DEFINING THE MEDICAL SPHERE

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ABSTRACT

Part of the debate on cost containment in health care systems can be characterized as applied political philosophy. Three philosophical directions can be traced. (1) Norman Daniels and Ronald Dworkin advocate a health care distributional system based on a Rawls' *A Theory of Justice*. (2) Tristram Engelhardt defends a market based approach, reminiscent of Nozick's *Anarchy, State, and Utopia*. (3) Daniel Callahan advocates a communitarian strategy which resembles the work of Christopher Lasch and Robert Bellah. In the first part of this article these three strategies will be discussed.

Occasionally health care philosophers also refer to Michael Walzer's *Spheres of Justice*. However, no one has undertaken the task to design a health care distributional system style Michael Walzer. According to the author this is to be regretted. Walzer argues that Americans ought to establish a health care system resembling the British National Health Service, because the concepts and categories in which they discuss the distribution of medical goods, as well as established institutions such as Medicare and Medicaid, reveal that they have been committed to something akin to the NHS all along. Walzer's critics point out that a large part of medical goods in the United States is bought and sold on the market. Why should the institution of private health care insurance not be taken as evidence that a straightforward market system is what Americans have wanted in their heart of hearts? In the second part of this article it will be argued that the controversy between Walzer and his critics is based on a serious mistake in *Spheres of Justice*. Once this mistake has been rectified Walzer's theory of justice might be a fruitful approach to the discussion of cost containment in health care services.

1 INTRODUCTION

Part of the debate on cost containment in health care systems may be characterized as applied political philosophy. One might say that the current debate between competing theories of justice that started with Rawls' *A Theory of Justice* in 1971[1], has acquired a small sister debate in health care philosophy. Major participants in the debate on social justice have become an important source of inspiration for bio-ethicists interested in a just distribution of health care resources. Thus Rawls' *A Theory of Justice* has been remodelled for health care philosophy by Norman Daniels. Nozick's libertarian manifesto *Anarchy, State, and Utopia*[2] has been used for bio-ethical purposes by H. Tristram Engelhardt. The books of Daniel Callahan evidently belong to a family of communitarian theories, though Callahan cannot be said to follow one or another communitarian thinker (be it Christopher Lasch, Alisdair MacIntyre or Amitai Etzioni) in particular. In the first part of this article (§2-3) I will give a very brief sketch of the debate on social justice in political philosophy and then discuss the sister debate on social justice in health care.

Up till now no health care philosopher has used Michael Walzer's *Spheres of Justice*[3] as a source of inspiration. *Spheres of Justice* was an intriguing contribution to the debate on social justice which has been widely criticized from the beginning. Reviewers disliked Walzer's radical particularism, they loathed his anti-universalist, anti-Rawlsian approach and went to great lengths to show that Walzer's spherical approach to distributive justice was doomed from the start.[4] A decade later the tide seems to have changed. The erstwhile critics have not renounced their former point of view, but a growing number of political philosophers seem to have taken sides with Walzer. They try to repair the unmistakable flaws in *Spheres of Justice* (notably a lack of theoretical rigour) so as to be able to save its basic principles.[5] In view of this reappraisal, it may be worthwile to revaluate *Spheres of Justice* as a source of inspiration in health care philosophy as well. In the second part of this article (§4-6) it will be argued that a slightly revised version of *Spheres of Justice* might be an important contribution to the debate on distributive justice in health care.

2 GENERAL THEORIES OF DISTRIBUTIVE JUSTICE

The basic idea of Rawls' *A Theory of Justice* is both simple and attractive: the results of the natural lottery are terribly unfair and should be compensated as much as possible. Mother nature provides some of us with talents in abundance while others have to struggle along being stupid, ugly, weak, deaf or cripple. In order to develop a fair system of justice we should imagine something called the “original position”. The original position is a hypothetical place where we do not know our own genetic make up, social background, race, gender and characteristics. A veil of ignorance has turned us into “empty selves”. These empty selves have to negotiate the

terms of justice for the real world. Not knowing whether we will turn out deaf, dumb or stupid, we will take care to develop a maximin system, a system that will guarantee us the best of possible worlds if we turn out to be the least favored children of mother nature. According to Rawls, we will choose a system that will guarantee basic liberties for all (freedom of speech, freedom of religion, etcetera) and that will tolerate socio-economic inequalities only in so far as these differences benefit the least advantaged members of society. The latter principle is usually called the "difference principle".

According to Robert Nozick, second major contributor to the social justice debate, the basic mistake in Rawls' approach is that he assumes that we *constitute or choose* our basic rights in a hypothetical original position. In Nozick's view we already *have* certain rights when we come into this world. We are born with a natural right to life, liberty and property and no one, not even a democratic government, has the right to infringe upon these rights against our will. Nozick admits that the natural lottery is unfair, but mere unfairness does not give anyone the right to commit injustice. You may be poor, deaf, dumb and blind, but that does not give anyone the right to take my rightful property in order to alleviate your sufferings. Of course there may be income transfers on a voluntary basis. People may decide to live together in benevolent communities and donate some part of their property in a collective fund for the sick or the poor. However, your claim for sympathy will never be as strong as my right to my rightfully acquired property.

Both Nozick and Rawls belong to a family of philosophers characterized as "universalist".[6] They try to find universal principles of justice *outside* the rules of their political community. Rawls' original position is located outside everyday reality, suggesting that justice cannot be found in our present societal arrangements but somewhere out there. Nozick's natural rights precede society's arrangements and cannot be changed or influenced by them. This is both an advantage and a disadvantage. It is an advantage because it enables the philosopher to criticize society's morals and to provide a rational, consistently designed alternative system of justice. It is a disadvantage because the philosopher's fellow citizens seem to have every right to disregard his suggestions: Why negotiate principles of justice in an imaginary original position when you are sure to get a much better end of the bargain in everyday life? Why believe in innate natural rights when you no longer believe in witches or unicorns, especially when the Nozick world of natural rights will leave you to the whims of private charity when you are less than fortunate?

There is another family of theories of justice that try to find principles of justice for specific political communities *within* those communities. These are referred to as communitarian or particularist theories of justice. Communitarians emphasize the importance of communities such as the family, the neighbourhood, associations, churches and the political community, i.e. the state. In their opinion universalist theories such as *A Theory of Justice* or *Anarchy, State, and*

Utopia, overemphasize autonomous individuals and their individual rights. Unlike universalist philosophers, communitarians do not invent or design systems of justice; they rediscover normative traditions within their community.

Sometimes they rediscover normative traditions hidden behind the dust of several centuries. Thus Alisdair MacIntyre seems to advocate a revaluation of Aristotelian virtue ethics.[7] Benjamin Barber writes about the old traditions of town meeting democracy.[8] Robert Bellah criticizes modern family life where spouses stay together as long as the benefits of being married outweigh the costs. He seems to prefer the old days when people felt they belonged together and stayed together as a matter of course.[9] Communitarians have been criticized for this conservative attitude. Their critics have pointed out that normative traditions from the past cannot be reintroduced in modern industrialized societies. These traditions do not fit anymore. Modern societies, the critics argue, are much more heterogeneous than communitarian philosophers seem to acknowledge. It is highly unlikely that they could adopt old fashioned family values or christian morals as the basis of public morality. People differ fundamentally on these matters in modern societies.[10]

However, communitarian philosophy does not have to be conservative. Michael Walzer argues that we do not need to dig beneath the layers of present morality in order to reintroduce Aristotelian ethics or christian morality. Instead we ought to take a closer look at our present morality. Walzer's theory of justice starts with the observation that there is a lot of morality in a plural society like ours, that has come to be unwisely disregarded.[11] A great part of morality in modern, liberal, political communities is constituted by walls. There are walls between church and state, between the public and the private realm, between administration and jurisdiction. There is considerable agreement on this separation of spheres or institutions. We do not tolerate political interference in the classroom or in academic life, we do not want free market principles in the courtroom, and we would be shocked if our lovers were to discuss our personal relationship in terms of financial advantages. These are the rules we live by. No matter how heterogeneous we are, the walls around and between institutions and social practices are the foundations of a shared morality. Following Walzer we can use these shared understandings to solve problems of distributive justice and other moral issues. We may make a stand against the politicization of schools, the marketization of schools, the medicalization of penal law, the scientification of politics, the politicization of faith etcetera. In Walzer's opinion there is a future, just society hidden in present American shared understandings: “The appropriate arrangements in our own society are those, I think, of a decentralized democratic socialism; a strong welfare state run, in part at least by local and amateur officials; a constrained market; an open and demystified civil service; independent public schools; the sharing of hard work and free time; the protection of religious and familial life; a system of public honoring and

dishonoring free from all considerations of rank or class; workers' control of companies and factories; a politics of parties, meetings and public debate."[12] This seems to be a picture of a just society that most Americans would hardly recognize as their own. Is this really the society that is hidden in "the world of meanings that we share"? Walzer's picture of the just society hidden in American shared understandings is an apt illustration of what one might call the communitarian dilemma.[13] Each communitarian philosopher faces a difficult choice between three possible philosophical positions all having serious disadvantages.

- He may take the most obvious shared values in his own political community and qualify these as the essence of justice. His critics will then point out that a philosopher should be able to criticize societal arrangements. A good philosopher should do more than merely legitimizing the status quo.
- He may advocate ancient traditions, such as Aristotelian virtue ethics. His critics will then argue that these are not the shared understandings of his society; that these are the shared understandings of the past and that the present calls for modern values. He will be accused of nostalgia or conservatism.
- He may argue that some future just society lies hidden in today's shared understandings and show his fellow citizens how this future society should look like and how it relates to today's norms and values. His critics will then point out that they can imagine any number of different interpretations of today's shared understandings, many of them more plausible than the one presented by the communitatian philosopher.

There is no easy way out of this dilemma. We may conclude that both universalist and communitarian philosophers have to *convince* their fellow citizens. They have to show them that the principles of justice which they propose are just, either because they are just in some objective way (universalist principles) or because `we have been committed to these principles all along' (communitarian principles). Apart from that, they have to persuade their fellow citizens by painting a picture of a just society in which most of these fellow citizens would want to live. Both universalist and communitarian philosophers can fail on both accounts. Political philosophy is not like mathematics; one cannot prove the rightness of one's principles of justice. A theory of justice cannot be more than convincing.

Part of a theory's being convincing consists in its being useful. A good theory of justice ought to be able to solve concrete problems of social justice. The distribution of health care is such a problem. In the next paragraph we will see whether and how the rival theories of justice discussed above can be used to solve concrete problems of distributive justice in health care.

3 Social justice in health care

Both Rawls and Nozick and the communitarian philosphers have their counterparts in health

care philosophy. The Rawlsian line of argument has been developed by Norman Daniels in two interrelated books: *Just Health Care* on the distribution of health care in general and *Am I My Parents' Keeper?*, an intriguing argument in favour of age discrimination with regard to health care resources.[14] According to Daniels, choosing the Rawlsian line of argument in health care philosophy means imagining a hypothetical original position, in which participants devoid of identifying characteristics (talents, gender, race) would have to discuss the distribution of health care resources. With regard to health care, transferring oneself to the original position is less complicated than it used to be in the Rawlsian original, which was built to discuss the distribution of incomes (amongst other things). There is a lot to disregard when one is about to discuss income redistribution the Rawlsian way. It is not terribly difficult to estimate one's earning capacity: people usually have a rather apt idea of their own market worth. With regard to their health people are much less certain; accidents take place everyday, anybody may be struck by a crippling disease, and since hospital bills are so tremendously expensive one can hardly afford to take risks. Of course this is a slight exaggeration, since there are obviously offensively healthy people as well as sickly or genetically disabled human beings. Nevertheless the health care original position is less hypothetical than the original one. In terms of Jon Elster: the Rawlsian original position needs a thick veil of ignorance, whereas in health care a thin veil will suffice. “The notion of a thin veil of ignorance can be understood quite literally. Because we do not know what the future will bring, it makes sense to take precautions. (...) The thick veils are only literary devices to express the idea that the welfare of individuals ought not to be affected by certain arbitrary properties - those precisely from which abstraction is made behind the veil of ignorance.”[15]

Being stripped of all the crucial characteristics that might influence our health (age, gender, genetic or medical condition), we would discuss the distribution of medical resources. According to Daniels, we would come up with the interesting argument that age is not something we have to disregard in the original position. Age is not like gender or color or physical strength, thus cannot be considered “arbitrary from a moral point of view”. We know that we all begin young and would opt for a fair chance to grow old. If necessary, we would prefer this fair chance to grow old over the possibility of growing still older once we are, say, over 75.[16]

It is not easy to apply Rawls' *A Theory of Justice* to concrete dilemmas of social justice. In fact, Daniels has done better than might have been expected. In the overall social justice debate discussed above, it has often been argued that Rawls' two principles of justice (a system of basic liberties for all; socio-economic inequalities are justifiable only as far as they benefit the least advantaged members of society) can justify almost any amount of income inequality. It is very difficult to estimate the positive effects of income inequality for the least advantaged. Say, a

Texas oil baron owns a large estate and a couple of million dollars. Some poor homeless person in New York city is allowed to spend the night in an asylum with a nice oil stove. Does this mean that the poor wretch benefits from the income inequality? If it is that difficult to rule out certain situations with Rawlsian arguments, one can imagine that it would be even harder to sketch a plan for a Rawlsian distribution of incomes that would be of any help for the federal government. Similarly it is very difficult to decide whether a given way to distribute health care resources may be considered a fair health care system according to Rawlsian criteria. With regard to health care it may be rather easy to imagine ourselves behind a veil of ignorance (thin veils of ignorance do not require much fantasy, as Elster argues), but it remains difficult to predict the outcome of the bargaining process in the original position. How much would we decide to spend on health care? The maximin criterion suggests that we would want a very large health care budget, that would guarantee us every possible medical treatment if we would be the least advantaged members of society. How are we to weigh this against, for instance, a budget for education, legal aid or national defence? Would we also opt for a maximin system at a micro level? If a doctor has to decide whom to treat first, is he supposed to choose the poorest patient, referring to the maximin criterion? Rawls' theory does not offer much help there. Daniels' proposal in favour of age discrimination is probably the least ambiguous application of Rawlsian philosophy in health care that we may come up with.

Now, suppose Daniels has managed to convince us that his system of health care distribution is just according to certain objective standards. We leave the original position, we turn back to reality and we have to face a 76 year old woman who, according to her doctor, needs a coronary bypass operation. Can we really tell her that she is not eligible for this kind of treatment because she would have consented to a system of age discrimination in a hypothetical original position? What would happen if she replied that she has never been ill before, that this is the first time she needs surgery and that she has paid insurance premium all her life?

The main disadvantage of the Rawlsian line of argument is that it works best as long as one remains in the original position. In these hypothetical circumstances we may reach consensus on the size the health care budget; we may for instance decide to cut expenses on the elderly, since Norman Daniels convincingly argues that we ought to do so. Back in reality, however, we are rarely able to uphold this consensus. We will be bothered by all sorts of competing claims. These claims are not merely expressions of self-interest; these are competing claims in terms of justice. The old woman mentioned above refers to her insurance premium and to some idea of entitlement. Her doctor will argue that he has pledged to treat his patients according to need and that he does not know how to reconcile his oath with the agreements in the original position. According to Rawls we have to test the principles agreed on in the original position with our everyday intuitions through a process called “reflective equilibrium”. However, if there are

many differences between the hypothetical consensus and our everyday moral principles, it will become terribly difficult to harmonize one with the other. There is an element of truth in Walzer's remark that Rawls' theory of justice is bound to be treated as some sort of "spare morality", which one might utilize in case some disaster were to wipe out the existing morality in a given society.[17] In short:

- It is difficult to apply Rawls' theory of justice to concrete questions of distributive justice. The theory is too vague to provide unambiguous answers.
- Even if we manage to find unambiguous principles of justice in the original position, it will be difficult to harmonize these with competing claims of justice in real life.

Nozick's line of argument has been followed by H. Tristram Engelhardt. Engelhardt's *The Foundations of Bioethics* is very clear on the distribution of health care resources. People's rightfully acquired property may not be taken away in order to meet other people's needs; it is as simple as that:

> If one owns property by virtue of just acquisition or just transfer, then one's own title to that property will not be undercut by the needs of others. One will simply own it. (...) The existence of any amount of private resources is the basis of an inequality among persons. Insofar as one owns things, one will have a right to them, even if others are in need, and even if the taxation as rent on one's resources is far from excessive or onerous. The test of whether one should transfer one's goods to others will not be whether such a redistribution will prove or onerous or excessive for the person subjected to the distribution, but whether the resources belong to that individual.[18]

Of course, a certain number of people may decide to contribute to a communal fund that will be used to pay for other people's medical needs. They may do so because they share a certain vision of the good life or because they like to be beneficent. However, if they do not choose to have such a communal fund, they cannot be forced to have one. Engelhardt's theory leads to a free market health care system, possibly with a second layer of communal funds based on voluntary donations. The main advantage of this theory is that one does not have to worry about the size of the health care budget. People may decide to spend their money on bicycles, hairdressers, education or medical care or whatever they please. The amount of money they decide to spend on health care is by definition the right amount.

Applying Nozick's theory has its own difficulties, however. If one's rightfully acquired property is to be considered inviolable, no matter what, it becomes very important to know whether one's property is indeed rightfully acquired. Suppose one lives on a large estate that one has inherited

from one's grandparents. Their grandparents (or their great great grandparents) took this land from the indians with force. Does this mean the land is no longer rightfully acquired? It has been argued that, based on Nozick's theory, the Americans ought to give their land back to the indians.[19] Similar arguments can be made with regard to a fortune that was created by slave labour. Engelhardt does not discuss this problem of rightful acquisition.

Apart from the problem of rightful acquisition, Nozick's theory presupposes a belief in natural rights. As mentioned before: one has to believe that people are born with a natural right to life, liberty and property in order to follow the rest of the argument. If this argument leads to a society in which rich people do not even have to pay for poor people's health care expenses, it may seem a wise decision *not* to believe in Nozick's or Engelhardt's natural rights. One may prefer to view rights as mere entitlements to be created by political communities.[20] This will give us room to create a right to property that is not absolute under all circumstances. It will also give us a chance to create useful citizen's rights, such as a right to medical care or a right to education. In short. There are two major difficulties in applying Nozick's theory in health care or anywhere else:

- One has to find an answer to the question of rightful acquisition. If it does not mean that Americans have to give their land back to the indians, why not? Where does the line of rightful acquisition and rightful transfer begin?
- Nozick's (or Engelhardt's) picture of a just society is terribly unattractive for many people. This will make them question Nozick's presuppositions.

The communitarian perspective, in health care philosophy as well as in general, started as a critique of liberalism.[21] According to the communitarian critics, liberal politics and liberal political philosophy have reduced people to mere bearers of rights and the political community to a neutral association for rational cooperation. People are no longer committed to a common good; they have learned to view themselves as autonomous, rational actors looking after their own interests. In Callahan's opinion "all of that autonomy is doubtless fine, and lofty, and lovely. (...) It is a good time philosophy for comfortable people living in the most powerful, rich nation on earth." He doubts, however, whether this kind of philosophy will work in hard times, because "[h]ard times require self-sacrifice and altruism - but there is nothing in an ethic of moral autonomy to sustain or nourish those values. Hard times necessitate a sense of community and the common good - but the putative virtues of autonomy are primarily directed toward the cultivation of independent selfhood."[22] Like other communitarians, Callahan advocates a reappraisal of ancient virtues. In his opinion we ought to reconsider an ancient concept called the natural life span. People grow up, they find jobs, get married and have children. There comes a time for most of us when these activities lie behind us. Children grow up and have their

own children; working life ends in retirement. Nowadays many people think that they can freely enjoy their old age. They have their face lifted, take up golfing, make trips all over the world and enjoy their lives in a hedonist way. Whenever they need medical care they seek it, without paying attention to the size of the medical budget. In Callahan's vision this is something we ought to reconsider. He argues that old people should behave as moral examples for the community. They should abandon their selfish lifestyle and forgo their right to lifesaving medical treatment, for the sake of the younger members of society. “It should be the special role of the elderly to be the moral conservators of that which has been and the most active proponents of that which will be after they are no longer there.”[23] Not being given expensive life prolonging treatment is part and parcel of the societal function elderly people are supposed to perform.

An important question for communitarian philosophers who propose a revaluation of ancient virtues is why these virtues disappeared and how we are to make them reappear. It seems plausible to assume that these virtues got lost in the process of modernization. A large scale industrial, heterogeneous society does not leave much room for ancient virtues. People move all over the country, they live in neighbourhoods, cities and states in which they did not grow up. One can imagine older people being a moral example for a neighbourhood in which they spent all their lives. It is much more difficult to imagine senior citizens showing exemplary behavior to a neighbourhood consisting of virtual strangers. It is not clear what kind of institutional changes would be needed to facilitate the reappearance of ancient virtues in the elderly. Apart from that, senior citizens might venture to ask why we should restrict the reappraisal of ancient virtues to the elderly. In the past many women were paragons of virtue too. They did not seek a career, they did not mind about their own happiness; they made a home for their husband and children. Often they also took care of their parents and their parents in law. Why not revaluate these virtues as well? In short:

- It is dubious whether it would be possible to introduce ancient community virtues in a modern society.
- It would be difficult to place the burden of this societal change first and foremost on one group in particular.

4 Spheres of Justice

Michael Walzer advocates a revaluation of our present morality, in particular the moral walls between institutions and social practices. There are many social goods to be distributed in a complex, modern society such as ours: honor, punishment, friendship, love, money, status, power, free time, etcetera. In Walzer's opinion there are three different mechanisms that we use to distribute these social goods: need, desert, and free exchange. Different distributive principles apply in different social spheres. Need does not count in the labour market; you may be poor

and destitute, but that does not oblige any factory owner to hire you. Desert does not count in the sphere of politics; it may be unfortunate that a deserving candidate loses the election, but we do not deem that unjust. Free exchange may seem eminently reasonable but there are a lot of things that money cannot buy: apart from love think of literary prizes, college grades, divine grace, fellow citizens, sentence reduction and seats in parliament. It is very important to safeguard the walls that separate spheres of justice. Firstly, they guarantee a multitude of freedoms. Secondly, they are a means to accomplish "complex equality": money may be unequally divided as long as money does not count outside its allotted sphere. Being rich should not lead to having political power, being honored, being loved, or having all your sins forgiven by the priest. Losing out in one sphere of justice should not lead to losing out in others.

Following Walzer's argument we can do much more with the spheres of justice approach than we are doing at present. We can use its basic principles to solve hard cases, such as racial integration in American schools, affirmative action in job application procedures, and citizen's rights for immigrant workers. We must reflect on the proper sphere in which the problem is to be located, rethink the principles of justice in that particular sphere and then perhaps rearrange them in ways we had not thought of before.[24]

In a critical review of *Spheres of Justice* Ronald Dworkin raised two important questions concerning Walzer's theory.

I. How does Walzer think that we should establish the existence of a particular sphere of justice? Are there certain preordained Platonic forms, like The School as it was meant to be from time immemorial? Do the Walzerian spheres reflect the Logic of Creation according to a Divine Plan?[25] Walzer has answered this question himself.[26] His theory of justice does not presuppose any preconceived eternal spheres. Spheres of justice are neither naturally given, nor made in heaven, nor static and eternal, nor universally applicable. They are man made, culture bound and changeable. One has to recognize spheres of justice as they exist in a particular community through empirical investigation. Our shared understandings are presumed to have been reflected in the way we have built institutions, in concrete societal arrangements, and they can be squeezed out of those arrangements when we need them to solve hard cases.

II. How does Walzer think we ought to consider what one might call `the problem of mixed arrangements'? Walzerian spheres of justice seem to be ordered as follows. Take one particular social good, say, higher education. Ask yourself how this should be distributed: according to need, according to desert or through a process of free exchange. Let us say we decide that higher education is to be distributed according to intellectual desert. Does this mean that we cannot ask students to pay for tuition? After all choosing in favour of distribution according to desert seems to imply choosing against free exchange. Yet a mixed school system in which rich students have to pay for tuition and talented, poor students get scholarships, does not seem totally unfair. How

should this be evaluated in Walzer's theory?

Or take the distribution of medical care. How should medical care be distributed, according to need, according to desert, or through free exchange? The introduction of Medicare and Medicaid reflects a shared understanding regarding health care in the US. These institutions seem to imply that medical care ought to be distributed in accordance with medical need. Following Walzer this implies that something like the British National Health Service lies hidden in the concepts and categories, in the institutions of American citizens. Dworkin:

> [Walzer] assumes that though any particular community is free to choose whether to assign some type of resource to one or another [sphere], by developing the appropriate conventions, it must do so on an all-or-nothing basis. It cannot construct new patterns of distribution that have elements drawn from different spheres. So if a community recognizes medicine as something people need, or establishes political offices, or develops institutions of specialized higher education, or recognizes some group of people as citizens, it is thereby committed to every feature of the spheres of social welfare or merit or education or citizenship as Walzer understands these[27]

The Walzerian solution to the problem of mixed arrangements is charmingly simple: there is nothing wrong with mixed arrangements as such, as long we are able to give satisfactory reasons for them. For example: if American citizens decide to have a medical need program restricted to the elderly, they are entirely free to do so, but they should be able to explain to younger members of society why the distributive logic of medical care does not apply for them. It is hypothetically thinkable that they would indeed be able do so. They might for example argue that the younger citizens have misinterpreted the distributive logic of medicine. The younger citizens were falsely thinking that medicine for the elderly was granted according to need, while actually it has been distributed according to desert. Elderly people have worked all their lives and deserve to be pampered when they become aged. Or they might argue (though this is unlikely) that they consider disease at old age a misfortune while disease earlier in life should be interpreted as divine punishment. Or they might say (far more likely) that younger people can buy private insurance on the market while elderly people have great difficulty to get themselves privately insured. But then they would have to face the HIV positive thirty year-old for whom this is evidently false, or the person who has a genetic defect that will cause a lingering disease in his forties; and they would have great difficulty explaining how these younger citizens could possibly get themselves private insurance. In short: there is no objection to a mixed health care system, but Americans so far have not come up with a satisfactory underlying moral logic, and as long as they have not done so, we must conclude, according to Walzer, that health care

institutions in the US reflect American's deeply shared understandings concerning medicine poorly.[28]

5 DEFINING THE MEDICAL SPHERE

How should we apply Walzer's theory of justice to the distribution of medical care? What sort of good is medical care and how is it to be distributed; according to desert (deserving patients go first?), according to free exchange (to the highest bidder?) or according to need? And what sphere of justice are we talking about when we are discussing the distribution of medical care? How would Walzer answer these questions himself?

Unfortunately, with regard to the distribution of health care, Walzer has not taken his “art of separation” far enough. Part of the confusion between Dworkin and Walzer has to do with this mistake. Walzer places the distribution of medical care in the sphere of social welfare, along with basic goods like housing, clothing and food; all those things which members of a political community need in order to be able to lead a decent life. This classification seems inappropriate for two reasons:

I. The first might be called the *historical accident reason*. Walzer's argument regarding health care, as stated above, draws on federal, tax financed programs for health care like Medicare and Medicaid. In *Spheres of Justice* it is argued that Americans ought to adopt something resembling the British National Health Service because their own shared understandings, as embodied in these federal programs, suggest as much. We might ask what would have happened if Walzer had written his theory of justice before the enactment of Medicare and Medicaid, say, in the 1950's. In those days there were no publicly funded American health care programs. Yet it seems plausible to assume that Walzer would have advocated a National Health Service equally wholeheartedly. Walzer admits as much when writing about the distribution of health care in the past:

> [T]he distribution of medical care has historically rested in the hands of the medical profession, a guild of physicians that dates at least from the time of Hippocrates (...) [I]t is in the interest of the members [of the guild] to sell their services to individual patients; and thus by and large, the well-to-do have been well cared for (...) and the poor hardly cared for at all. (...) Doctors were the servants of the rich, often attached to noble houses and royal courts. *With regard to this practical outcome, the profession has always had a collective bad conscience. For the distributive logic of medical care seems to be this: that care should be proportionate to illness and not to wealth.* Hence, there have always been doctors, like those honored in ancient Greece, who served the poor on the side, as it were, even while they earned their living from paying patients. Most doctors, present in

> an emergency, still feel bound to help the victim, without regard to his material status. It is a matter of professional Good Samaritanism that the call `Is there a doctor in the house?' should not go unanswered if there is a doctor to answer it. In ordinary times, however, there was little faith in its actual helpfulness. And so the bad conscience of the profession was not echoed by any political demand for the replacement of free enterprise by communal provision.[29]

Walzer then continues by saying that in the Middle Ages the cure of souls was considered much more important than the cure of bodies. The fact that there were monks going around selling divine grace was much more abhorrent than medical doctors offering their services to the nobility only. Walzer does not seem to acknowledge that the distributive logic of a certain social good can be important as such, regardless of the importance of the social good in a given society. Nowadays many western liberal countries are highly secularized. The political order of society no longer depends on anything like the redemption of souls. However, a priest who would go around selling absolution would still be considered perverting what one might call, irreverently, the distributional logic of divine grace. The distributional logic of divine grace, like the distributional logic of medical care should apply, regardless of the relevance of religious or medical transactions in a given political community. Our shared understandings concerning medical care seem to reflect certain ideas concerning medicine that can be traced back to the Hippocratic oath. Examining our concepts and categories as well as our institutions regarding medical care would teach us that the distributive logic of medical care in our society is basically Hippocratic. Somehow we seem to be committed to the principle that a sick person ought to get medical treatment in accordance to medical need, to the best of his doctor's abilities.

II. The second reason why Walzer's classification of medical care is mistaken has to do with his *interpretation of the need criterion*. The distributional logic in the sphere of social welfare is described as "From each according to his ability (or his resources) to each *according to his socially recognized needs*".[30] Walzer does not seem to notice that distribution according to need is not the same for doctors and patients as it is for welfare civil servants and their clients. For the social welfare civil servant, distribution according to need is indeed distribution according to socially recognized needs. Each welfare recipient receives approximately the same allowance, and having received that allowance is not entitled to more, no matter how `needy' he still feels, and even if the social welfare employee understands his remaining sense of deprivation. Distribution according to need means something altogether different in a hospital context. A doctor does not distribute according to socially recognized needs. To him need is a combination of individual feelings and professional judgment. He keeps offering help until either the patient is or feels cured, or until his capability runs out because the patient is beyond help. This has no

equivalence at the social welfare office. As soon as a welfare worker decided to follow the moral principles of medicine, all clients would surely begin feeling as needy as possible, thus making a mockery of the welfare distributional logic.

Of course, we might decide to rearrange the distributional logic of medical care so as to make it resemble the welfare logic. We might decide to make a list of basic medical goods, to define `socially recognized medical needs'. We might teach our doctors not to treat patients if their medical needs have not been socially recognized, except perhaps for those patients who are willing to spend private funds to satisfy their socially unrecognized medical needs. However, that would not be a plausible interpretation of existing shared understandings, as they have developed since the Hippocratic oath. Doctors ought to treat patients, not because of their socially recognized medical needs, but to make them better when they are ill, and because they are ill. That is what they have pledged to do, it is their proper job, and it seems to be a widely shared understanding that they should stick to it.[31] This seems to be the distributive logic of a separate medical sphere.

6 Salvaging the rescue principle

Health care ought to be distributed according to medical need. Doctors ought to disregard their patients' wealth; they should not behave like car salesmen selling their merchandise to the highest bidder. Nor are they expected to behave like social-democratic politicians, giving priority to poorer patients, so as to make up for the misfortunes befalling them in other areas of life. This is a deeply felt shared understanding concerning medicine. Even Dworkin, who is anxious to abandon it, acknowledges as much when he writes:

> For millennia doctors have paid lip service, at least to an ideal of justice in medicine which I shall call the rescue principle. It has two connected parts. The first holds that life and health are (...) chief among all goods: everything else is of lesser importance and must be sacrificed to them. The second insists that health care must be distributed on grounds of equality: that even in a society in which wealth is very unequal and equality is otherwise scorned, no one must be denied the medical care that he needs just because he is too poor to afford it. (...) The rescue principle is so *ancient*, so *intuitively attractive*, and so *widely supported in political rhetoric*, that it might easily be thought to supply the right standard for answering questions about rationing.[32]

Let us suppose that this is the most appropriate interpretation of our shared understandings concerning medicine. Let us suppose that I convinced you that there is such a thing as a separate sphere of medicine and that the distributional logic of this sphere of medicine differs from the

principles of distribution in the sphere of money and commodities (the market: distribution according to free exchange) and in the sphere of social welfare (distribution according to socially recognized needs). How does this affect the debate on cost containment? In Dworkin's opinion the so-called resue principle is entirely useless in modern times. Dworkin argues that the rescue principle would lead us into a society that would spend all of its resources on health care services. There is always another liver to be transplanted, another brain-dead body to be kept alive, another chemotherapy treatment to be tried on a patient dying of cancer, another diagnostic test to be performed just to be on the safe side. Since the rescue principle is not able to guide us through times of medical scarcity (if Dworkin is right, it will not even be able to guide us in times of affluence; because there never will be such a thing as medical abundance in the first place) we ought to look for more sensible principles. Dworkin recommends a Rawlsian approach called the prudent insurance scheme, which abandons both elements of the rescue principle. We ought to accept that society will never be able to provide each and every medical service that the rich are able to buy for themselves to each and every citizen who may happen to need it. And we ought to recognize that there are certain medical risks that we would not choose to ensure, given the high costs of treatment and the slight chance of success. If the chance of recovering from a liver transplant at age eighty is less than 5%, it may be argued that you would not have paid an insurance premium to have a transplant operation at that advanced age. Choosing the Walzer line of argument means that we have to find a way of salvaging the rescue principle, being our deepest shared understanding regarding medical care. We have to find an answer to Dworkin's problem. I think three theoretical exercises are needed in order to be able to uphold the rescue principle: we have to rethink the need criterium in view of the large cultural and technological changes in the twentieth century; we have to determine the limits of the medical sphere; and we have to take a closer look at Walzer's “sphere of office”.

I. Rethinking the need criterion

Choosing the Walzer line of argument means that we remain firmly committed to the second part of Dworkin's rescue principle: there is nothing intrinsically wrong with economic inequality, but it should not be mirrored in the sphere of education, the sphere of politics, or the sphere of medical need. The first part of the rescue principle, however, should be reinterpreted for us to be able to uphold it. In Walzer's *Spheres of Justice* there is ample room for moral change. The Walzer line of argument is not static; Walzerian spheres are not like Platonic Ideas, they may change over time through a process of reinterpretation and redefinition. One never starts afresh, but technological or cultural change may require an adaptation, a new interpretation of shared understandings. The need criterion must be modernized or `evolved', within the limits of the medical sphere. In the past it may have been acceptable to state that anything

doctors could do, ought to be done. Medicine could perform a few miracles and these miracles certainly should occur for those patients who might profit from what old-fashioned medicine had to offer. There is a tendency to cling to this anything-that-can-be-done-should-be-done ethic, despite the fact some of modern medicine's works are dubious or worse. Very old senile patients who are tired of life have to undergo operations to which they can no longer consent, because these operations will keep them alive and are therefore assumed to be in their interests. Patients are kept alive in a permanently comatose condition. Dying patients have to undergo strenuous chemotherapy treatments for a one in a hundred chance of a few extra months, when they might be better off spending their last weeks at home with their loved ones. There is every reason to `evolve' the need criterion. One does not need to be treated when there is no longer anything worthwile in staying alive. Mere biological life is not good enough and if that is all that the doctor can offer, he ought to realize that his patient is beyond help, that he has reached the limits of his capacity to cure. Discussing a liver transplant with the eighty year old patient mentioned above becomes much more straightforward. Instead of saying, as Dworkin would have it, that the old man would never have paid for such an operation in a sensible insurance scheme, the doctor merely explains that the chances of ever recovering are very slim, that the side effects will be enormous and that what little is left of his life will probably be spent in hospitals. Most patients will, under these circumstances, prefer to spend their last months at home, with their family and friends. (A few patients may desperately want the operation despite everything and, unless the operation is evidently useless from a medical point of view, the doctor may go along with their request.)

As long as we stay within the borders of the medical sphere we may safely discuss a modernization of the need criterion. Once we step out of it other motives cloud our judgement. As soon as we start talking about sick and vulnerable people from a political point of view, criteria like societal usefulness will come up: it becomes a waste of good money to spend it on permanently vegetative patients, retired senile citizens or dying cancer patients. We could spend taxpayer's money on much more useful objects like fighting crime, educating children or cleaning the environment. Once we start discussing the needs of sick and vulnerable people from a utilitarian, political perspective, they are bound to lose. Within the boundaries of the medical sphere we may distinguish between apparent needs and real medical needs and we can allow ourselves to meet only the latter.

II. The limits of the medical sphere

Reinterpreting the need criterion is not enough. We also have to establish the borders of the medical sphere. If we want to uphold the distributional logic of medical care - medical treatment ought to be distributed according to medical need - both `medical treatment' and `medical need'

have to be clearly defined categories. I shall give a short impression of the kind of questions we need to ask and the kind of answers that might be given.

- Which needs are to be considered medical? The World Health Organization has introduced a very strange definition of health. According to the WHO, health is not merely the absence of sickness or pain, health is a condition of total physical, mental and social well-being. This means that poverty, grief, marital problems and loneliness should all be considered medical needs. If we adopt the WHO definition of health, it will be impossible to define a separate medical sphere in which patients can be treated according to medical need. I think we ought to settle for a much more modest definition, such as for instance: needs are to be considered medical when they sprout from biological or psychiatric diseases. Not vice versa though. Not every biological aberration that the doctor may come up with has to be qualified as a medical need. It has become increasingly possible to find faults or flaws in people's DNA, without these faults being noticed by the person himself. People can be diagnosed as having a gene for homosexuality, for agressive behavior, a predisposition for colon cancer for schizofrenia, and for a huge number of other qualities. The medical profession should not be allowed to translate all these biological characteristics into medical needs. Following Walzer's approach we ought to beware of a medicalization of everyday problems and daily needs, not only because this might lead to rising medical costs but also because this would give doctors too much power.
- Which kinds of treatment are to be considered medical? There seems to be only one feasible answer to this question. Medical treatment is any kind of treatment that has been scientifically tested and that has proven to work better than placebos. We cannot extend the definition of medical treatment to `anything that might help anyone to feel better'. This would transform medical goods into a wholly vague anything goed category. It would not only extend the definition to non-scientific kinds of treatment (homeopathy, faith healing, magnetism); it would result in patients demanding tax-financed vacations on their personal healer's orders.

III. Economizing in the sphere of office

Medical practice and medical practitioners are related to more than one sphere of justice. From a Walzerian perspective, each and every one of us is related to several spheres of justice: we are all citizens in the sphere of politics or citizenship, family members in the sphere of kinship and love, consumers in the marketplace and students in the sphere of education. Walzer pictures us as having multiple identities. The medical practitioner's problem goes beyond this multiple identity, however. He or she is related to more than one sphere of justice qua doctor. He not only operates in the sphere of medicine, but must also deal with what Walzer calls the sphere of office. The sphere of office consists of all those functions that require professional expertise and/or in which society takes specific interest: members of the bar, teachers, civil servants,

experts of various kinds, and medical doctors. (Thus: physicians are related to the sphere of office even if they are employed in private practice.) The logic of the sphere of office seems to be (Walzer is not altogether clear on this): we, ordinary citizens need the expertise of technicians, teachers, lawyers, and doctors. We are willing to grant you, experts and professionals, some rewards in return, such as status and money and a certain professional autonomy. However, that does not mean that we have to put up with "the insolence of office". As soon as you, professionals, begin abusing your priviliges, we may threaten to take them back. Doctors are allowed to guard the entrance to their profession. Professional expertise is something which can only be properly recognized by other experts; there is a certain logical necessity in that. However, that must not lead to an artificial shortage of physicians, simply because the medical elite wants to receive excessive incomes. Professional autonomy must not turn into the insolence of office. Part of the debate on cost containment is about the privileges and financial interests of the medical profession. That part of the debate ought to be discussed in the concepts and categories related to the sphere of office. Doctors do not necessarily have to be turned into civil servants, we do not have to adopt a British National Health Service, but professionals must be held accountable by the public at large. We need to have an open discussion about the size of their incomes and the hospitals financing system. If a fee for service system leads to all kinds of unnecessary medical treatments in order to keep the doctor's income as high as possible, a flat salary or hourly rates might be considered as an alternative.[33]

7 Conclusion

The three dominant lines of argument in applied health care philosophy, the Rawls/Daniels line, the Nozick/Engelhardt approach, and the communitarian approach all have advantages and disadvantages. The Rawlsian approach is difficult to uphold in the face of competing moral claims in everyday reality, the Nozick line of thinking presupposes a belief in natural rights which is questionable, and the communitarian approach does not seem to work in a modern, heterogeneous society. The line of argument developed in this article, based on Walzer's *Spheres of Justice* might be a way to avoid these disadvantages. It is based on shared understandings hidden in concepts and categories, in institutional practices of all sorts. Hence, it does not run the risk of losing power in the face of everyday moral reality, as the Rawlsian approach does. It would lead to a society that many people will prefer over the Nozick world of inviolable rights. And it can be applied in a modern, heterogeneous society, because, unlike other communitarian theories, it is not based on a revaluation of ancient virtues; it is based on shared understandings that modern people, no matter how much they differ, all claim to uphold. In the case of medicine this shared understanding is the idea "that the call `Is there a doctor in the house?' should not go unanswered if there is a doctor to answer it". Even opponents of this so-

called rescue principle acknowledge its widely felt appeal. If there were no longer consensus on this issue; if, for example we were to decide that the call for a doctor should go unanswered when the patient cannot afford to pay for treatment, then the Walzer line of argument no longer holds. The spheres of justice approach presupposes consensus hidden in concepts and categories and if there is no agreement to be found even at that level we might just as well advocate ancient virtues, a Rawlsian scheme or a natural rights approach.

However, as long as we are committed to the rescue principle, Walzer's "art of separation" may guide us effectively through the debate on cost containment and the distribution of health care, provided we succeed in `evolving the need criterion', in defining the limits of the medical sphere and in shifting part of the debate on cost containment to the sphere of office, where we can discuss the privileges of the medical profession.

Notes

1. Rawls J. *A Theory of Justice.* Cambridge: Harvard University Press, 1971.

2. Nozick R. *Anarchy, State, and Utopia.*, New York: Basic Books, 1974.

3. Walzer M. *Spheres of Justice. A Defence of Pluralism and Equality.* New York: Basic Books, 1983.

4. Cf. Dworkin R. To each his own, *The New York Review of Books* 1983;14(apr):4-6 and Barry B. *Liberty and Justice: Essays in Political Theory 2*. Oxford: Clarendon Press, 1991:9-22.

5. See for example: Miller D. Complex equality. In: Miller D, Walzer M, eds. *Pluralism, Justice, and Equality*. Oxford: Oxford University Press, 1995:197-225; Andre J. Blocked exchanges: a taxonomy. In: Miller D, Walzer M, eds. *Pluralism, Justice, and Equality*. Oxford: Oxford University Press, 1995:171-196; Carens J. Complex justice, cultural differences, and political community. In: Miller D, Walzer M, eds. *Pluralism, Justice, and Equality*. Oxford: Oxford University Press, 1995:45-66; Hartogh GA den. De architectuur van Walzers rechtvaardigheidstheorie [The structure of Walzer's theory of justice]. In: Berg P van den, Trappenburg MJ, eds. *Lokale Rechtvaardigheid* [Local Justice]. Zwolle: Tjeenk Willink, 1994:231-256.

6. Bovens MAP. Tussen Kant en conventie. De rechtvaardiging van beginselen van rechtvaardigheid [Between Kant and convention. Justifying principles of justice], *Acta Politica* 1988;23:333-57. Other members of the family of universalist thinkers include Bruce Ackerman (Ackerman BA. *Social Justice in the Liberal State*. New Haven: Yale University Press, 1981), and Murray Rothbard (Rothbard M. *For a New Liberty: the Libertarian Manifesto*. New York: Herz ed. Collier Books, 1978). In his later work Rawls has rewritten his theory in order to make it less universalist (Rawls J. *Political Liberalism*. New York: Columbia University Press, 1993).

7. MacIntyre A. *After Virtue*. London: Duckworth, 1981.

8. Barber B. *Strong Democracy: Participatory Politics for a New Age*. Berkeley: University of California Press, 1984.

9. Bellah RN. *Habits of the Heart: Individualism and Commitment in American Life.* Berkeley: University of California Press, 1985.

10. Bovens MAP. Tussen Kant en conventie. De rechtvaardiging van beginselen van rechtvaardigheid [Between

Kant and convention. Justifying principles of justice], *Acta Politica* 1988;23:333-57.

11. Walzer M. Liberalism and the art of separation, *Political Theory* 1984;12:315-30.

12. Walzer M. *Spheres of Justice. A Defence of Pluralism and Equality*. New York: Basic Books, 1983:318.

13. Cf. Cohen J. Review of Spheres of justice, *Journal of Philosophy* 1986;83:457-68.

14. Daniels N. *Just Health Care*. Cambridge: Cambridge University Press, 1985; Daniels N. *Am I My Parents' Keeper? An Essay on Justice between the Young and the Old*. Oxford: Oxford University Press, 1988.

15. Elster J. *Solomonic Judgements. Studies in the Limitations of Rationality*. Cambridge: Cambridge University Press, 1989: 210.

16. Daniels N. *Am I My Parents' Keeper? An Essay on Justice between the Young and the Old*. Oxford: Oxford University Press, 1988. Similar conclusions are reached by Dworkin in his `prudent insurance' scheme, which may be characterized as a quasi-Rawlsian approach: Dworkin R. Will Clinton's plan be fair?, *The New York Review of Books* 1994;13 (Jan):20-5. Cf., however, Keasberry H. Reddingssloep-ethiek [Lifeboat ethics]. In: Jacobs FCLM, Wal GA van der, eds. *Medische Schaarste en het Menselijk Tekort* [Medical Scarcity and Human Imperfection]. Baarn: Ambo, 1988:143-69 for a Rawlsian approach reaching different conclusions.

17. Walzer M. *Interpretation and Social Criticism*. Cambridge: Harvard University Press, 1987.

18. Engelhardt HT Jr. *The Foundations of Bioethics*. Oxford: Oxford University Press, 1986:341

19. Lyons D. The new indian claims and original rights to land. In: Paul J, ed. *Reading Nozick*, Totowa: Rowman & Allanheld, 1981: 355-79.

20. Oversloot J. Klein bezwaar tegen het libertarisme [Small objection to libertarianism], *De Vrijbrief* 1995;20:13-4. Of course this argument assumes that a belief is something one may *decide* to adopt, which is a questionable assumption.

21. Bovens MAP. Liberalisme als gemeenschap [Liberalism as community]. In: Beus JW de, Lehning PB, eds. *Beleid voor de Vrije Samenleving* [Policy for a Free Society]. Meppel, Amsterdam: Boom, 1990:105-29.

22. Callahan D. Minimalist ethics. On the pacification of morality. In: Caplan AL, Callahan D, eds. *Ethics in Hard Times*. New York: Plenum Press, 1981:261-281(263).

23. Callahan D. *Setting Limits. Medical Goals in an Aging Society*. New York: Simon and Schuster, 1987:43.

24. Cf. Walzer M. *Just and Unjust Wars. A Moral Argument with Historical Illustrations*. New York: Basic Books, 1977:xi.

25. Dworkin R. To each his own, *The New York Review of Books*, 1983;14(Apr):4-6.

26. Walzer M. Spheres of justice: an exchange, *The New York Review of Books*, 1983;21(Jul):43-6.

27. Dworkin R. To each his own, *The New York Review of Books*, 1983;14(Apr):4-6.

28. Walzer M. Spheres of justice: an exchange, *The New York Review of Books*, 1983;21(Jul):43-6.

29. Walzer M. *Spheres of Justice. A Defence of Pluralism and Equality*. New York: Basic Books, 1983:86-87

(emphasis added).

30. Walzer M. *Spheres of Justice. A Defence of Pluralism and Equality*. New York: Basic Books, 1983:156-157 (emphasis added).

31. Cf. Kuitert H. *Mag Alles Wat Kan? Ethiek en Medisch Handelen* [May We Do Everything We Can? Ethics and Medicine]. Baarn: Ten Have, 1989.

32. Dworkin R. Will Clinton's plan be fair?, *The New York Review of Books* 1994:13(Jan):20-5(22) (emphasis added).

33. Does not this lead to laziness? Not necessarily. In the Netherlands there are doctor's who work in a fee for service system as well as doctors enjoying a flat salary. Empirical research shows that there is not much difference between the two groups. Commissie Modernisering Curatieve Zorg. *Gedeelde Zorg: Betere Zorg* [Shared Care: Better Care]. Zoetermeer:WVC, 1994.