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Gorovitz: Equity and Efficiency in Health Care

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We spend a stunning amount on health care. That amount is soaring, and there seems no end in sight. Yet a significant portion of the American public suffers from poor health, and a different, but overlapping segment of the American public receives poor health care, or none. The vast sums that are spent on high technology medicine not only benefit just a small number of patients, but do so in ways that raise new and troubling moral dilemmas. Nearly everyone agrees that our total system of health care delivery— including the distribution of costs and benefits—is not in excellent health, in spite of our large investment in it. There is a fair amount of agreement about the symptoms, a scant amount about the diagnosis, and next to none about the treatment. Complicating our attempts to set the matter right is the fact that we want our expenditures to be used efficiently, and we believe in, or at least say we believe in, equity as a value to be reflected in the functioning of all our social arrangements. But we are not very clear about what efficiency and equity are. And we have barely begun to consider the relationship between these two notions in the specific context of our concerns about containing the costs of health care.

I will look first, and separately, at the notions of efficiency and of equity, then at the relationship between them, and finally, briefly, at a few of the issues that arise as we apply these notions to the context of health care. First, however, I want to acknowledge several related propositions about health care that strike me as unassailable.

(1) The medical care of individuals at present has remarkably little to do with the general level of health of the population. The factors that most influence health are stress, diet, sanitation, environmental pollutants, self-destructive habits, and the like. But in medicine, as in so many other dimensions of life, the drama, glory, and money are in response to crisis, not in avoidance of it. So health care is primarily medical care—response to illness or injury—and the maintenance and nurturance of health take second place to its restoration as the objective of health care. Of course, whatever the success of preventative public health measures, there will always be a need for medical care. In fact,

(2) The demand for medical care is potentially limitless. The more successful we are at curing people and keeping them alive, the greater the demand for medical care will be. This is especially true with chronically ill and geriatric patients. The longer they live, the more medical care they tend to require. Thus an increase in the quality and supply of medical care will not tend to diminish, limit, or meet the demand. In this respect, medical care is like education, and unlike almost everything else. Therefore,

(3) There is no identifiable "adequate level" of investment in medical care; the demand can absorb any increase in expenditure no matter what the level of that increase. This is not mainly due to the highly visible fact that physicians largely wish to live like the aristocracy so many of them view themselves as constituting, nor because of the frequently touted inefficiency in the organization and administration of our medical institutions. Physicians are not alone in being well paid, they often work hard and well to earn their incomes—in spite
Equity, Efficiency, and the Distribution of Health Care

of the continuing exposure of far too many instances of egregious greed — and in any case it can readily be shown that physician’s fees, though high, are not the main ingredient in rising costs. Further, hospital inefficiency, though sometimes outrageous, is surely no more outrageous than the inefficiency in any other large and complex social organization — such as the railway system, the postal system, the GSA, or any state university. The potential limitless of medical costs is more because we will always want to learn more from medical research, because high technology medicine, along with its dazzling price tags, will continue to become increasingly accepted as the standard of optimal medical care, because social pressures increasingly force physicians to practice a more costly sort of defensive medicine, and because eventual illness and injury will be with us always.

(4) The business of health care is government business to a large extent, and the government is in that business to stay. People argue about the proper role of government in regard to medical matters, but no one can credibly predict — and few people would really want — much of a diminution of that role.

(5) It is not true that “when you’ve got your health, you’ve got just about everything.” Health is only one of the many things we care about, and often it is not even the most important to us. The point does not rest on chronic indolence, dietary self-indulgence, or other imprudent behavior. People knowingly and willingly undergo risk and suffer injury and sometimes illness for the sake of service to others, creative achievement, or a sense of accomplishment. And why should they not?

Having made these background remarks, I turn to questions surrounding equity and efficiency.

When we speak of efficiency, we tend to do so in a way that reflects the usage of that notion in physics. There, efficiency is a calculable ratio — the ratio of work input to work output — which approaches the value one as a limiting and unachievable ideal. Every machine has an efficiency, every efficiency is a number, and any two efficiencies can therefore be compared. But when we leave the realm of physics, we leave its precision behind. Our talk of efficiency in other contexts suffers from the tempting but false assumption that it is still a precise notion, quite serviceable for making quantitative decisions. And it doesn’t help to dress the old notion of efficiency up in the fancy new clothes of cost-benefit or cost-effectiveness language.

Consider this illustration. Two automobile engines are mounted on a bench. Engine A, which can propel a two-ton car for twenty five miles on a gallon of gasoline, hums smoothly on the bench. Engine B, in contrast, can propel a two-ton car only for fifteen miles on one gallon of the same gasoline at the same speed. It sits on the bench, clattering and sputtering, whistling and clanging. Which is the more efficient engine? So long as it is propelling cars that is at issue, of course Engine A is more efficient. But if I tell you that I am a movie producer at work on the sound track of a film about antique automobiles, and that what I am after is the most automotive engine clatter I can get per gallon, then it is obviously Engine B that is more efficient.

The point should be clear enough. Implicit in any use of the notion of efficiency is an assumption about what the desired outcome is. In classical physics, it is well defined. In ordinary discourse about cars, it is contextually implied. In the example of the two engines, it was hidden at first, and perhaps surprising when revealed.

When we talk about efficiency in health care, what exactly are the values and the output products in terms of which — and only in terms of which — we can
make sense of claims about efficiency? We have not answered this question in any adequate way. But until we can reach some clarity about what the output objectives of medical care are to be, we cannot usefully make more than impressionistic judgments about efficiency.

Lest it be thought that the answer is clear enough, except to the fussing of the philosopher, let me illustrate:

(1) If an investment by a hospital in one of those infamous CAT scanners saves 30 additional lives a year, is it an efficient investment as compared with endowing a community diagnostic program that could improve the health of hundreds of people?

(2) Is a multi-million dollar public immunization program an efficient investment of health care dollars if it protects most of the population at risk against an epidemic of unknown likelihood?

These questions are not clear yet hard to answer. Rather, the questions themselves are unclear. They utilize a notion of efficiency which is not well defined or well understood.

Regarding the first example: we often spend a great deal to save the life of an identified person. We are less likely to invest in the statistical saving of lives — to incur expenses that will save the lives of persons unspecified. Sometimes, however, we invest heavily to that end — for instance, in the establishment of a shock-trauma unit or in a hospital's acquisition of a hyperbaric chamber. Yet we do not make all the investments that would surely save lives, in part because we are not sure how important to us it is to save all the lives it is medically possible to save. But unless we know how much a life is worth to us, how can we judge the efficiency of an investment that saves the life? Further, it is impossible to compare such an investment with one that provides non-vital medical care without understanding what value we place on good health. It is not obvious, anyway, that we clearly favor saving a few lives over substantially improving the well-being of a large number of people.

Regarding the second example: the problem is not just one of empirical uncertainty about the epidemic and its severity. It is partly an uncertainty about how important it is to relieve anxiety and about what the prevention of symptoms is worth.

These questions, of course, are not for philosophy to answer alone. They are problems of social decision, the answers to which must be fashioned by all those whose risk and whose resources are involved. Further, the question of what to take as the appropriate objective in terms of which to evaluate efficiency is itself a question of value on which considerations of equity can have bearing.

It is time, then, to turn to equity — what common usage and the dictionary both take as equivalent to justice, fairness, doing the right thing. There are various competing views of what constitutes equity. One prominent view is that equity is or requires equality. What might that mean in the context of the distribution of health care? There are at least these choices:

(1) Equality in the dollar expenditure on each individual. This interpretation makes little sense. Some lucky people just don't need health care; they thrive until they die, and there isn't anything to spend their health care dollars on. Perhaps we could approximate to equal expenditure by adopting a plan invented, I think, by Dan Callahan, whereby each person is allowed some fixed amount — say $100,000 — over his lifetime, with a refund of any unused portion to go to his estate.

(2) Equality in the state of health of each individual. The problem here is that this sort of equality is impossible no matter what we spend or how. Some
Equity, Efficiency, and the Distribution of Health Care

people enjoy robust health, some are sickly or worse all their lives, and we have only limited leverage on the natural distribution of physiological characteristics.

(3) Equality in the maximum to which each individual is benefited. This would mean that each person has equal access to medical care up to some limit, to be drawn on as needed, with no pretense of equalizing actual expenditures. We may find this becoming a position to be taken seriously, though the question of what sorts of limits should be set is just beginning to rear its vexsome head.

(4) Equality in the treatment of like cases. Under this interpretation, a national health service, for example, could have a program in renal dialysis, treating as needed all medically qualified cases. At the same time, it could refuse to treat cases of hemophilia at all — arguing that such an exclusion was necessary on grounds of economy, and going on to claim that the health care was wholly equitable, thoroughly equal, in the sense that each person had equal claim on such treatments as were made available. Both the patient with kidney failure and the hemophiliac would have equal access to dialysis as needed according to this plan.

So if we interpret equity as equality in some sense or other, we immediately face problems of interpretation. Each interpretation, moreover, is problematic. It is not clear, nor unchallenged, that any sort of egalitarian interpretation of equity is tenable. First, there is the problem of scarcity. There will always be medical treatments or supplies in short supply — at least the ones that have just been developed. How are we to achieve equality here, except by a lottery that provides not equal treatment, but an equal chance of getting treatment? Second, there is the problem of entitlement. Consider the research scientist who has devoted his life to the search for a vaccine that is effective against a disease that has slaughtered his ancestors for generations. Now he has the vaccine, but initially in short supply. Are we to deny his claim on a dose for himself or his child because that would violate our commitment to equal access? Many would argue that he has an entitlement that sets him apart from the rest; that to deny it would itself be to abandon our commitment to equity.

So equity, like efficiency — although for different reasons — is an elusive notion. We rely on them both in the rhetoric that surrounds the defense of policy, and we rely on our intuitions about them in the setting and advocacy of policy. But when it comes to a specific case of defending a policy under careful scrutiny, these notions slip away from precise clarification. What, then, is to be said for them?

One way to interpret the notion of efficiency — a way that seems to correspond well with the way we actually use it — is as a measure of the extent to which an action produces good — where good is itself defined as the satisfaction of human needs and desires. That action, program or policy then is the most efficient which, at a given level of expenditure, is the one among all available alternatives that maximizes good. Comparative judgments are then possible to the degree to which we have a clear conception of what is good, and also a clear account of what consequences will flow from the various acts we contemplate.

This is classical utilitarianism, and moral philosophy for the last century, like economics and Anglo-American legislative policy over the same century, has been dominated by the influence of utilitarian theory. The objections to it are numerous and powerful, but its appeal is nonetheless unsurpassed as an account of what we ought to do, individually and collectively, and why. This appeal rests ultimately in the simple fact that we do care about the satisfaction of human wants and needs — about the production of good — and we therefore want our efforts and our resources to produce as much of it as possible. This want translates into our concern with efficiency.
Equity is a more obviously moral notion. It means justice, fairness in our dealings with one another. But how are we to understand what is just? Here, again, there is a historical tradition of thought to guide us. From the ancient Pythagorean rules of conduct and the ten commandments, through the austere moral strictures of Immanuel Kant, to an extensive body of antiutilitarian moral theory, we have nurtured and sustained a sense that some kinds of actions are right and other kinds are wrong, regardless of the consequences they lead to or the ends they serve, simply because of the kinds of acts they are. Thus we condemn the framing of an innocent man, no matter how great the social benefits of the conviction might be, just as we condemn torture, slavery, and other moral abominations without regard to the role they may play in the larger pursuit of noble ends. Or, at least, all of us do except the most intransigent of the hard-core utilitarians. And we do so not because such actions strike us as inefficient in the production of good, but because they violate our sense of justice.

Providing an account of that sense of justice is no small task. But it does seem that Mill’s view that justice is derivative from considerations of utility, of efficiency in the production of good results, is in decline. Recent moral philosophy has shown reluctance to consider justice as a derivative concept. Rather, it has come to be largely viewed as a dimension of morality that is separate from and independent of utility, and which can therefore be in conflict with it.

Efficiency as a value thus reflects our concern with the maximum production of good, and equity as a value reflects our concern with doing what is just or fair, regardless of its efficiency. In an ideal world, these values would never be in conflict, but in fact the conflict is notorious. We may want both equity and efficiency, but at least sometimes one may be purchased only at the cost of the other.

To see the conflict between equity and efficiency etched sharply, consider a hypothetical example. Real cases, if they are interesting, involve complexity of the sort that can obscure a simple point; I use an artificial example, just as the physicist does when he speaks of the frictionless plane. Imagine that we are all on a desert island, struggling to survive. Most of us cluster into a village, but a few set out for remote parts of the island where the fishing is perhaps better. There is little rain, so drinking water is a constant problem; there is just marginally enough to keep us alive. Suddenly, a rescue mission flies overhead. Using remote sensing technology, they assess our situation. They depart, then return with a large crate which they parachute to the island. We open the crate and find a tank truck filled with pure water and a message that the water is for all the people on the island. How shall we distribute the water?

There are 100 people on the island; 1000 gallons in the tank. Specify whatever distribution you think is equitable. You can favor ten gallons per person, or more for those who work more, or most for those in positions of authority — it doesn’t matter which distribution you favor as most equitable. For you now discover that the tank truck has a steam engine. In order to move it around at all you have to use water. And the conflict between efficiency and equity — however you construe equity — becomes plain. Assuming that each gallon of water is as valuable to each person as any other gallon — that is, there is no diminishing marginal utility of water in the range of quantities at issue — then the most efficient thing to do is not use the engine at all. Let water go to those who come for it — to the able-bodied who live nearby. The weak, the ill, the aged, the distant will get none, but since there is linearity in the good produced by incremental allocations of water, their deprivation is of no consequence, for we produce more good this way than...
by spending some of the water on operating the delivery truck. It would be hard to argue that justice is served, however, especially given that the water was sent to all the people on the island.

So equity costs something. In some situations the most efficient action and the most equitable action are not the same. Some balance must then be struck between the two competing values. For one who places justice above all, considerations of efficiency may legitimately come into play, but only after justice is fully served. This position would be exemplified by the egalitarian who insisted on an equal distribution of water to all island inhabitants, even if most of the water were used by delivering it. But he could still be seriously concerned with mapping the best route, in order to conserve water, and thus to distribute it most efficiently within the constraints of equity. He would be the mirror image of the complete utilitarian who advocated making the decision solely on the grounds of efficiency and therefore leaving the truck in place. For many people, myself among them, some middle ground is best — some approximation to complete equity, tempered by an unwillingness to let efficiency fall too low.

I have not shown, of course, that equity and efficiency are always in conflict — only that they are competing values in some situations. It is a separate question whether the kinds of situations that arise in regard to the distribution of health care are of the sort in which equity and efficiency are in conflict. But the answer is apparent; one example should suffice to show that the conflict is present.

Assume that considerations of equity — of justice or fairness in the treatment of persons — require that each individual be free to choose the geographical location in which he or she will seek work. Assume further that considerations of equity require that in an affluent industrialized nation like ours a minimally decent level of health care should be available to all citizens, including those in poor, rural communities. Finally, assume that our concern with containing the costs of health care places limits on the amount of financial incentive we can provide to induce physicians to practice in otherwise undesirable locations. Then the conflict is evident: we can resolve the problem only by some sacrifice in the freedom of the physician, the health care of the poor, or the pocketbook of the public. And any such sacrifice will be to some extent a concession with respect either to equity or efficiency.

Having argued that equity and efficiency, however we interpret them, are different and competing values, I want to turn next to some further questions of health care distribution and cost containment.

Since health is not the only thing we care about — nor should it be — we want to have substantial resources available for other expenditures. It may, therefore, seem obvious that we ought to decide how much to spend on health care, and also how it should be spent. It would be a mistake, however, to think that any such determination takes place in any systematic or comprehensive way. Rather, what we spend on health care is the total of the expenditures in diverse sectors ranging from the individual buying a bottle of useless cold pills or a much needed bandage to the government building a useless new 21 million dollar Navy hospital in New Orleans or purchasing essential medical care for a large class of people in need. There simply is no coherent, organized or regulated arrangement regarding how much is spent, what it is spent on, or how care is distributed. Nor is there much effective coordination among the various sectors of health care activity. Therefore there is no overall determination of a total level of expenditure — indeed, we know only approximately what the total expenditure is. And there is no systematic control over the ways in which the funds are spent. Any approach to health care distribution or cost containment must therefore be piecemeal, addressing individual
aspects of the health care landscape one locale at a time.

If we are speaking of a single individual or family, it is relatively easy to say how to keep costs down: live prudently, carry a good medical insurance program, and be an alert, informed, active and critical consumer of health care services. Then, most probably, the costs of health care will be reasonably well contained. But that by itself will not relieve the rising costs associated with high technology medicine nor will it keep insurance costs from rising beyond the reach of increasingly many people. For the problem is not fundamentally one of individual choice and action; it is one of a cumulative financial effect that can only be addressed, however piecemeal, by collective response — that is, as a matter of public policy.

Governmental expenditure on health care is approximately 75 billion dollars a year, and the government role is exceedingly diverse. The government functions:

1. As direct provider of care. Example: the Veterans Administration's system of nearly 200 hospitals, for which the 1978 fiscal year budget appropriation for medical care is over 4.7 billion dollars.

2. As provider of medical insurance. Example: the Medicare and Medicaid programs, through which the government is the largest provider of medical insurance in the country.

3. As the operator of support systems for health care research and delivery. Example: the National Center for Disease Control in Atlanta.

4. As a medical educator. Example: the Uniformed Services University of the Health Sciences.

5. As a supporter of medical education. Example: capitation grants to medical, nursing, and allied health professional schools.

6. As a sponsor and operator of medical research programs. Example: the National Institutes of Health.

7. As a regulator of persons, substances, and institutions. Example: rulings by the Food and Drug Administration. And finally,


Each of these functions is itself diverse, and each thus provides a complex context of expenditure wherein questions of efficiency and of equity can be raised. Further, the government's regulatory and legislative powers will play a crucial role in any collective response to the problems associated with cost containment. So the government is the central figure in the story.

Any consideration of containing costs must deal with problems of distribution and supply, among others. Basically, there are just two possibilities for containing costs: one can limit or reduce service, or one can limit or reduce the cost for the average instance of service. One way to reduce or limit service is to distribute it only to a limited portion of those cases where a need is present.

The reduction of service is also possible, however, through the redefinition of need. We can increase or diminish the claims for health care services by broadening or narrowing the definitions of illness, without thereby affecting anyone medically. If our clinics are too crowded, we can thin the crowds by a decision that although people with dandruff, obesity, bizarre noses, and lackadaisical libido may have problems, they are not necessarily sick, and do not qualify to make claims on the health care facilities. The closer we move toward publicly funded health care or health care insurance, the more critical it will become to clarify what is to count as illness for purposes of claiming entitlement to health care resources.

Now consider the notion of limiting costs by leaving some needs unmet. Recall specifically those inevitably cited patients with kidney failure. In the early
days of renal dialysis, we had a classic problem of allocating limited vital resources. There were not enough machines to go around. That problem is now essentially past, but a similar situation exists with respect to live organ transplants. Many more patients are medically qualified to receive transplanted kidneys than can be accommodated given the present rate of supply. How shall we respond to this situation?

Various principles of distribution come to mind. Consider:

(1) To each according to his means. This is a free market policy. Kidneys go to those who can afford them, with the price determined by market phenomena.

(2) To each according to his social utility. This is roughly the approach adopted in the original dialysis selection in Seattle, where an assessment was made of the social utility of the applicants. It is the utilitarian approach, the one that seeks to maximize efficiency.

(3) To each according to his entitlement or status. A policy like this might favor veterans, landowners, members of the party in power, or other groups or individuals making special claims.

(4) To each according to his luck. This is the policy of the strict egalitarian: count every medically qualified individual as an equal, and draw lots to determine who will get the kidneys.

(5) To each according to his need. To implement this policy, of course, requires an increase in the supply of the resource the scarcity of which presents the problem in the first place.

The choice among these distributional policies will be difficult because our values do not all point to a single choice. In particular, we are sympathetic both to considerations of social utility and to the desirability of meeting everyone's need where we have the ability to meet anyone's. So there is a pressure to increase service to meet demand, thereby to eliminate some of the conflict we feel, and that yields pressure to increase the supply of transplantable kidneys while keeping a lid on the costs. Is there any possibility of doing that?

ABC news reported in the Autumn of 1978 that recent legislation in France makes a person's organs available at death for transplantation unless the individual has exercised a prior option of objection. Should we adopt a similar policy? The government could go a step beyond France, requiring organ donation without option of prior objection. Or it could go two steps beyond, drafting people into a national organ bank battalion. These people might be selected if they are in good health, late in life and of low social utility. They would then be required to donate one kidney, with the rest of their organs to be taken at death. The French policy is moderate in the context of what is possible. Still, it is seen as overly coercive by many critics. Milder measures include a proposal made recently by an officer of the American Kidney Foundation, who suggested that each individual agree or decline at the time of registration with the Social Security Administration. But Sidney Wolfe, of the Health Research Group, responded that any such association with a government agency that provides vital support services could be implicitly coercive. Still milder measures are available, however. The government could decide to support the present system of total voluntarism with a campaign aimed at persuading large numbers of people to become donors. Or the government could leave the matter wholly to the workings of the private sector.

For an illuminating comparison, consider briefly a different problem. We provide military manpower in various ways at various times depending not only on our national security needs but also on our moral priorities. The draft, favored in wartime, is the most efficient way to provide the manpower, especially combined with selective deferment. The government conscripts soldiers, paying what it decides
to pay — thereby containing payroll costs, and exempting those whose greater social utility lies elsewhere — thereby maximizing social efficiency. The principle is: from each according to his usefulness. But this policy is criticized on grounds of equity. It sends the poor and underprivileged off to battle, favoring further the already favored, while the benefit of national defense — that is, the security of the nation — is equally enjoyed by all. Moved by conscience to provide military manpower more equitably, we change to a lottery. Now the principle is: from each according to his luck in an equal risk lottery. But this policy has critics, for it obliterates the freedom of the unlucky draftee, as well as reducing efficiency by drafting some who would be more usefully placed elsewhere. So out of respect for personal liberty, we move to a volunteer service. From each according to his choice. Freedom is honored, but the costs soar because the incentive to join is not great for most people in a reasonably sound economy. And now we hear lamentation from the Pentagon: we have liberty, but the price is getting beyond our reach, and the efficiency is low. So once again we may move to another system, striking a different balance among the competing values of efficiency, equality and liberty.

A parallel situation exists in regard to kidney supply and distribution. The various plans clearly exhibit different degrees of respect for different values. A plausible utilitarian case can be made for the very coercive plans to increase supply, and as we move through the shadings of coercion from a draft or universal requirement, to coercion of varying degrees, to persuasion, education, and voluntarism, the level of efficiency seems to drop. At the same time, the level of equity in the treatment of persons seems to rise, especially if we take equity to require respect for personal autonomy and the bodily integrity of individual persons. But now a curious bind seems to emerge. For if the most equitable policy for distribution requires meeting the needs of all patients who require transplants, that policy also seems to require, as a practical matter, a highly efficient policy for obtaining transplantable kidneys. Yet the policies that seem most efficient in this regard seem least equitable from the point of view of potential donors. Thus we see equity not only in opposition to efficiency, but to equity itself.

We need to sustain a systematic inquiry into the considerations of equity and efficiency in health care, and as part of that process we need a more sophisticated understanding of how to assess the value of the outcomes that health care provides. This is particularly important as our concern with cost containment heightens, for although the crisis in health care costs is not primarily a government spending crisis, only the government is in any position to get real leverage on the currents of supply and distribution of health care goods and services. And when we look to government to solve large scale social problems, we should remember that we are looking to a ponderous and unpredictable force, mighty in itself, yet subject to the shifting drifts of political sentiment. We are well advised to understand what we are asking it to do.

My own view is that we have a tendency to weigh efficiency too heavily in its conflict with equity, in part — but only in part — because of the difficulty of measuring the value of considerations of equity. Perhaps the basic mistake is to assume that the kind of assessment needed can be measurement at all, as opposed to the informed and sensitive judgment that lies at the heart of leadership and statesmanship.

One final example: imagine a large family next door. They treat all their children well except the youngest. That one is neglected, disdained — an outcast. We would, I think, judge that family harshly, accepting as a mark of its degree of decency the way it treats the one whom it treats least well. John Rawls, in A
Equity, Efficiency, and the Distribution of Health Care

The Theory of Justice, argues that equity requires us to use a similar criterion in judging social institutions. The keystone of his theory is respect for liberty conjoined with concern for the least advantaged among us. Those who suffer from debilitating illness or handicap are, in an important sense, the least advantaged among us, and we neglect them at our own moral risk. There is no way to assign a dollar value to such considerations, and they may in tragic circumstances even be defeasible on grounds of excessive cost. Nonetheless they have a force that should not be underestimated. It may be useful to keep Rawls’ criterion in mind as a prima facie constraint on our pursuit of efficiency. That constraint would prevent us from assessing health care policies in a purely utilitarian way or in a way that excludes the interests of any segment of the population. It would not by itself determine what policies we should set, but by narrowing the range of choices it would play some role in the process. That larger process of setting public policies for health care that are equitable and affordable will be more complex even than the systems of supply and distribution, and it would be futile to expect any stable resolution of policy to be achieved. Rather, there must be a process of assessment and reassessment in the public and political forums — an on-going exchange of which the perspectives of philosophy are an essential part.

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