accord with other sets of figures: for example, only 11.5% of the population is hospitalized each year, and 15% of those hospitalized consume some 55% of hospital expenditures. (Natalie Gagner, "Where Does the Medical Dollar Go?" *American Medical News*, July 20, 1992, p. 26. This observation is seconded by Uwe Reinhardt when he notes that "in any given year, some 70 to 80% of health care expenditures tend to be caused by only about 10% of the population. Cf. Uwe E. Reinhardt, "Resource Allocation in Health Care: The Allocation of Lifestyles to Providers," *Milbank Quarterly* , vol. 65, no. 2 [1987], p. 169.) And, as Canadian and American demographers inform us, the population will age as the baby-boom generation begins to retire in the next fifteen to twenty years. An aging population will only reinforce these figures, for the elderly consume a disproportionate share of health-care expenditures. (Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* [New York: Simon & Schuster, Inc., 1987], pp. 225-28.)
15. Jane Cassel Record et al., "New Health Professionals after a Decade and a Half: Delegation, Productivity, and Costs in Primary Care," *Journal of Health Politics, Policy, and Law*, vol. 5, no. 3 (Fall 1980), p. 478.
16. Dorothy Robyn and Jack Hadley, "National Health Insurance and the New Health Occupations: Nurse Practitioners and Physicians' Assistants," *Journal of Health Politics, Policy, and Law*, vol. 5, no. 3 (Fall 1980), p. 450.
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20. Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (Princeton: Princeton University Press, 1979), p. 191; subsequent references to this book will be given parenthetically in the text.
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22. John B. McKinlay and Sonja M. McKinlay, "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century," *Milbank Memorial Fund Quarterly* , vol. 55, no. 3 (Summer 1977), p. 414; emphasis in original. The graph in Figure 1 extends the McKinlays' graph (p. 415) by including the most recent figures for American health-care expenditures.
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25. Mark Perlman, "Economic History and Health Care in Industrialized Nations," in *The Economics of Health and Medical Care*, p. 21.
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27. Morris L. Barer and Robert G. Evans, "Riding North on a South-Bound Horse? Expenditures, Prices, Utilization, and Incomes in the Canadian Health Care System," *Medicare at Maturity: Achievements, Lessons, and Challenges*, ed. R. G. Evans and G. L. Stoddart (Calgary: University of Calgary Press, 1986), p. 83.
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