SUPPOSE THAT WE HAD DECIDED exactly what the medical profession ought to be. Given that resources—time and money, as well as organs, fetal tissue, hospitals, operating rooms, etc.—are limited, it would still be difficult to decide how to distribute health care in a just manner. Why should some people get more and better health care than others? It certainly does happen. Is it due to planning or is it just “the luck of the draw”? Should something so important as health care be left to luck?

In this next set of readings we see two different answers to these questions. Larry Churchill and H. T. Engelhardt agree that rationing is both a reality and a necessity. The question is how to deal with the reality and the necessity.

H. T. Engelhardt addresses the need for a program of allocation based on autonomy, in other words, the freedom of individuals to make their own decisions. Engelhardt discusses organ transplants in particular but is actually facing the general issue of macro-allocation. He mentions three important values. Force should not be used to impose a concept of the good life. We ought to respect the values of others. My body and its parts are mine; if I have a right to anything I have a right to my body and its parts.

Engelhardt points out that in a free, pluralistic society there will be occasions where some people are harmed by the fact that individual freedom must be respected because this is the only way to ensure the social good, the good of all. Notice how he uses two distinctions: between the natural and the social lottery, and between the unfortunate and the unfair.
**Some Moral Presuppositions**

*The Problem*

Some controversies have a staying power because they spring from unavoidable moral and conceptual puzzles. The debates concerning transplantation are a good example. To begin with, they are not a single controversy. Rather, they are examples of the scientific debates with heavy political and ethical overlays that characterize a large area of public-policy discussions.\(^1\) The determination of whether public-policy not heart or liver transplantation is an experimental or nonexperimental procedure for which it is reasonable and necessary to provide reimbursement is not simply a determination on the basis of facts regarding survival rates or the frequency with which the procedure is employed. Nor is it a purely moral issue.\(^2\)

It is an issue similar to that raised regarding the amount of pollutants that ought to be considered safe in the workplace. The question cannot be answered simply in terms of scientific data, unless one presumes that there will be a sudden inflection in the curve expressing the relationship of decreasing parts per billion of the pollutant and the incidence of disease or death, after which very low concentrations do not contribute at all to an excess incidence of disability or death. If one assumes that there is always some increase in death and disability due to the pollutant, one is not looking for an absolutely safe level but rather a level at which the costs in lives and health do not outbalance the costs in jobs and societal vexation that most more stringent criteria would involve. Such is not a purely factual judgment but requires a balancing of values. Determinations of whether a pollutant is safe at a particular level, of whether a procedure is reasonable and necessary, of whether a drug is safe, of whether heart and liver transplantations should be regarded as nonexperimental procedures are not simply factual determinations. In the background of those determinations is a set of moral judgments regarding equity, decency, and fairness, cost-benefit tradeoffs, individual rights, and the limits of state authority.

Since such debates are structured by the intertwining of scientific, ethical, and political issues, participants appeal to different sets of data and rules of inference, which leads to a number of opportunities for confusion. The questions that cluster around the issue of providing for the transplantation of organs have this distracting heterogeneity. There are a number of questions

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with heavy factual components, such as, “Is the provision of liver transplants an efficient use of healthcare resources?” and “Will the cost of care in the absence of a transplant approximate the costs involved in the transplant?” To answer such questions, one will need to continue to acquire data concerning the long-term survival rates of those receiving transplants.3–8 There are, as well, questions with major moral and political components, which give public policy direction to the factual issues. “Does liver or heart transplantation offer a proper way of using our resources, given other available areas of investment?” “Is there moral authority to use state force to redistribute financial resources so as to provide transplantations for all who would benefit from the procedure?” “How ought one fairly to resolve controversies in this area when there is important moral disagreement?”

These serious questions have been engaged in a context marked by passion, pathos, and publicity. George Deukmejian, governor of California, ordered the state to pay for liver transplantation for Koren Crosland, and over $265,000 was raised through contributions from friends and strangers to support the liver transplantation of Amy Hardin of Cahokia, Illinois.9 Charles and Marilyn Fiske’s testimony to the Subcommittee on Investigations and Oversight of the House Committee on Science and Technology provided an example of how fortuitous publicity can lead to treatment10—in this case, to their daughter Jamie’s receiving payment through Blue Cross of Massachusetts by agreement on October 1, 1982,11 along with contingency authorization for coverage for liver-transplantation expenses through the Commonwealth of Massachusetts on October 29, 1982.12 The proclamation by President Reagan of a National Organ Donation Awareness Week, which ran from April 22 through 28, further underscored the public nature of the issues raised.13 In short, several serious and difficult moral and political dilemmas have been confronted under the spotlight of media coverage and political pressures.14–17 What is needed is an examination of the moral and conceptual assumptions that shape the debate, so that one can have a sense of where reasonable answers can be sought.

**Why Debates About Allocating Resources Go On and On**

The debates concerning the allocation of resources to the provision of expensive, life-saving treatment such as transplantation have recurred repeatedly over the past two decades and show no promise of abating.18–21 To understand why that is the case, one must recall the nature of the social and moral context within which such debates are carried on. Peaceable, secular, pluralist societies
are by definition ones that renounce the use of force to impose a particular ideology or view of the good life, though they include numerous communities with particular, often divergent, views of the ways in which men and women should live and use their resources. Such peaceable, secular societies require at a minimum a commitment to the resolution of disputes in ways that are not fundamentally based on force. There will thus be greater clarity regarding how peaceably to discuss the allocation of resources for transplantation than there will be regarding the importance of the allocation of resources itself. The latter requires a more concrete view of what is important to pursue through the use of our resources than can be decisively established in general secular terms. As a consequence, it is clearer that the public has a right to determine particular expenditures of common resources than that any particular use of resources, as for the provision of transplantation, should be embraced.

This is a recurring situation in large-scale, secular, pluralist states. The state as such provides a relatively neutral bureaucracy that transcends the particular ideological and religious commitments of the communities it embraces, so that its state-funded health-care service (or its postal service) should not be a Catholic, Jewish, or even Judeo-Christian service. This ideal of a neutral bureaucracy is obviously never reached. However, the aspiration to this goal defines peaceable, secular; pluralist societies and distinguishes them from the political vision that we inherited from Aristotle and which has guided us and misguided us over the past two millennia. Aristotle took as his ethical and political ideal the city-state with no more than 100,000 citizens, who could then know each other, know well whom they should elect, and create a public consensus. It is ironic that Aristotle fashioned this image as lie participated in the fashioning of the first large-scale Greek state.

We do not approach the problems of the proper allocations of scarce resources within the context of a city-state, with a relatively clear consensus of the ways in which scarce resources ought to be used. Since the Reformation and the Renaissance, the hope for a common consensus has dwindled, and with good cause. In addition, the Enlightenment failed to provide a fully satisfactory secular surrogate. It failed to offer clearly convincing moral arguments that would have established a particular view of the good life and of the ways in which resources ought to be invested. One is left only with a general commitment to peaceable negotiation as the cardinal moral canon of large-scale peaceable, secular, pluralist states.
As a result, understandings about the proper use of scarce resources tend to occur on two levels in such societies. They occur within particular religious bodies, political and ideological communities, and interest groups, including insurance groups. Then take place as well within the more procedurally oriented vehicles and structures that hold particular communities within a state. The more one addresses issues such as the allocation of scarce resource in the context of a general secular, pluralist society, the more one will be pressed to create all answer in some procedurally fair fashion, rather than hope to discover a proper pattern for the distribution of resources to meet medical needs. However, our past has left us with the haunting and misguided hope that the answer can be discovered.

There are difficulties as well that stem from a tension within morality itself: a conflict between respecting freedom and pursuing the good. Morality as an alternative to force as the basis for the resolution of disputes focuses on the mutual respect of persons. This element of morality, which is autonomy-directed, can be summarized in the maxim, Do not do unto others what they would not have done unto themselves. In the context of secular pluralist ethics, this element has priority, in that it call more clearly be specified and justified. As a result, it sets limits to the moral authority of others to act and thus conflicts with that dimension of morality that focuses on beneficence, on achieving the good for others. This second element of morality may be summarized in the maxim, Do to others their good. The difficulty is that the achievement of the good will require the cooperation of others who may claim a right to be respected in their nonparticipation. It will require as well deciding what goods are to be achieved and how they are to be ranked. One might think here of the conflict between investing communal resources in liver and heart transplantations and providing adequate general medical care to the indigent and near indigent. The more one respects freedom, the more difficult it will be for a society to pursue a common view of the good. Members will protest that societal programs restrict their freedom of choice, either through restricting access to programs or through taxying away their disposable income.

The problem of determining whether and to what extent resources should be invested in transplantation is thus considerable. The debate must be carried on in a context in which the moral guidelines are more procedural than supplied with content. Moreover, the debate will be characterized by conflicting views of what is proper to do, as well as by difficulties in showing that there is state authority to force the participation of unwilling citizens. Within these vexing constraints societies approach the problem of
allocating scarce medical resources and in particular of determining the amount of resources to be diverted to transplantation. This can be seen as a choice among possible societal insurance mechanisms. As with the difficulty of determining a safe level of pollutants, the answer with respect to the correct level of insurance will be as much created as discovered.

**Insurance Against the Natural and Social Lotteries**

Individuals are at a disadvantage or an advantage as a result of the outcomes of two major sets of forces that can be termed the natural and social lotteries. By the natural lottery I mean those forces of nature that lead some persons to be healthy and others to be ill and disabled through no intention or design of their own or of others. Those who win the natural lottery do not need transplantations. They live long and healthy lives and die peacefully. By the social lottery I mean the various interventions, compacts, and activities of persons that, with luck, lead to making some rich and others poor. The natural lottery surely influences the social lottery. However, the natural lottery need not conclusively determine one’s social and economic power, prestige, and advantage. Thus, those who lose at the natural lottery and who are in need of heart and liver transplantation may still have won at the social lottery by having either inherited or earned sufficient funds to pay for a transplantation. Or they may have such a social advantage because their case receives sufficient publicity so that others contribute to help shoulder the costs of care.

An interest in social insurance mechanisms directed against losses at the natural and social lotteries is usually understood as an element of beneficence-directed justice. The goal is to provide the amount of coverage that is due to all persons. The problem in such societal insurance programs is to determine what coverage is due. Insofar as societies provide all citizens with a minimal protection against losses at the natural and the social lotteries, they give a concrete understanding of what is due through public funds. At issue here is whether coverage must include transplantation for those who cannot pay.

However, there are moral as well as financial limits to a society’s protection of its members against such losses. First and foremost, those limits derive from the duty to respect individual choices and to recognize the limits of plausible state authority in a secular, pluralist society. If claims by society to the ownership of the resources and services of persons have limits, then there will always be private property that individuals will have at their disposal to trade for the services of others, which will create a second tier of
health care for the affluent. Which is to say, the more it appears reasonable that property is owned neither totally societally nor only privately, and insofar as one recognizes limits on society’s right to constrain its members, two tiers of health-care services will by right exist: those provided as a part of the minimal social guarantee to all and those provided in addition through the funds of those with an advantage in the social lottery who are interested in investing those resources in health care.

In providing a particular set of protections against loses at the social and natural lotteries, societies draw one of the most important societal distinctions—namely, between outcomes that will be socially recognized as unfortunate and unfair and those that will not be socially recognized as unfair, no matter how unfortunate they may be. The Department of Health and Human Services, for instance, in not recognizing heart transplantation as a nonexperimental procedure, removed the provision of such treatment from the social insurance policy. The plight of persons without private funds for heart transplantation, should they need heart transplantation, would be recognized as unfortunate but not unfair.29–31 Similarly, proposals to recognize liver transplantation for children and adults as nonexperimental are proposals to alter the socially recognized boundary between losses at the natural and social lotteries that will be understood to be unfortunate and unfair and those that will simply be lamented as unfortunate but not seen as entitling the suffering person to a claim against societal resources.32

The need to draw this painful line between unfortunate and unfair outcomes exists in great measure because the concerns for beneficence do not exhaust ethics. Ethics is concerned as well with respecting the freedom of individuals. Rendering to each his or her due also involves allowing individuals the freedom to determine the use of their private energies and resources. In addition, since secular pluralist arguments for the authority of peaceable states most clearly establish those societies as means for individuals peacefully to negotiate the disposition of their communally-owned resources, difficulties may arise in the allocation of scarce resources to health care in general and to transplantation in particular. Societies may decide to allocate the communal resources that would have been available for liver and heart transplantation to national defense or the building of art museums and the expansion of the national park system. The general moral requirement to respect individual choice and procedurally fair societal decisions will mean that there will be a general secular, moral right for individuals to dispose of private resources, and for societies to dispose of communal resources, in
ways that will be wrong from a number of moral perspectives. As a result, the line between outcomes that will count as unfortunate and those that will count as unfair will often be at variance with the moral beliefs and aspirations of particular ideological and moral communities encompassed by any large-scale secular society.

Just as one must create a standard of safety for pollutants in the workplace by negotiations between management and labor and through discussions in public forums one will also need to create a particular policy for social insurance to cover losses at the natural and social lotteries. This will mean that one will not be able to discover that any particular investment in providing health care for those who cannot pay is morally obligatory. One will not be able to show that societies such as that of the United Kingdom, which do not provide America’s level of access to renal dialysis for endstage renal disease, have made a moral mistake. Moral criticism will succeed best in examining the openness of such decisions to public discussion and control.

It is difficulties such as these that led the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to construe equity in health care neither as equality in health care nor as access to whatever would benefit patients or meet their needs. The goal of equality in health care runs aground on both conceptual and moral difficulties. There is the difficulty of understanding whether equality would embrace equal amounts of health care or equal amounts of funds for health care. Since individual health needs differ widely, such interpretations of equality are fruitless. Attempting to understand equality as providing health care only from a predetermined list of services to which all would have access conflicts with the personal liberty to use private resources in the acquisition of additional care not on the list. Construing equity as providing all with any health care that would benefit them would threaten inordinately to divert resources to health care. It would conflict as well with choices to invest resources in alternative areas. Substituting “need” for “benefit” leads to similar difficulties unless one can discover, among other things, a notion of need that would not include the need to have one’s life extended, albeit at considerable cost.

The commission, as a result, construed equity in health care as the provision of an “adequate level of health care.” The commission defined adequate care as “enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisf-
fying life.” However, this definition runs aground on the case of children needing liver transplants and other such expensive health-care interventions required to secure any chance of achieving “a reasonably full and satisfying life.” There is a tension in the commission’s report between an acknowledgment that a great proportion of one’s meaning of “adequate health care” must be created and a view that the lineaments of that meaning can be discovered. Thus, the commission states that “[i]n a democracy, the appropriate values to be assigned to the consequences of policies must ultimately be determined by people expressing their values through social and political processes as well as in the marketplace.” On the other hand, the commission states that “adequacy does require that everyone receive care that meets standards of sound medical practice.” The latter statement may suggest that one could discover what would constitute sound medical practice. In addition, an appeal to a notion of “excessive burdens” will not straightforwardly determine the amount of care due to individuals, since a notion of “excessiveness” requires choosing a particular hierarchy of costs and benefits. Neither will an appeal to excessive burdens determine the amount of the tax burden that others should bear, since there will be morally determined upper limits to taxation set by that element of property that is not communal. People, insofar as they have private property in that sense, have the secular moral right, no matter how unfeeling and uncharitable such actions may appear to others, not to aid those with excessive burdens, even if the financial burdens of those who could be taxed would not be excessive.

Rather, it would appear, following other suggestions from the commission, that “adequate care” will need to be defined by considering, among other things, professional judgments of physicians, average current use, lists of services that health-maintenance organizations and others take to be a part of decent care, as well as more general perceptions of fairness. Such factors influence what is accepted generally in a society as a decent minimal or adequate level of health care. As reports considering the effects of introducing expensive new technology suggest, there is a danger that treatments may be accepted as part of “sound medical practice” before the full financial and social consequences of that acceptance are clearly understood. Much of the caution that has surrounded the development of liver and heart transplantation has been engendered by the experience with renal dialysis, which was introduced with overly optimistic judgments regarding the future costs that would be involved.
Even if, as I have argued, the concrete character of “rights to health care” is more created as an element of societal insurance programs than discovered and if the creation is properly the result of the free choice of citizens, professional and scientific bodies will need to aid in the assessment of the likely balance of costs and benefits to be embraced with the acceptance of any new form of treatment as standard treatment, such as heart and liver transplantation. A premature acceptance may lead to cost pressures on services that people will see under mature consideration to be more important. At that point it may be very difficult to withdraw the label of “standard treatment” from a technologic approach that subsequent experience shows to be too costly, given competing opportunities for the investment of resources. On the other hand, new technologic developments may offer benefits worth the cost they will entail, such as the replacement by computerized tomography of pneumoencephalography. But in any event, there is no reason to suppose that there is something intrinsically wrong with spending more than 10.5 percent of the gross national product on health care.

**Is Transplantation Special?**

All investments in expensive life-saving treatment raise a question of prudence: Could the funds have been better applied elsewhere? Will the investment in expensive life-saving treatment secure an equal if not greater decrease in morbidity and mortality than an investment in improving the health care of the millions who lack health-care insurance or have only marginal coverage? If the same funds were invested in prenatal health care or the treatment of hypertension, would they secure a greater extension of life and diminution of morbidity for more people? When planning for the rational use of communal funds, it is sensible to seek to maximize access and contribution to the greatest number of people as a reasonable test of what it means to use communal resources for the common good. However, not everything done out of the common purse need be cost effective. It is unclear how one could determine the cost effectiveness of symphony orchestras or art museums. Societies have a proclivity to save the lives of identifiable individuals while failing to come to the aid of unidentified, statistical lives that could have been saved with the same or fewer resources. Any decision to provide expensive life-saving treatment out of communal funds must at least frankly acknowledge when it is not a cost-effective choice but instead a choice made because of special sympathies for those who are suffering or because of special fears that are engendered by particular diseases.
The moral framework of secular, pluralist societies in which rights to health care are more created than discovered will allow such choices as morally acceptable, even if they are less than prudent uses of resources. It will also be morally acceptable for a society, if it pursues expensive life-saving treatment, to exclude persons who through their own choices increase the cost of care. One might think here of the question whether active alcoholics should be provided with liver transplants. There is no invidious discrimination against persons in setting a limit to coverage or in precluding coverage if the costs are increased through free choice. However, societies may decide to provide care even when the costs are incurred by free decision.

Though none of the foregoing is unique to transplantation, the issue of transplantation has the peculiarity of involving the problem not only of the allocation of monetary resources and of services but of that of organs as well. In a criticism of John Rawls’ *Theory of Justice*, which theory attempts to provide a justification for a patterned distribution of resources that would redound to the benefit of the least-well-off class, Robert Nozick tests his readers’ intuitions by asking whether societal rights to distribute resources would include the right to distribute organs as well. He probably chose this as a test case because our bodies offer primordial examples of private property. The example is also forceful, given the traditional Western reluctance, often expressed in religious regulations, to use corpses for dissection. There is a cultural reluctance to consider parts of the body as objects for the use of persons. No less a figure than Immanuel Kant argued for a position that would appear to preclude the sale or gift of a body part to another. This view of Kant’s, one should note, is very close to the traditional Roman Catholic notion that one has a duty to God regarding one’s self not to alter one’s body except to preserve health.

The concern to have a sufficient supply of organs for transplantation has expressed itself in recent political proposals and counter-proposals regarding the rights of individuals to sell their organs, the provision of federal funds for the support of organ procurement, the study of the medical and legal issues that procurement may raise, and even the taking of organs from cadavers by society with the presumption of consent unless individuals have indicated the contrary. It will be easier to show that persons have a right to determine what ought to be done with their bodies, even to the point of making donor consent decisive independently of the wishes of the family, than to show that society may presume consent. A clarification of policy, to make donor decisions definitive, would be in accord with the original intentions of
the Uniform Act of Donation of Organs and would ease access to needed organs. It would not impose on people the burden of having to announce to others that they do not want their organs used for transplantation. The more one presumes that organs are not societal property, the more difficult it is to justify shifting the burden to individuals to show that they do not want their organs used. If sufficient numbers of organs are not available, it will be unfortunate, but from the point of view of general secular morality, not unfair. Free individuals will have valued other goals (e.g., having an intact body for burial) more highly than the support of transplantation. One will have encountered again one of the recurring limitations on establishing and effecting a general consensus regarding the ways in which society ought to respond to the unfortunate deliverances of nature.

**Living with the Unfortunate, Which Is Not Unfair**

Proposals for the general support of transplantation are thus restricted by various elements of the human condition. There is not simply a limitation due to finite resources, making it impossible to do all that is conceivably possible for all who might marginally benefit. There are restrictions as well that are due to the free decisions of both individuals and societies. Individuals will often decide in ways unsympathetic to transplantation programs that would involve the use of their private resources, including their organs. Insofar as one takes seriously respect for persons, one must live with the restrictions that result from numerous free choices. One may endeavor to educate, entice, and persuade people to participate. However, free societies are characterized by the commitment to live with the tragedies that result from the decisions of free individuals not to participate in the beneficent endeavors of others. There are then also the restrictions due to the inability to give a plausible account of state authority that would allow the imposition of a concrete view of the good life. Secular, pluralist societies are more neutral moral frameworks for negotiation and creation of ways to use their common resources than modes for discovering the proper purpose for those resources. If societies freely decide to give a low priority to transplantation and invest instead in generally improving health care for the indigent in the hope of doing greater good, there will be an important sense in which they have acted within their right, even if from particular moral perspectives that may seem wrongheaded.

These reflections on the human condition suggest that we will need in the future to learn to live with the fact that some may receive expensive life-
saving treatment while others do not, because some have the luck of access to the media, the attention of a political leader, or sufficient funds to purchase care in their own right. The differences in need, both medical and financial, must be recognized as unfortunate. They are properly the objects of charitable response. However, it must be understood that though unfortunate circumstances are always grounds for praiseworthy charity, they do not always provide grounds, by that fact, for redrawing the line between the circumstances we will count as unfortunate but not unfair and those we will count as unfortunate and unfair. To live with circumstances we must acknowledge as unfortunate but not unfair is the destiny of finite men and women who have neither the financial nor moral resources of gods and goddesses. We must also recognize the role of these important conceptual and moral issues in the fashioning of what will count as reasonable and necessary care, safe and efficacious procedures, nonexperimental treatment, or standard medical care. Though we are not gods and goddesses, we do participate in creating the fabric of these “facts.”

ENDNOTES


25 _____, *Politics*, vii 4a.1326b.


36 Ibid., p. 37.

37 Ibid.

38 Ibid., pp. 42–43.

39 Ibid., pp. 43–46.

40 Ibid., pp. 37–47.


49 Ibid., Senate. by O. Hatch, Senate Report 2048: 1983.9