What Constitutes a Just Health Services System and How Should Scarce Resources Be Allocated?

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Over the last century health has ceased to be a private matter concerning mainly individuals and has become a public problem, a political issue. The terms “health” and “politics,” initially mutually exclusive, have become inextricably intertwined in the expression “health policy,” until today it is hard to find any aspect of health completely detached from the immense bureaucratic apparatus of health policy.

Many consider the interference of politics in health excessive, while for others it is still insufficient; but both sides justify their points of view by appealing to the concept of distributive justice. Thus it is not surprising that one of the liveliest and most polemic chapters of bioethics today is that of justice in health.

When should a health service be considered just or unjust? What resources must be allocated to comply with the obligation of justice? How should one proceed when available resources are less than those theoretically needed? How can insufficient resources be justly distributed? These are some of the questions members of the general public ask repeatedly.

Perhaps any attempt to provide definitive answers will be pretentious; but this should not lead us to believe that such questions are useless or have no answers. Indeed, there are answers, but clearly not easy ones.

In my view, all answers acknowledging the issue’s tremendous complexity must unfold on two distinct levels, which I shall call deontologic (i.e., addressing principles) and teleologic (i.e., addressing consequences). A coherent theory of justice is impossible if either of these is missing. Hence, what follows is divided into two sections, which correspond to the two parts of the title to this study: What constitutes a just health services system? and How should scarce resources be justly allocated? In the conclusion I will integrate the partial results of each section in an effort to suggest a comprehensive response to these questions.

THE DEONTOLOGIC MOMENT: WHAT CONSTITUTES A JUST HEALTH SERVICES SYSTEM?

The primary and basic meaning of “justice” is correction or adjustment of something in accordance with a model of
what it should be. In this first sense, "just" means "adjusted," that which is adjusted to the model. Thus, we will say that an act is "just" when it is in accordance with the law, and that the law is "just" when it is an expression of moral principles. "Unjust," to the contrary, is that which is not adjusted to the general principle, norm, or criteria being applied.

That general principle of justice with which all other criteria and acts of man must be brought into line was defined by the Roman jurists as *suum cuique tribuere,* "to each his due." An act is just when each is given his due, and unjust otherwise. The problem lies in spelling out precisely what this means. Throughout Western cultures there have been no fewer than four different interpretations, which to some extent contradict one another; these have variously interpreted justice as "natural proportionality," "contractual freedom," "social equality," and "collective welfare." I will endeavor to characterize each of them as concisely as possible and to examine their impact upon the world of health.

**Justice as Natural Proportionality**

Historically, the theory of justice that has been the most widely applied is doubtless that which understands justice as "natural proportionality." Initiated by the Greek thinkers around the sixth century B.C., it went unrivaled until the seventeenth century.

According to this notion, justice is a natural property of things, whose name need only be known and respected. This is the meaning that the Greek philosophers attributed to the term "*dikaiosyne.*" As natural entities, things are just, and any type of maladjustment constitutes a denaturalization. Everything has its natural place, and it is just that it remain there. This applies not only to the cosmic order, but also to the political order.

Plato’s *Republic* tells us that in a "naturally ordered" society, which is thus "adjusted" or "just," there will be inferior men, artisans; there will also be guardians; and, finally, there will be rulers.²

In addition to this "general" justice, Greek philosophy distinguished other more concrete or partial meanings of the term. Aristotle differentiated at least two. They are called partial because they neither pertain to all of nature nor to the body politic as a whole, but are limited to relations among different members of society. One is "distributive justice," which governs relationships between the ruler and his subjects. The other, "com- mutative justice," regulates relationships between private persons. In the health world both are important, but especially the first (in the expression "justice in health," justice is always understood to mean "distributive justice").³

According to Aristotle, distributive justice regulates the distribution "of honors, or money, or anything else" among the members of society (1). If by our nature we were all identical, there is no doubt but that such distribution would not be considered just if it were unequal. But given the "natural" character of inequality and hierarchy in society, for the Greeks the distribution of honors, wealth, etc. cannot and should not be done on an "identical" basis, but rather "proportionate" to one’s natural abilities.

Aristotle applies distributive justice to the distribution of "honors and wealth." The effect of this upon wealth is abundantly clear, but that of honors requires greater clarification. For all the philosophers of antiquity (understanding by this all those before the 17th century), the moral perfection achieved by each person

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in the community depended upon his place therein. The individual good of the sovereign was identified with the common good of all. The individual goods of the subjects, however, were not considered moral or good unless they were geared to achieving the common good of the sovereign. Hence the maximum individual good of the subject was obedience. This is the sense in which Aristotle understands the just or proportional distribution of “honors.” The ruler is owed obedience and piety in the same manner as a father. This is the foundation of paternalism, a constant throughout the naturalist sociopolitical tradition.

The repercussions of these schemes upon medicine have been tremendous. The physician embodies the common good, while the patient seeks a particular good, health. But the patient cannot achieve this good other than through the general economy embodied in the physician. Therefore, the only virtue that should be demanded of the patient is obedience. In the relationship between patient and physician, as in the relationship between parishioner and priest, or subject and sovereign, there is no place for commutative justice. The services of physicians, priests, and sovereigns are deemed so superior to those rendered by all other members of the community that it will never be possible to achieve equality in the exchange. Therefore, none of them is paid in accordance with the principle of commutative justice, but rather in “honor.” The money they receive is an “honorarium.”

The concept of justice as natural proportionality also has another health consequence of great importance. This derives from the fact that “proportionality” should be reflected in medical care, in accordance with an individual’s social rank. This belief was already evident in Plato’s Republic, which not in vain endeavored to describe the order of a “just” polis. There one can see how medical care should have a certain differential character, precisely by virtue of the principle of “distributive” justice. Slaves were attended by slave doctors; artisans had no access to lengthy or costly therapeutic procedures; and only the rich had complete access to the world of health.

All of this, written in the fourth century B.C., maintained its validity throughout the Middle Ages. Medieval society tried to follow platonic dictates insofar as possible, and medical care basically accommodated to these norms.

Thus was the theory of justice as adjustment to the proportional order of Nature, and thus it functioned in the field of medicine. Distributive justice led to the existence of three easily distinguishable levels of medical care throughout antiquity and the Middle Ages: that of the poorest strata of society (serfs, slaves, etc.); that of the free artisans; and that of the free citizens and the rich. Of the three groups’ members, only those belonging to the latter fully benefited from the goods of the city, and only its members could have been and should have been just and virtuous. Perhaps that is why only they were beneficiaries of complete health care.

Justice as Contractual Freedom

In more recent times, political science has come to make basic alterations in the concept of justice, and also has come to insist increasingly on the importance of a social contract as the basis for all justice-related duties. In this way, justice was transformed from a mere “natural adjustment” into a strict “moral decision.” The relationship of the subject and the sovereign was no longer based on “submission” but on free “decision.” Man was seen as being above Nature, and as the sole and exclusive source of rights.

In his Second Treatise of Government (2),
John Locke described what he regarded as basic rights of every man that derive from the mere fact of being a man. These are what are known as civil and political “human rights”: the right to life, to health or bodily integrity, to liberty, and to property, together with the right to defend these rights when they are believed to be endangered.

In this view, these rights are the “individual good” and inalienable rights of every man. But in order for them to be converted into the “common good,” a compact or contract known as the social contract must be entered into. Its purpose is to bring about “social justice,” which is identified with the “common good,” understood as “an established, accepted, known and firm law that serves by common consent as a norm of what is just and what is unjust” (3).

For Locke, social or legal justice has no aim other than that of protecting the rights that men have already had from the beginning, in such a way that they can never transgress those limits or oppose them. The social compact has the sole aim of protecting the natural rights (i.e., civil and political rights) of individuals. Political power, delegated as it is, has no realm other than that granted in the delegation—which, in turn, can have no object other than to protect natural rights and freedoms. All that transgresses these bounds is an unjustified and unjust abuse on the part of the State.

Obviously, this was a new concept of distributive justice, justice as contractual freedom. According to this theory, the distribution of honors and wealth is governed by several principles. One of them is the principle of acquisitive justice. According to this concept, work provides the primary title to property, since a worker puts something of his own into the object of his labor that is untransferable. Therefore, it is not Aristotelian proportionality that can tell us whether wealth has been distributed in a just fashion, but its manner of acquisition—and such acquisition will be just if it results from one’s own work.

Together with this initial principle goes another, that of the just transfer of property—whether by gift, purchase, or inheritance. (Regarding the latter, according to this principle children have a just right to inherit the property justly acquired by their parents.)

The result for Locke is a minimalist notion of the State. Specifically, the State’s only legitimate purpose is to facilitate people’s exercise of their natural rights to life, health, liberty, and property. When the State does not do so, or does so poorly, i.e., when the laws do not respect the natural limits, or the State steps beyond its bounds and dictates laws that go beyond the powers granted to it in the social contract, such laws are unjust.

In sum, according to liberal thought, justice is understood to consist of “contractual freedom,” as embodied in a contract that assures and protects individual freedom. This contrasts sharply with the old idea of natural adjustment.

This approach to the problem of distributive justice had a great impact upon all liberal thought, perhaps most notably that of the classical economists—including Adam Smith, David Ricardo, and Robert Malthus. Although liberal economics was gradually replaced by so-called social market economics as time passed, since 1970 the old liberalism has been regaining relevance, not only in economics (through Hayek, Friedman, and others), but also in ethics. Thus, philosopher Robert Nozick vigorously defends distributive justice as contractual freedom in his book Anarchy, State, and Utopia that was published in 1974 (4).

All this has been and continues to be of enormous importance to the world of medicine. According to liberal philosophy, the health market should be gov-
erned, like all others, by the laws of free trade, without the intervention of third parties. This has been the guiding concept of so-called "liberal" medicine, which insists that the physician-patient relationship must accommodate itself to free-market principles, and therefore should not be mediated by the State. In this light, any state intervention is considered artificial and harmful.

Throughout the nineteenth century, one can see how medical deontology in every country condemned the physician to become a wage-worker; and even today, when health insurance pays for almost all health care in many countries, there are still countries such as France where the patient continues to pay the physician directly, rather than having such compensation handled by Social Security or the State (5).

Within this model of liberal medical practice as it existed in nineteenth century Europe, one can distinguish three types of medical care. The first was for the well-to-do, who had sufficient resources to pay physicians' and surgeons' fees. The second was for a much larger middle-class group that used private insurance to cover the special expenses of surgery and hospital stays. And the third was for the poor, who had no chance of gaining access to the liberal health care system on their own, and who were provided for by so-called "benevolent" institutions. The moral obligation of benevolence, however, was not based on the moral principle of justice, but upon the concept of charity. Hence it was much more lax. Indeed, this "benevolence" generally involved poor and miserly financing that produced conditions that were miserable or clearly bordered upon misery. The literary works of the era are rife with testimony starkly depicting the impoverished character of all such benevolent health institutions (6).

In recent years, the liberal theory of justice has found new health applications. Confronting possible excesses by a "benevolent" State, the new liberals have returned to the thesis that health is an individual right that should be protected by the State, but only "negatively," not in a positive fashion. The State has the obligation in justice to hinder anyone attacking another's bodily integrity, but not to provide health care for all citizens. This is the difference between the negative right to health and the positive right to health care.

Within this context, compulsory health insurance cannot be demanded according to the principle of distributive justice, once distributive justice has been defined in the sense of Locke and Nozick. Thus H. Tristram Engelhardt concludes that "a fundamental human right to health care, even to a decent minimum of health care, does not exist." The reason, says Engelhardt, is that the right to health care exists only where it has been discovered or legislated as such.

In current discussions of health justice, the liberal point of view has found major proponents, though important nuances of difference exist among them. For example, Daniel Beauchamp considers that the clear negative right to health may compel the State to provide certain health services—because physical integrity is threatened not only by a physical attacker but also by harmful factors of a collective and social nature, which are in some way controlled by the State. Since these disease-related factors are caused by society, the State has the obligation to

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attend to them through a wide-ranging health care program.5

A third approach to the matter of distributive justice from the standpoint of liberal theory has been proposed by Baruch Brody. This author begins by accepting Locke’s criterion of work as the basis of appropriation; but he understands it as a principle of “acquisition,” not of “property.” Such a change must be introduced, Brody argues, because the value of a good (farmland, for example) is determined not only by the work done on it but also by the value of its natural resources.

Work, therefore, confers ownership of the value added, but not of the natural resources, which belong to all. In all probability, he continues, it is not possible to distribute these resources among everyone; and so those who exploit them should compensate all others for the benefit they receive for using something that is not theirs.

Accordingly, the social contract must always stipulate the following: that the natural resources in the land belong to those who possess them; but such persons, to compensate, owe a rent to all others that is proportional to the resources used. This rent may be charged in the form of taxes and used to finance a social security fund distributed equally among all. This would constitute redistributive justice. Health care should be considered part of this redistributive justice, but not as a separate and autonomous right, there being no specific right to health care, but only a generic right to the redistribution of certain wealth (7).

Justice as Social Equality

The third of the great theories of justice, which regards justice as social equality, involves numerous variants, some more “utopian,” others more “scientific.” Of them all, Marxism stands out because of its importance. For Marx and Engels the only advantage of the liberal state is that it does away with the despotic and absolutist State. All else—the attempt to convert the State into a permanent institution based on the theory of civil and political rights—is meaningless.

It is absurd to hypostatize rights as liberal thought does, because neither those rights nor the State based upon them go to the core of human existence. Rather, they are mere superstructure built on an infrastructure defined by the material conditions of life—in particular private property’s control over the means of production. For Marx the modern constitutional State, based upon respect for civil and political rights, perpetuates inequality and injustice, because it perpetuates private property’s control over the means of production.

This, in turn, makes possible a new definition of distributive justice. Those things that should be distributed equitably are not the means of production but the means of consumption. The problem is defining what is meant by “equitably.” Marx solved this problem by adopting an idea of Louis Blanc, which is: “From each according to his ability, to each according to his needs.”6 If we return from here to the classic definition of justice offered by Justinian, “Justitia est constans et perpetua voluntas justum cuique tribuens” (“just-


tice is the perpetual and constant will to give to each his due"), we see that the change lies in the way in which one defines what is "his due." For liberal thought it is "that which pertains to oneself," while for Marx it is "what one needs." Distributive justice is not adequate if it does not give to each "according to his needs." Only in this way can justice coincide with equality.

With communist justice thus defined, let us now see how it has been applied to health. For that purpose health has been defined as an "ability" and illness as a "need." This interesting pair of definitions makes health a production good and illness a consumption good. Since the State should give to each according to his needs, it has an obligation to provide free and comprehensive health care for all its citizens. This was done in Russia immediately after the 1917 Revolution, drawing on the medical insurance system (known as the zemstvo) that had existed in Czarist Russia since 1867. In the process, the Soviet State strengthened the zemstvo's coverage and effectiveness, turning it into a fundamental part of the new socialist order. This Soviet public insurance system has been the model for all those that have been established since in its sphere of political influence.

Justice as Collective Welfare

The socialist thinking that has exercised the greatest influence in Western countries has not been orthodox Marxism but what is called "democratic socialism." As its name indicates, it has advocated a mixed system combining elements of liberal democracy and the social State; and it has given rise to the so-called "social rights State," in particular the "welfare" State.

Using this approach, justice is not defined as mere contractual freedom, but neither is it defined as social equality. Instead, it is understood to mean "collective welfare." The quantitative novelty of the new system is found in the concept of welfare.

During the last century we have been witnessing the birth of a welfare economy, a welfare State, and also, naturally, a welfare ideology. This ideology has its own concept of justice. And since that concept of justice may be the one that is most widespread in the Western countries today, it is worth taking the time to review briefly its origins and nature.

Initially, the principal aim of democratic socialism was to correct the liberal theory by introducing a principle of redistributive equality. Therefore, it did not seek to annul the liberal theory's list of human rights, but rather to round it out with others—namely, economic, social, and cultural rights. The former rights of the liberal theory were called "negative" human rights, since they preceded formation of the State and could be demanded before the existence of any positive law. The latter were considered "positive" human rights, because they could be implemented only by the State, and therefore had no value other than that conferred on them by positive law—hence the need to demand them in the political, social, and labor struggle.

In essence, this is what leftist trade unions did in Europe in the second half of the nineteenth century. Democratic socialism arose confronting democratic liberalism. While the latter promoted the minimal State, the former tried by all means to establish a maximal State, i.e., a State that would promote and protect not only the negative rights but also the positive ones, establish a fair workday, prohibit exploitation of women and children, demand a minimum wage, and protect the unemployed, the sick, the retired, widows, and others from misfortune. Thus arose consciousness of everyone's right to education, adequate housing,
well-paid work, unemployment compensation, a pension, and health care.

The importance of this movement for health is clear. While liberalism discovered the right to health, socialism cast light on a new right, the right to health care. The first is a negative right preceding the social contract, and the State can do nothing but protect it; the second is a positive right that the State must actively guarantee. The first is a specification of the principle of freedom, while the second is deduced from the principle of equality.

Nevertheless, it should be noted that equality, for socialism, is the condition that makes possible all authentic freedom. Thus it turns out that both rights are derived, albeit by different routes, from freedom. Here one must distinguish between two types of freedom, "freedom from" and "freedom to." However much one may be "free from" external coercion, one cannot live in society under adequate conditions if one does not have "freedom to" work, have a family, raise children, etc., such freedoms being granted by economic, social, and cultural rights. For this reason, socialism began to consider the "freedoms from" as purely formal human rights vis-à-vis the "freedoms to," which were seen as "real" rights.

In the realm of health, this attitude has led people to conceive of health care as something that can justly be demanded. This in turn has prompted a radical change in the way governments deal with health problems; for in this light health can no longer be considered merely a private matter; rather, it becomes a matter of public concern and hence a political issue. This marks the beginning of "health policy" as a chapter in social and welfare policy. The social justice State, which in the Western countries has become identified with the welfare State (or benevolent State), must have as one of its top priorities protection of the right to health care. Otherwise, the development of the entire Western system of compulsory health insurance would be incomprehensible.

Because the pressure for the aforementioned economic, social, and cultural rights was brought to bear by the labor movement, at first these rights were only applied to workers. (This is why the first compulsory health insurance systems covered only workers.)

Bismarck, Germany's Iron Chancellor, was a pioneer in this area. In the early 1880s he established an extensive social security system to help protect workers against the consequences of accidents, illness, and old age. The medical insurance component of this system, known as the "fund for the ill" ("Krankenkassen"), was the first compulsory health insurance and a key foundation-stone of the modern welfare State.

This example was followed shortly thereafter by Great Britain, which approved a Pensioners’ Law in 1908 and a National Insurance Law in 1911 that gave rise to a system similar to that of the Krankenkassen in the area of health. In 1915 Sweden followed suit with a law on pensions and retirees, which helped create a society that Marquis Childs later dubbed "the Sweden of the just average."

But the definitive take-off of social security and health insurance systems came about as a result of the 1929–1931 economic crisis. As a more or less late response to this crisis, almost all the European states imitated the German health insurance model and instituted health protection for the working class.

The United States entered into a similar process from 1932 to 1943, but concrete gains were very limited—resulting in what Hirschfield has called "the lost reform" (8). In 1946 a general employment law was passed that recognized the Government’s responsibility to maintain
"maximum employment, productive capacity, and purchasing power." Later, in 1953, the Department of Health, Education, and Welfare (HEW) was established, and this was later used by President Lyndon B. Johnson for his "war on poverty." The medical programs known as Medicare (compulsory health insurance for the elderly) and Medicaid (payment of health care expenses for those considered by local authorities to be needy) were established under the auspices of HEW.7

In England, events took a different course. In 1942 the British economist William Beveridge prepared a report for the British Government entitled Social Insurance and Allied Services, in which he proposed establishment of a National Health Service that would provide for all citizens’ health needs. In 1945 and 1946 the Labor Government issued very advanced social legislation that did not accept the private elements in Beveridge’s plan, but that was otherwise based largely upon the Beveridge report. This legislation included the National Health Service Act, which went into effect in 1948. Thus appeared the first National Health Service in the Western world that was obligated to provide coverage for the entire population under all circumstances.

Ever since then, the Western countries’ national health systems have had to choose among the three existing types—the liberal, or U.S. system; the socialized, or British system; and the German, or intermediate system—or else they have had to come up with a more or less original mix of the three. In any event, protection of health as a social right became general as health came to be considered a basic aspect of any social welfare policy; and so the "benevolent" or "welfare" State had to include health care among its priorities.

Beginning in the 1970s, coinciding with the new economic recession, the need for all these welfare policies came to be questioned. Was health care, as had been claimed for decades, a demandable right by virtue of the principle of justice? The polemic was unleashed in the United States, which had never accepted the need for the so-called National Health Systems. In 1971 John Rawls’ well-known work, A Theory of Justice, appeared. This defined justice not as natural proportionality or contractual freedom or social equality but as "fairness."

By fairness Rawls meant something equally distant from Aristotle, Locke, and Marx, and very close to some of the fundamental ideas of Kantian ethics. In Rawls’ view, the naturally moral human being may construct a "well-ordered" society with the following two characteristics: (1) It will be effectively regulated by a public concept of justice; i.e., it will be a society in which all accept, and know that all others also accept, the same principles of right and justice. And (2) the members of a well-ordered society will be free and equal moral persons, and will see themselves and others as such in their political and social relations. Therefore, on the basis of the moral person, one can think of a well-ordered society governed by the principles of freedom and equality.

Rawls’ thesis is that a society can only be considered just when it complies with the following principle: "All social values

—freedom and opportunity, income and wealth, as well as the social bases and respect for oneself—must be distributed equitably, unless unequal distribution of some or all of these values is to the advantage of all, especially the neediest" (9). Within this context, Rawls' primary social goods are civil and political rights as well as economic, social, and cultural rights.

In effect, his theory of justice is an intelligent reformulation of social democratic thought. His is thus an intermediate theory between pure "liberalism" and pure "egalitarianism" that understands justice as "fairness."

This theory has been extremely successful. Indeed, no other theoretical study on justice has had such a great impact in this century. Among other things, Rawls' work has had major repercussions for medicine. Whether they accept or criticize Rawls' work, all major studies related to justice in health in the past 15 years have taken his work as a point of departure.

One of the authors who has attempted to apply Rawls' theory of justice to health has been Norman Daniels. In his opinion the right to health care is a primary good subsidiary to the principle of equal opportunity proposed by Rawls. Only in that way, Daniels believes, can an adequate theory on the "right" to health care be constructed whose only possible correct meaning is that of the "justice" of medical care, or "just" medical care.

But, Daniels continues, this demands a precise definition of the "needs" for medical care. Daniels attempts to answer this question using as criteria the "typical functioning of the species." This makes it possible to define conditions that require care, in accordance with the principle of distributive justice to all, as those involving "deviations from the natural functional organization of a member of the species" (10), but not those involving other deviations. For instance, appendicitis should be covered under this approach but not an aquiline nose that could be altered by plastic surgery.

Considering health to be a primary social good that should be added to Rawls' original list has enabled another bioethicist, Ronald M. Green, to make some important contributions to justice in health, especially in relation to our duty to safeguard the quality of life of future generations. This latter subject, which received scant attention until recently, is growing progressively more serious—to a point where in the next few years it may become the key topic of discussions on bioethical justice.

Theories other than Daniels' and Green's that should be cited include that of Charles Fried, according to which it is not possible to justify health care as a right derived from the principle of distributive justice, but only as a duty derived from the principle of benevolence. Fried believes that this duty to be benevolent generates a right to assistance that is naturally related to all others, and therefore creates a secondary right of distributive justice. This confers on the State the right and obligation to come to the aid of those most in need of health care until a decent minimum of care is provided.8


Other specific models could be added. But it may be more important to reflect on certain common characteristics. One, perhaps the most significant, is the authors' persistent appeal to the bases of Kantian ethics. The entire Rawlsian tradition is based on ethical Kantianism, which is not difficult to justify, as all of the authors cited do, on the grounds that every society is obligated to comply with certain "moral minima."

These moral minima, which Adorno called "minima moralia" (11), relate to the concept of justice, i.e., to what the State owes its citizens by virtue of the principle of distributive justice. Some, like Rawls, place these "minima" on the list of "primary social goods"; others, like Amartya Sen, place them elsewhere (12). But all agree on two fundamental points: (1) These moral minima are demandable by virtue of the principle of justice; and (2) such minima totally or partially cover the area of health care.

THE TELEOLOGIC MOMENT: ALLOCATING SCARCE RESOURCES

As previously noted, however, justice in health has another equally important dimension. That is because the term "justice" is ambiguous; it has two sides. One looks to principles, the other to consequences. For the first instance, we say something is not just when it violates a deontologic principle, such as that of truthfulness. But in the second we use the term in clearly teleologic contexts; for example, we say that something which fails to attain the maximum benefit at the minimum cost appears to be unjust. If the director of a hospital has a certain sum of money, he must consider how he can spend it so as to produce the maximum health benefit for the community being served. Only then should he feel he has acted justly. Hence, justice involves not only respecting moral principles but also maximizing good consequences.

This second, consequence-oriented aspect of the ethics of justice is extremely important. It also tends to be easier to apply than the principle-oriented aspect, since the issue of consequences is readily quantifiable using mathematical procedures such as those used, for example, by economists. Indeed, this aspect of the ethical doctrine has been developed primarily by economists—including Adam Smith, David Ricardo, and John Stuart Mill.

In this regard, economic rationality is essential to ethical rationality. Among other things, the idea of justice is not completely removed from the economic criterion of "maximum utility" or the so-called "Pareto optimality." Unfortunately, situations to which such criteria can be applied are not very common. Moreover, as originally formulated, the Pareto optimality had only "retrospective" value, being useful only in judging situations already past. It was K. J. Arrow who provided a "prospective" version, which Allan Gibbard has applied to the problems of justice in health.10

Another approach was taken by two British-based economists, John Hicks and Nicholas Kaldor, who developed a broader criterion than Pareto's. This made it possible to accept an act as efficient or efficacious not only if it was good for someone, but also if it could improve everyone's situation, although in fact it might not. Today this idea of Kaldor and

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Hicks survives in the form of cost-benefit and cost-effectiveness analyses. In addition, other indices have been derived from these, the best known of which is probably "quality-adjusted life years" (QALY) (13).

The importance of these methods was not recognized until recently. In the 1970s, just as a serious worldwide recession was beginning, economists began to speak of the health cost "explosion." Until then health expenditures had been rising, but at a pace resembling that of economic growth in the developed countries; so the rise was considered normal. Only when the economic recession began and the gross national product stagnated or declined did it become clear that containing health expenditures was very difficult, if not impossible.

This was the moment economists had been awaiting—to chide physicians and policy-makers for irrational health resource management. Until then, the deontologic moment had been thought sufficient for establishing health policy, but at this point the consequences of such an approach became apparent. A radical change in policy was needed, according to the economists, one that gave priority to the teleologic moment. Health expenditures, like all others, should be made in accordance with the laws of economic reality. All else was pure squandering, which could lead only to disaster.

This disaster began to be perceived as uncomfortably imminent in the 1970s. In 1978 economist J. M. Simon used data published by the MacKinsey Institute to calculate that health expenditures by the rich countries had increased by 1 supplementary percentage point of the gross national product of each country from 1950 to 1960; by 1.5 supplementary points from 1960 to 1970; and by 2 supplementary points from 1970 to 1980. These figures clearly illustrate the rapid growth of health expenditures as a share of domestic product.

However surprising it may seem, this rate of growth is actually no surprise at all, since in our century we have changed from treating health care like a production good to treating it as a consumption good. In 1857 German statistician Ernst Engel formulated three laws on the evolution of consumption, which are as follows: First, food spending as a share of the family budget decreases as income increases. Thus, food expenses in France accounted for 64.2% of the family budget in 1950, 27.9% in 1970, and 25.9% in 1976. Second, the percentage of the budget spent on buying goods such as clothes and furniture, and on paying rent, tends to remain constant. These expenditures evolve in proportion to income. Thus, they accounted for 27.1% of the family budget in the France of 1950, as compared to 29.4% in 1960 and 31% in 1970 and 1975. And third, the share of the budget spent on services, cultural goods, and leisure (hygiene and health, culture, education, vacations, transportation, communication and telecommunications, insurance, etc.) tends to increase as income increases. In France these expenditures accounted for 26.7% of the total budget in 1950, 34.5% in 1960, 41.1% in 1970, and 43.2% in 1975 (14).

The fact that health is a consumption item obeying Engel's third law explains why there are no theoretical obstacles to health expenditures increasing more quickly than a country's total wealth. (In the United States, per capita health expenditures have tripled since 1950.)

Nevertheless, the figures prompt certain questions. Can other social and pub-

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lic services be allowed to go underfunded in order to attend to health demands? Is every health expenditure ethically justified and demandable in justice? Must the right to health and the right to health care be covered in all of their unending dimensions, or are there some limits to demand, beyond which nothing can be demanded in justice? If so, what are those limits?

These questions, which have become urgent since the 1973 economic crisis, have led to a massive influx of economists and their teleologic criteria into the health field. This would seem all the more necessary because technologic advances of the preceding decade had shot costs upwards, partly because such advances permitted people who in any other epoch would have died without recourse to be kept alive for long periods.

The young Karen Ann Quinlan lived in a permanent vegetative state for over 10 years. Was there an obligation by virtue of the principle of justice to provide her all sorts of medical care? The question has considerable social import, for hers is but one example of a practice that has become commonplace for medicine—the practice of acting in an anti-Darwinian direction.

If Nature, according to Darwin, selects the most apt and condemns to death the weak and unadapted, medicine does exactly the opposite. This constantly increases the number of chronically ill with no hope of recovery (disabled children, the retarded, the incapacitated elderly, etc.) and contributes very substantially to the "cost explosion." So the question comes around again: Is there an obligation grounded in justice to attend to all these patients with all the resources involved in their care? Up to what point should they be treated? When does the obligation cease to be perfect (or one of justice) and become imperfect (or one of charity)?

For economists and health managers this series of questions has a relatively clear answer. The cost explosion can only be halted by "cost containment," and this must be done in accordance with the criteria of economic rationality. Thus, distributive justice must be governed by the cost-benefit ratio, so that there is never any obligation to do something "irrational" in justice (understanding rationality to mean economic rationality). In other words, that which is just is identified with some approximation of the economically optimal.

This has several implications. First, however "limited" health resources (they will always be limited whenever health consumption is unlimited), it is not just to divert funding from other budget areas to health if the cost-benefit ratio is better in fields other than health. Thus, for example, education or housing policy may have a higher cost-benefit ratio, in which case what is just is to invest in those areas.

Second, within the health realm the limited resources should be earmarked for activities that yield a relatively great health benefit at a relatively low cost. For example, if one must choose between a vaccination campaign and heart transplants, in most cases the cost-benefit ratio will accord greater priority to the vaccination program, even though this may lead to damage and even death for some people.

Third, certain health benefits and services cannot be demanded in justice, given their low cost-benefit ratios. This was the case until a short time ago with respect to heart, lung, and liver transplants; at present it appears to be the case regarding brain-dead patients, permanent vegetative states, etc.

These examples help to show why economic rationality is important in health care and how it provides a new and essential perspective on the issue of justice.
in health. Today we know that one cannot construct a coherent theory of justice with deontologic principles alone. The teleologic complement, which weighs and assesses consequences, is also needed.

All this makes it easy to see why bioethical studies of what is now known as "cost containment" and "distribution of scarce resources" are important. Such studies include the interesting work that Haavi Morreim has been carrying out on the problem of justice in U.S. health, and also the impressive group of works by various authors partaking in the lively current debate over the limits of the younger generations' duty of justice vis-à-vis the elderly.

But this does not resolve all the problems. It is still unclear whether economic rationality must be reconciled with the rationality of the principles of justice, or whether it should supplant the rationality of justice, leaving utility as the sole criterion. When the latter happens, when utility becomes the only criterion capable of defining an action as just or unjust, then we have another theory of justice, the utilitarian theory so common in our culture since the times of Jeremy Bentham.

In his *Fragments on Government*, Bentham established that the objective of any ruler can be none other than to bring about the greatest happiness of his subjects; and to do so he has no recourse other than to be guided by the principle that "the greatest happiness of the greatest number is the measurement of what is just and what is unjust" (15). There can be no other criterion of distributive justice. As a promoter of the *res publica*, the politician must seek to achieve the greatest benefit at minimal cost, so as to maximize utility. This is very important today in medicine, since health has become a public matter, a political issue.

But is it not unjust to govern health policy solely and exclusively by criteria of economic utility? And conversely, is it not equally unjust to "reject" the utilitarian and consequence-oriented dimension of health as rendering health policy "absolute"? More specifically, is justice in health solely consequence-oriented, or is it also consequence-oriented? This is the last point we will address.

**CONCLUSION: THE TWO MOMENTS OF JUSTICE IN HEALTH**

This brief review of the contemporary debate on justice in health illustrates just how complex the matter is. One reason for that complexity is that workable theories in this field, to explain events, must perform articulate the two moments cited, the deontologic or principle-oriented moment and the teleologic or consequence-oriented moment.

In the Western world, there seems to have been a certain convergence of the various deontologic theories contesting
the explanation of distributive justice—such that the theory which understands justice to be synonymous with collective welfare is clearly the most generally accepted. The fact that almost all human rights declarations and the constitutions of many Western countries place the slate of economic, social, and cultural rights alongside civil and political rights suggests that the deontologic theory of justice cannot be understood today as "natural proportionality," or as "contractual freedom," or (at least in most of our countries) as "social equality," but rather as "collective welfare."

Agreement is even clearer regarding the teleologic moment. Health promoters and policy-makers have an obligation to maximize the "public utility" of available resources, for which purpose they must act in accordance with economic principles and criteria. And although economics is neither alien to nor separable from deontologic principles, it has developed a wide range of techniques and procedures of a strictly teleologic nature, which are the ones that may prove most useful to those in government in their endeavors. Hence, to deny the consequence-oriented moment of justice in health would be as dangerous as rendering that moment absolute.

Once the duality of moments is accepted, the mode of their articulation must be established. How do they relate to one another? In some cases they "complement" one another, and then there is no doubt that one's moral duty is to respect all the principles involved and optimize all the consequences. Unfortunately, however, such cases do not abound and may well be exceptions. Indeed, what is most common in ethics is not complementarity but conflict, conflict between principles and consequences as well as between different principles.

How should such situations be resolved? Ideally, the two categories should be reduced to a single one, since properly speaking there are no conflicts between principles and consequences, but only between principles. That is because we use the consequences as criteria for ranking the principles.

Generalizing this procedure, one arrives at conclusions very similar to those proposed half a century ago by David Ross. According to these, deontologic principles (e.g., those involving each and every human right—civil and political, economic, social, and cultural) may be considered "prima facie duties." When these primary duties do not enter into conflict among themselves, then they are morally binding, and therefore also constitute "actual duties." But when two or more are incompatible in a concrete situation, such that respecting one necessarily harms another, then they must be ranked.

This can be done in several ways. In some cases one can establish the order among them using solely deontologic criteria; thus, civil rights are generally accorded a higher rank than social rights. But these cases are the least of it. In general, to establish a proper hierarchy one must bear in mind the so-called teleologic principles relating to the consequences of the various possible acts. This ranking of deontologic principles partly in accordance with the second moment of the theory of justice makes it possible to resolve conflicts among principles and convert the "prima facie duties" into "actual duties."

Any of the methods just presented for solving conflicts among the different constitutive elements would appear theoretically correct. However, this does not mean the selected method would be adhered to in real, everyday practice. Indeed, it is likely that the greatest problem of justice in health facing our countries today is that of the failure of actual practice to conform to the theoretical princi-
ples set forth above. Health policies are usually devised with almost exclusively utilitarian criteria in mind, paying little heed—less than should be paid—to the principles of equity. To put it more graphically, it could be said that economics and politics have done away with ethics. In this sense, I believe that what the Hastings Center said in a study about the ethics of cost-benefit analysis (CBA) holds across the board: "The traditional approach of CBA excludes formal considerations of the distributive effect, of the equity and justice variety. Although economists disagree on how to resolve this problem, it is likely that considerations of equity will continue to be underestimated in practice" (16).

This is the concluding point of our analysis: that in the obligatory dialectic between principles and consequences, the latter receive little attention in theory, and the former continue to be underestimated in practice. In other words, in issues related to distributive justice in health, ethics appears to have ignored economics and politics, which in turn have decided to ignore ethics, if not supplant it; and this appears to constitute a serious form of injustice.

REFERENCES