Book Review

Our Irrelevant Right to Health Care

Mortal Peril: Our Inalienable Right to Health Care? By Richard A. Epstein. Reading, Massachusetts: Addison-Wesley Publishing Company, 1997. Pp. xvi, 503.

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From the advance publicity for *Mortal Peril: Our Inalienable Right to Healthcare?*,[1] one might suppose the book would offer a closely reasoned argument for a market-based health care system with minimum government involvement and maximum deference to individual autonomy. While Epstein does advocate such a system, he fails to provide the reasoned argument. The book actually presents a collection of topics that seem to have been chosen because Epstein has strong views about them, not because taken together they yield a coherent view of health policy. To make matters worse, the discussion of each topic is a confusing mixture of broad generalizations, often unsupported by argument or data, and narrow analyses of specific laws, court cases, and regulations.

The first half of this 503-page book is about access to health care. It includes chapters on the existence of a right to health care, futile medical treatment, care for the indigent, wealth and disability, community rating and pre-existing conditions, Medicare reform, and the Clinton health plan. The second half addresses self-determination and choice, with chapters on the buying and selling of babies and human organs, euthanasia and physician-assisted suicide, and the malpractice liability system. Since I cannot cover all this ground adequately in a review, I have chosen to focus primarily on the access issues.

A RIGHT TO HEALTH CARE?

Epstein's central thesis can be stated simply: The roots of the current

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1. RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997)

problems with the American health care system lie in universal acceptance of a false premise—the existence of a right to health care.[2] According to Epstein, basing a health care system on such a right is wrong not only on philosophical grounds (there are no positive rights, only negative rights),[3] but also on practical grounds, since such a right to health care cannot be implemented successfully.[4] The result of this false premise is a jumble of burdensome rules and costly health care "entitlements" that fail to make sense on equity or efficiency grounds.[5]

There is an obvious response to this thesis. Not all Americans believe there is a right to health care, and those who do believe in such a right disagree fiercely on its extent. It might be more plausible to blame our contradictory policies on the lack of a consensus on health care rights.

While such a response is not bad, it does not go far enough. A better response would be that the rights debate is *irrelevant* to practical policy. In fact, it is a dangerous distraction. The policy issue is not, "Does every American have a moral right to health care?" but, "Would designing the health care system to ensure every American a decent minimum of health care be good public policy?"

Consider the interstate highway system. This massive government undertaking is popular, but not, as far as I know, because the public believes in "a right to drive." In a market economy, why not leave it to private enterprise to build toll roads for profit? The common sense answer is that we would not like the results, given the cost of toll collection, the opportunity for monopoly pricing, and the advantages of a rational overall design. Consequently, government has built the interstate highways and financed them with taxes.

Once a society is willing to make some things collective tax-financed projects, for whatever reason, the existence of a positive right to health care is beside the point. The issue is, should guaranteeing universal access to a decent minimum of health care be one of those things?

Epstein prefers limited government, but I am not sure how limited; perhaps he thinks the public provision of highways is a mistake. If his basic premise is that governments should confine themselves to protecting negative rights—from which it follows that the public should not be taxed to fund highways, public schools, scientific research, and libraries—probably very few Americans would agree with him, and the book has little to offer the current health policy debate.[6]

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2. *See id.* at 1-4.
3. *See id.* at 6-19.
4. *See id.* at 43-58.
5. *See id.* at 14-17.
6. For the purposes of this Review, however, I assume his position to be somewhat less

THE MARKET FAILURE ARGUMENT FOR GUARANTEED ACCESS

Economics provides a framework for thinking about these matters under the theory of the general equilibrium of perfectly competitive markets (a framework which Epstein often employs in the book). The theory offers both a rationale for a presumption in favor of markets as efficient resource allocation mechanisms and a basis for identifying circumstances under which markets are likely to be inefficient (i.e., a theory of "market failure").[7]

Market failure is the standard reason for the public provision of highways and (albeit somewhat differently) can also be an argument for guaranteeing access to a decent minimum of health care. Kenneth Arrow outlined the basis for this in 1963 in a classic article which applies insights from the economics of uncertainty to health care.[8] Arrow and others[9] had extended general equilibrium theory to include uncertainty and shown that the optimality properties of perfectly competitive market equilibrium continue to hold, *provided* there are "futures markets" allowing participants in the economy to reallocate consumption and production freely across all possible states of the world. In real economies, the complexity and transaction costs associated with such markets severely limit their availability. The main significance of the result, therefore, was to identify an important class of market failures associated with the absence of a full set of markets for risk-bearing.

The health insurance market is an example of such market failure. Since consumers are uncertain about their future health and therefore about the amount they will want to spend on health care, they find health insurance useful; however, private insurance is limited in its ability to protect against the financial risk of ill health. For example, in a perfectly competitive market, insurers adjust premiums according to risk, so that people who are expected to spend more on health care pay more. People who are already ill or have a very high probability of illness may be unable to buy insurance at all.

In a narrow sense, linking premiums to risk is efficient, since the cost

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radical.

7. For background information on the theory of general equilibrium and competitive markets, see WILLIAM J. BAUMOL & ALAN S. BLINDER, ECONOMICS: PRINCIPLES AND POLICY 55-57, 536-555 (5th ed. 1991).

8. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

9. *See generally* G. DEBREU, THEORY OF VALUES (1959); M. Allais, *Généralisation des théories de l'équilibre économique général et du rendement social au cas du risque*, ECONOMETRIE 1-20 (1953); Kenneth J. Arrow, *Les rôles des valeurs boursières pour la réparation la meilleure des risques*, ECONOMETRIE 41-46 (1953); E. Baudier, *L'introduction du temps dans la théorie de l'équilibre général*, CAHIERS ECONOMIQUES 9-16 (1959); G. Debreu, *Une économique de l'incertain*, ECONOMIE APPLIQUÉE 13, 111-16 (1960), cited in Arrow, *supra* note 8, at 945 n.6.

of the risk-bearing is shared in accord with the contribution of each insured to the total risk.[10] In a broader sense, it is inefficient, since people cannot protect themselves against deteriorations in risk status over time or against being born into a high risk state, unless there are complex futures markets which do not (and often could not) exist.[11] Arrow concluded that there is a strong case for collective action to provide nonmarket mechanisms for risk-bearing such as social insurance.[12]

Arrow's basic point holds in the simple model in which people maximize utility functions that depend only on their own consumption. Its practical significance is increased, however, if utility is affected by the consumption of health care by others.[13] This is often the case. A close associate's poor health may affect the benefits a person receives from the association, as well as generate claims for assistance.[14] People may also be unselfishly concerned about the well-being of others, whether family, friends, or strangers.

Epstein is aware of Arrow's arguments but rejects them.[15] He claims that efficiency demands the adjustment of premiums to risk; anything else is forced redistribution of wealth from the healthy to the sick, to which he is opposed on principle.[16] In other words, he misses the point, even though Arrow says explicitly:

> [A] good part of the preference for redistribution expressed in government taxation and expenditure policies and private charity can be reinterpreted as desire for insurance ... virtually nowhere is there a system of subsidies that has as its aim simply an equalization of income. The subsidies or other governmental help go to those who are disadvantaged in life by events the incidence of which is popularly regarded as unpredictable ... optimality, in a context which includes risk-bearing, includes much that appears to be motivated by distributional value judgments when looked at in a narrower context.[17]

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10. *See* Arrow, *supra* note 8, at 963-64.

11. *See id.*

12. *See id.* at 967. Arrow's article also highlights other market failure elements in health care, such as the importance of imperfect information and the resulting role of the physician as agent for the patient. *See id.* at 949-52.

13. *See id.* at 954 ("[T]here is a more general interdependence, the concern of individuals for the health of others .... The taste for improving the health of others appears to be stronger than for improving other aspects of their welfare. In interdependencies generated by concern for the welfare of others there is always a theoretical case for collective action if each participant derives satisfaction from the contributions of all.").

14. Medicare is broadly popular because it benefits not only those who are old now and those who will be old someday, but also their children and grandchildren, nieces and nephews—all those who would be obliged to help the elderly get health care if the program didn't exist.

15. *See* EPSTEIN, *supra* note 1, at 2-4, 2 n.3 (The reader should note that Arrow's classic article is the third citation in this book of 852 footnotes).

16. *See id.* at 2, 122.

17. Arrow, *supra* note 8, at 947-48.

THE ROLE OF PRIVATE CHARITY

Although Epstein defines social insurance as forced redistribution and rejects it, he does have an alternative for those too poor or too unhealthy to obtain private insurance: voluntary redistribution.[18] Government action is unnecessary, he says, because people share a moral sense that they should help others obtain important health care and respond by giving generously to charity.[19] In fact, he chastises advocates of government intervention for their lack of trust in the kindness of Americans:

> It is therefore regrettable that so many academics regard charitable responses as occupying only a tiny corner of the social space . . . The only human interactions they envision are market exchanges or coerced exactions.[20]

Private charity is recognized as a response to market failure; the issue is whether it is adequate. At the theoretical level, if the motive for charity is interdependent utilities, charitable giving is a public good and the standard arguments for the inefficiency of the voluntary outcome apply. The general welfare could be unambiguously improved (in the sense that everyone would be at least as well off and some would be better off) with the right structure of mandatory contributions.

Epstein rejects this theoretical argument,[21] and also makes strong claims about the practical advantages of private over public assistance: "The same amount of money distributed . . . does more good in the former system than the latter, which chews up huge portions of its revenues in administrative expenses and loses another significant proportion to fraud and abuse at every level of its operation."[22] He offers no empirical evidence for this statement, however, and it may not be correct. Most private charities spend a significant part of their funds on fund-raising and administration, rather than on direct assistance, and are not immune

18. *See generally* EPSTEIN, *supra* note 1, at 38-39.

19. *See id.* at 30-31, 36, 38.

20. *Id.* at 36.

21. *See supra* note 15; *see also* Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 54 PHIL. & PUB. AFF. 13 (1984). Epstein is familiar with Buchanan's analysis but rejects it; however, it is clear from his discussion that he does not understand it. For example, he seems to think that as long as all wealthy individuals contribute money, the problem disappears, and that allowing a tax deduction for charitable contributions will bring this fantasy about. He portrays the tax deduction as a matching grant, paid in effect from all other citizens, to those individuals who are prepared to spend their own resources in charitable endeavors. *See generally* EPSTEIN, *supra* note 1, at 37-39 (discussing Buchanan). But if it is wrong to tax people to support the endeavors directly, why isn't it wrong to use their taxes to give the matching grants? Furthermore, Epstein fails to mention, let alone justify, the fact that under the tax deduction, the richer the donor, the greater the tax rebate per dollar of contribution. *See generally* I.R.C. §§ 1, 170(a)(1998) (noting that under a system of progressive taxation, the higher a taxpayer's bracket, the more an itemized deduction for a charitable donation will cost the government).

22. EPSTEIN, *supra* note 1, at 37.

from fraud and abuse.[23]

Epstein also asserts that private charity is better than government at targeting aid to truly needy people who will use it well.[24] This also is not self-evident. Who hasn't wondered whether the panhandler asking for money for food is really in need, and whether he wouldn't actually spend one's money on alcohol or drugs? Organizations may be better able to discriminate than the average individual, but to do so they must spend resources to investigate, without the advantages of government's information sources and legal sanctions.

Too often, the key to receiving private charity is simply knowing a reporter. In a recent example, the parents of Iowa septuplets were overwhelmed with donations, from diapers to a new house, while the parents of sextuplets in the District of Columbia received nothing—until the publicity surrounding the Iowa births led someone to bring their situation to the press's attention.[25]

Accountability is an important issue, especially in the light of Epstein's claim that charities should be completely free to spend their funds as they wish.[26] (He argues that even if a charity announces a policy on who will receive assistance, it should not be legally required to observe it.)[27] Government must account to taxpayers through the political proc-

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23. The recent United Way scandal was a dramatic example, and a particularly sad one, since the United Way is a creative attempt to reduce the inherent inefficiency in raising and allocating charitable funds. For general background on the United Way scandal, see John S. Glaser, THE UNITED WAY SCANDAL: AN INSIDER'S ACCOUNT OF WHAT WENT WRONG AND WHY (1994).

24. *See* EPSTEIN, *supra* note 1, at 55-56.

25. *See generally* Patrice Gaines, *Iowa Miracle Brings Help for D.C. Sextuplets*, WASH. POST G11 (Nov. 22, 1997). In light of Epstein's opinions on taking health risks, it is interesting to note that the Iowa births resulted from a controversial decision to implant seven fertilized eggs and let all seven resulting pregnancies continue to term, whereas the DC births did not did not involve in vitro fertilization. *See* Gina Kolata, *Many Specialists Are Left in No Mood for Celebration*, N.Y. TIMES, Nov. 21, 1997, at A5.

26. *See* EPSTEIN, *supra* note 1, at 84, 104-05 (discussing EMTALA).

27. *See id.* at 82-85 (arguing against the holding in *Wilmington General Hospital v. Manlove*, 174 A.2d 135 (Del. 1961), in which a hospital that had previously offered emergency services to the general public was found liable on the basis of this established practice for refusing care to a patient). He makes this point most strongly in the context of his discussion of EMTALA, a law which obliges hospitals that have emergency rooms to provide emergency care on demand, without requiring advance payment. *See id.* at 91-105; *see also id.* at 84 ("There are enormous practical benefits to being able to announce standing policies [e.g. the provision of emergency care] without being legally forced to adhere to them."); *id.* at 103 ("As far as government is concerned, any hospital should be able to 'just say no' to any patient, without giving reasons for its decisions."). Epstein also sees no reason why hospitals should not use charity cases in medical education:

> [I]t is wholly indefensible to attack as immoral the common practice of having medical residents perform their initial operations on charitable cases, albeit the outcomes are on average likely to be less successful than when experienced surgeons operate. Clearly we cannot exhaust the talents of the ablest surgeons by requiring them to perform all cases; nor could we train the next generation of surgeons unless younger surgeons gain experience in dealing with live patients, if only to learn from their mistakes.

ess, imperfect though it may be. Individual donors can hold charities accountable only through the threat of reduced contributions in the future, and then only if they can obtain trustworthy information about the way their money is being used. Because this is so difficult, there is public demand for government regulation of charities.[28]

Epstein acknowledges that with voluntary redistribution, not all those in need will be helped: "[T]he common law rules had no built-in gyroscope to right any imbalance .... The common law system offers no grandiose guarantees that help will be forthcoming, but it relies on the decentralized efforts of private groups to fill the vital function."[29] In other words, people cannot rely on charity for the security they do not get from the market.

It is significant that nowhere in the book does Epstein provide a systematic discussion of the position of children and people with disabilities in his world of purely voluntary exchange.[30] Children are dependent on their parents, who may be too poor or too irresponsible to ensure that they have health care, and people with disabilities are at a disadvantage in both the labor and health insurance markets. Yet the clear implication of his analysis is that children and people with disabilities must rely on the kindness of others for access to health care, with no guarantee that there will be enough kindness to go around.

THE MORAL ARGUMENT FOR GUARANTEED ACCESS

Epstein's optimism about private charity is ultimately unconvincing. The real problem, however, is more basic: a fundamental misunderstanding of the nature of the shared "moral intuition." To him, the perceived obligation to help others is personal, an issue for an individual and his conscience, whereas to most Americans, it is probably collective.[31] The intuition behind the collective obligation is that a society is morally obliged to ensure all of its members have a decent minimum of basic goods such as food, shelter, and health care—not because everyone necessarily has a right to these goods, but because societies that fail to guarantee them are morally repugnant.

Id. at 115.

28. *See id.* at 86-87.

29. *Id.* at 40.

30. Chapter 5, called "Wealth and Disability," raises expectations that the disability issues will be discussed, but the disability section is only a few pages long and focuses entirely on the relationship between the Oregon Medicaid rationing proposal and the Americans with Disabilities Act (42 U.S.C. § 12101 (1994)). *See id.* at 107-20; *see also infra* note 55 and accompanying text. There are brief discussions of disability in other chapters, but only in the context of arguments against prohibitions on discrimination on the basis of disability in insurance and employment. *See, e.g.*, EPSTEIN, *supra* note 1, at 141-45.

31. *See infra* note 41.

It follows that every member of a society has a moral *and civic* obligation not merely to write an occasional check to a health charity, but to participate, through established democratic processes, in the creation of a structure to discharge the collective obligation. Such a structure will necessarily involve some compulsory redistribution from the rich to the poor as well as from the healthy to the unhealthy. This is the consensus that is now the implicit basis for health policy, not acceptance of an individual right to health care or an individual obligation to help others.

Defining the policy goal in terms of societal obligation avoids some of the objections Epstein raises to a positive rights framework. As Epstein notes, the amount of health care at stake cannot be unlimited, whether one speaks of rights or obligations.[32] In a societal obligation framework, however, it is more apparent that health care is only one of our collective projects, albeit one of high priority, and that overall societal resources will *and should* influence the specific standard of care guaranteed. Moreover, there is no ambiguity about where the obligation falls; it falls on the same democratic institutions used for other collective projects, like national defense, interstate highways, and the protection of negative rights.

The public's acceptance of such an obligation is based on a combination of religious beliefs, philosophical analysis, moral principles, pragmatism, self-interest, and plain "gut feelings." Since Epstein defends negative rights with the heuristic device of rational contracting 'behind the veil of ignorance,"[33] it is reasonable to apply that device here as a rough check on the plausibility of this acceptance.

Suppose we ask the following question of people who don't know the circumstances into which they will be born: "Would you prefer a society which accepts a collective obligation to guarantee universal access to a decent minimum of health care, or a society in which private insurance and private charity are the only means of protection from the consequences of the natural lottery?" The decision would likely be for universal access. In fact, I think that even someone who is *not* "behind the veil"—someone who knows his health status, assets, and earning capacities, but is also aware that these can change in unpredictable ways—would prefer at least some social insurance over Epstein's alternative.

Is Guaranteed Access Affordable?

But, as Epstein might say, what if implementing such a guarantee is so costly that the first society has far fewer resources for other goals relative

32. *See* Epstein, *supra* note 1, at 44.
33. *Id.* at 9.

to the second? First, note that contrary to the impression Epstein gives,[34] this question also arises with negative rights. A negative right is worth little without a corresponding societal obligation to enforce it. A person who is robbed has a claim against the robber, not against the bystanders who fail to come to his defense.[35] Nevertheless, surely the bystanders are obliged to participate in a societal response—by maintaining a criminal justice system to prevent and prosecute such crimes—even if they are strong enough to defend themselves against attack. And a good criminal justice system does not come cheaply.[36]

In the case of health care, the issue is not whether the first society might spend somewhat more in total on health care (after all, the goal is to increase access), but whether social insurance would bring with it large extra expenses for overconsumption and administration.

Increased spending could result because changed financial incentives lead to inefficient use of care. When people are insured and do not pay directly for their care, price does not force them to weigh the benefits of care against the cost; for efficiency, there must be limits on beneficial care such as non-price rationing.[37] Such rationing is as necessary in private insurance as it is in social insurance, however. If the private insurance market can do this, there is no reason in principle why a well-designed social insurance system cannot do it, given that the societal obligation is explicitly understood to be defined in relation to total societal resources.

Increased spending could also result because changed financial incentives lead people to be less careful of their health. Epstein makes much of this effect, and argues that it would be greater under social insurance because social insurance breaks the link between insurance premiums and risk category.[38] For the effect to be significant, however, there must be a strong connection from premium differential to behavior to health. Epstein likely overstates both the control people have over their health and

34. "In contrast [to the tradition of positive rights] the tradition of negative rights, whatever its flaws, at least avoids the sin of extravagance." *Id.* at 7.

35. *See generally* Danny R. Veilleux, Annotation, *Construction and Application of "Good Samaritan" Statutes*, 68 A.L.R. 4th 294 (1989).

36. In fact, in the era of the O.J. Simpson and Menendez trials and seemingly endless investigations by special prosecutors, some might say that the negative rights tradition *can* be associated with extravagance.

37. This effect is called moral hazard. It has been compared to the situation that arises when people dining out together decide in advance to split the bill evenly. Each person has a financial incentive to order a more expensive meal, yet the group as a whole must pay the total cost. If the check is to be evenly divided, it would be prudent to agree to some constraints on ordering, such as choosing from a limited menu, i.e., to submit to some non-price rationing.

38. *See* EPSTEIN, *supra* note 1, at 52-53 ("Social insurance builds in at the ground level a system of cross-subsidies across persons .... As the price of ill health goes down, the willingness of individuals to take health risks will increase.").

the extent to which their behavior responds to insurance incentives. After all, how likely will a premium surcharge persuade someone to quit smoking or engage in monogamous sex when the prospect of disease and death did not?[39] More importantly, the private insurance market does not tie premiums closely to behavior anyway, because the cost is prohibitive.[40] As for administrative costs, the relative size of these in private and social insurance is a controversial subject. However, the controversy is mainly over whether social insurance would *lower* administrative costs, since administrative costs are known to be high in private, risk-rated individual insurance.

CAN IT BE DONE?

On the conceptual level, the economic and moral arguments in favor of government action to guarantee universal access to a decent minimum of health care seem robust to many Americans, if not to Professor Epstein.[41] There is, however, a practical question: Can a real government get it done, at affordable cost? Epstein says definitely not:

In large measure, state intervention in health care markets yields outcomes no different from those found elsewhere. Noble intentions quickly lead to an endless tangle of hidden subsidies, perverse incentives, and administrative nightmares which in the long run often backfire on its intended beneficiaries, if not in the first generation, then like social security, surely in the second. Government schemes are organized Ponzi operations that eventually go broke by using the capital of later contributors to satisfy the obligations to earlier plan participants.[42]

And,

> The empirical objections to positive welfare rights cannot be overrun or ignored; it is a feat of blind optimism to assume that any political process is capable of translating the idea of minimum standards into a set of workable administrative norms, which must cover thousands of existing procedures,

39. Even less plausible is Epstein's contention that guaranteed access would lower health status because it would remove the fear that one's medical history would make one uninsurable sometime in the future. *See id.* at 57-58. It could be argued that universal access would actually improve health-related behavior if it made individualized health information and cost-effective preventive care more available.

40. Epstein himself says that private insurers are more likely to focus on the risk factors that people cannot change, such as age, sex, ethnic background, personal and family medical history, and genetic predisposition to illness. *See id.* at 122 (explaining that insurance companies rely on simple, rough classifications to preserve the market equilibrium because they cannot possibly gather at a reasonable cost all the information that is relevant to determining risk).

41. *See, e.g.*, Robert J. Samuelson, Editorial, *The Medicaid Morass*, WASH. POST, Feb. 14, 1996, at A21 (citing two polls, from 1938 and 1991, which show that four out of five Americans believed the government should provide access to health care for those unable to afford it).

42. EPSTEIN, *supra* note 1, at 2-3.

with new ones coming on line all the time.[43]

The obvious response to these statements is: But it *has* been done. Curiously, the book says almost nothing about health care systems in other countries, despite the fact that almost all other industrialized countries do guarantee a basic standard of care, all spend a smaller percentage of their total output on health care, and some even have better health statistics.[44] Like the United States, all are struggling with quality and cost containment problems and some are experimenting with market-like financial incentives within their social insurance systems.[45] However, their citizens are at least as content with their health care as Americans are and show no signs of a desire to abandon social insurance for a pure private market/charity regime.

Of course, what is possible in other countries may not be possible here (although some comparative analysis would seem to be in order, to explain why). This brings us to Epstein's analysis of selected health programs and policies in the United States.

LESSONS FROM AMERICAN HEALTH POLICY

Epstein's stated goal is to demonstrate the adverse economic effects of interfering in individual and organizational autonomy in the vain attempt to implement positive health care rights. In his policy explorations, he claims an advantage as an outsider: "Although abstract theorists may lack detailed knowledge on the specifics of health and related fields, they can avoid the correlative risk of intellectual capture .... [T]he virtues of an outsider are easily underappreciated: a broad command of theory and its application in neighboring areas form a useful corrective against the enthusiasms of special pleading."[46]

Unfortunately, with regard to health care, Professor Epstein has waded in over his head. An outsider can indeed provide a fresh perspective on policy goals, but when it comes to explaining what is going on, detailed knowledge is essential. Someone who intends to sing the praises of market competition should also have a mastery of economic analysis.

The book's discussion of programs and policies simply doesn't work. The choice of topics is idiosyncratic, and Epstein does not provide

43. *Id.* at 50.

44. *See generally* Gerard F. Anderson, *In Search of Value: An International Comparison of Cost, Access, and Outcome*, 16 HEALTH AFF. 162 (1997). Of the 29 industrialized nations in the Organization for Economic Cooperation and Development (OECD), only the United States, Turkey and Mexico had failed to achieve nearly universal health insurance coverage for all their citizens as of 1995. *See id.* at 169.

45. *See id.*

46. EPSTEIN, *supra* note 1, at 5.

enough background on the health care system to allow the reader to place the topics in context. The analyses are flawed in interpretation and inaccurate in details. They contain controversial statements unsupported by argument or evidence and economic arguments that are incomprehensible or wrong. Some selective comments can perhaps convey an impression of the problems found throughout the book. One problem is the author's repeated references to the virtues of competitive markets, despite the fact that health care markets don't meet the assumptions required for those virtues to be present. A typical example is his discussion of the method Medicare uses to establish physician fees, which is based on a resource-based relative value scale (RBRVS).[47] He says, correctly, that it is supposed to approximate a competitive market fee structure,[48] and then delivers a basic economics lecture on why an actual competitive market process works much better. He says nothing, however, about the imperfect information, uncertainty, agency, and insurance issues that prevent a real physician services market from behaving like the market he describes. He also says nothing about the payment method that the RBRVS fee schedule replaced.[49]

Some statements about the way markets work are simply wrong. As an example:

> [S]uppose the same procedure can be used to save the life of a young woman or old one, otherwise equal in all respects, whereby it yields a longer stream of benefits in the first case than in the second. Or suppose that the same procedure can be used to save the lives of two men of the same age, one of whom is a successful earner, and the other will be a future burden on the system. . . .Those who are able to produce in the future or to enjoy the long-term benefits of care are the persons who should receive it. Where markets are operative, the bidding reflects these differences . . . .[50]

Not so. The bidding gives the treatment to the person who will pay the most for it. That could be a seventy-year-old who offers every penny of his accumulated wealth, easily outbidding a hard-working thirty-year-old with no wealth, and then lives his life out on social security.[51]

Professor Epstein also does not understand the economic role of physicians, as the following passages demonstrate:

> [I]t has been reported that standard office visits in California now take four minutes—hardly time to generate empathy and trust, but enough time to look into a pair of ears or check for a sore throat. Why should we expect oth-

47. *See generally id.* at 170-74.

48. *See id.* at 170.

49. For political reasons, the original Medicare program had to be as much like private insurance as possible. Thus, the original payment method, the Usual, Customary and Reasonable (UCR) fee system, was modeled on the private insurance market. The UCR fee structure proved to be distorted and inflationary; the RBRVS system, while far from perfect, is superior to the inefficient system the private market produced.

50. *Id.* at 51.

51. The normative assumptions in this passage are also not obvious, and certainly do not follow from economic theory.

> erwise? The soft stuff may work, but its effectiveness is hard to verify. Physicians are paid for the time they spend; their technical training is the expensive input. Their psychological insights can be duplicated by others whose hourly rate is far less. In other businesses, services are unbundled so that high-priced labor does not tarry over tasks that less talented labor can provide....[52]

> The better the test, the less interpretation and evaluation is required. The physician becomes ancillary to the dominant sources of knowledge, and empathetic intuitions are pushed aside by hard data. To have a physician chat with each patient for five minutes out of an hour may not seem like much, but over a year it amounts to a month of time....[53]

He does not realize that "the soft stuff" and "empathetic intuitions" are core elements in medical practice. In a world of imperfect information and uncertainty, we pay physicians to help us make the decisions we would make if we had their medical knowledge and experience. They cannot do this without spending enough time talking to us to understand our goals and preferences. Moreover, sophisticated diagnostic technology requires physicians with advanced cognitive and communication skills to determine which tests are appropriate in a particular patient's circumstances and what the results mean.[54] The more resources are constrained, the more important—and challenging—this decision-making role becomes.

The book contains no discussion of the Medicaid program (except for a brief treatment of Oregon's Medicaid rationing experiment that emphasizes its relationship to the Americans with Disabilities Act).[55] There is a chapter on indigent care, but it focuses primarily on emergency care and the Emergency Medical Treatment and Active Labor Act (EMTALA).[56] Since the complexities of Medicaid are overwhelming even to an experienced health policy analyst, I have some sympathy for his avoidance of the subject. Nevertheless, it is odd to read a chapter called "Necessity and Indigent Care: The Right to Say No" that doesn't so much as mention the main entitlement program for large categories of the poor.[57] It is a lost opportunity: Medicaid exemplifies the conflict between an entitlement program that lacks efficient ways to limit care and a

52. *Id.* at 423.

53. *Id.* at 424.

54. Several articles on clinical problem-solving in the New England Journal of Medicine provide a sense of this. *See, e.g.*, Michael Berkwits & Stephen J. Gluckman, *Seeking an Expert Interpretation*, 337 NEW ENG. J. MED. 1682 (1997); David J. Keljo & Robert H. Squires, Jr., *Just in Time*, 334 NEW ENG. J. MED. 46 (1996); R. Sean Morrison et al., *When Too Much is Too Little*, 335 NEW ENG. J. MED. 1755 (1996); Yoseph Rosenman et al., *Where Did Good Old Clinical Diagnosis Go?*, 336 NEW ENG. J. MED. 1435 (1997).

55. *See* EPSTEIN, *supra* note 1, at 116-20.

56. 42 U.S.C. § 1395dd. *See generally* EPSTEIN, *supra* note 1, at 87-105.

57. *See* EPSTEIN, *supra* note 1, at 81-105.

government that must limit expenditure, and the sly ways the system finds to say no whether it has a right to or not.

Furthermore, Epstein barely mentions the tax subsidies to employment-related health insurance.[58] It is an extraordinary lapse, and the omission makes his discussions of some insurance issues peculiar. For example, he objects to the Americans with Disabilities Act on the grounds that it forces employers to hire workers who will raise the firms' health insurance costs, and he proposes an intricate contract-based solution to job lock (the situation in which an employee hesitates to change jobs because he will lose insurance coverage).[59] However, he does not make the obvious point that these problems exist only because health insurance is linked to employment, or inform the reader that this link exists primarily because of a set of tax rules considered inefficient and inequitable by both liberal and conservative economists. It is odd also that someone who reveres personal autonomy seems positively enthusiastic about creating financial incentives that lead employers to control their employees' personal behaviors with respect to diet, smoking, and exercise.[60]

Instead of providing an organized discussion of moral hazard and the need for non-price rationing in private and public insurance, he confuses the reader by focusing on futility, which is only an arcane bioethics footnote to that discussion.[61] The centerpiece of his treatment of futility is the *Helga Wanglie* case.[62]

> I shall examine the converse challenge to the autonomy principle within a framework of positive rights: may a patient or his family secure public payment for futile treatment? Helga Wanglie's husband refused to allow physicians to disconnect her life support systems even though at 86 years of age she had been in a permanent vegetative state for over a year, at an estimated cost between $800,000 and $1,000,000, expenses that were covered partly by Medicare and partly by her Medigap insurance .... In the Wanglie case, the state seeks to meddle in family affairs to protect its own pocketbook.[63]

58. The topic of tax subsidies for employment-related health insurance only surfaces as a minor point in a discussion of Medical Savings Accounts in Medicare. *See id.* at 182.

59. *See id.* at 141-45.

60. "[T]he New York subsidy plan undercuts any rate distinction between employed and unemployed workers. Because firms can no longer capture the gains from keeping their workers in trim by taking aggressive health measures, they are less likely to insist on exercise, diet, or smoking restrictions." *Id.* at 125.

61. In a world in which the need for limits on beneficial care is accepted, the precise dividing line between positive and zero benefit is not important, because it is obvious that individuals cannot make unlimited demands on common funds.

62. In re Conservatorship of Wanglie, No. PX-91-283 (Minn. Dist. Ct., June 28, 1991). For background information about *Wanglie*, see Alex M. Capron, *In Re Helga Wanglie*, HASTINGS CENTER REP. 21 (No. 5) (1991); Steven H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512 (1991), cited in EPSTEIN, *supra* note 1, at 60.

63. EPSTEIN, *supra* note 1, at 60. *But see* Miles, *supra* note 62, at 513 ("Neither the hospital nor the county had a financial interest in terminating treatment.").

Unfortunately, he misrepresents the case. *In re Wanglie* was not about the state (or, for that matter, any other entity) seeking to protect its pocketbook. Medicare paid for the early phase of Mrs. Wanglie's treatment, but during that phase, she was not in a persistent vegetative state, and futility was not an issue.[64] By the time the futility issue arose, she had exhausted her Medicare hospital coverage, and private insurance was covering the cost of life support.[65]

Mrs. Wanglie's physicians and nurses began the legal process because Mr. Wanglie was insisting that they provide care they considered medically inappropriate, since it could in no way benefit the patient.[66] At the request of the hospital ethics committee, the hospital's board of directors (the county Board of Commissioners) authorized the health professionals to seek a court ruling on whether they were obliged to provide care.[67] The entities paying the medical bills (the private insurer and, to a much lesser extent, Medicare) were not involved in the suit at all.[68]

Since the funds at issue during the relevant treatment phase were mostly private, the real question Epstein should be addressing is why the private insurer took no steps to protect its policy-holders' resources. It did not deny coverage, despite the fact that insurance contracts generally define coverage in terms of "medically necessary care," and the health professionals' position provided a solid basis for declaring the treatment unnecessary in this case. If the company did not believe it had grounds for denial—if it considered the contract language legally ambiguous—why hadn't it used tighter language? What is interesting about this case is the private insurance market's inability or unwillingness to impose reasonable limits on care.

The futility chapter also contains a remarkable example of Professor Epstein's penchant for contractual solutions to problems. He devotes five pages to a proposal to deal with expenditures on end-of-life care by having purchasers of insurance precommit to individualized termination of care rules based on numerical scores on the APACHE (Acute Physiology, Age, Chronic Health Evaluation) III, a 160 point severity of illness scale used in intensive care units.[69] Although APACHE III can be used to make estimates of survival probabilities, its creators consider it inappropriate for making treatment decisions in particular cases. Whether or not they are correct, it is breathtakingly unrealistic to assume that con-

64. *See* Miles, *supra* note 62, at 512-13.

65. *See id.* at 513. According to customary practice, Medicare of course continued to be liable for the cost of physician services and some ancillary services provided in the hospital.

66. *See id.*

67. *See id.*

68. *See id.*

69. *See* EPSTEIN, *supra* note 1, at 72-76.

sumers can use it as Epstein proposes in their insurance decisions:

> [T]he relevant information could be presented to an individual or plan in tabular form. Column A contains the APACHE III ratings, corrected for various types of disorder, and the probability of death in hospital. Column B contains a schedule of additional premiums for increasing APACHE III insurance by fixed-point intervals from APACHE 0 to APACHE 10, and so on down the line to APACHE 120, 125, 130 . . . , 160. These explicit tables are meant to force honest ex ante revelations on consumers as to their willingness to purchase health insurance increments, judged by its impact on their survivability. This dramatic information could be supplemented by a further breakdown that reveals the source of the increment . . . . Still additional figures could indicate the expected length of survival and quality of life for the fraction of the population that leaves hospital. This information could be updated regularly, and individuals could then shift the levels of health care purchased based on the revised information . . . .[70]

There are problems like these in every chapter of the book. In the end, Epstein can't get where he wants to go by this route anyway. Observers across the ideological spectrum agree that the current health care system is inefficient and inequitable; the disagreement is about what to do about it. One cannot prove that government should stay out of health care altogether by demonstrating that some government interventions don't work.

MAKING HEALTH POLICY IN A PLURALISTIC SOCIETY

At the beginning of this review, I claimed that the rights debate is a dangerous distraction. The danger lies in the encouragement it gives to a mistaken view of policy-making. Early in the book, Professor Epstein makes a revealing statement:

> What is needed first is a theoretical discussion of whether the elevation of health care as an affirmative right makes intellectual sense, regardless of its magnetic appeal in the political realm. The details of individual programs . . . [are] . . . subject to constant tugs from warring political factions. Yet none of these short-term fixes . . . is likely to be correctly undertaken unless and until we answer collectively some fundamental questions of philosophy and economics. The wrong conceptual apparatus always leads to the wrong practical choices, no matter how much data is accumulated and analyzed.[71]

The last sentence is not true. Obviously, the "right" conceptual apparatus is better than the "wrong" one, and if the sentence said sometimes, or often, I would not quarrel with it. But *always*? The fact is, different conceptual frameworks can lead to the same practical choices,[72] and it's a

70. *Id.* at 73-74.

71. *Id.* at 28.

72. For example, refraining from sexual intercourse at the age of fourteen is the right practical choice, whether it is done for religious reasons or for fear of sexually transmitted diseases.

good thing, too, or we would never be able to get anything done! The essence of public policy is the identification of practical choices on which people with incompatible conceptual frameworks can agree.

Designing a health care system is one of the most difficult tasks the political process faces. The standard of care a society chooses to guarantee its members is a complex compromise that must take account of the amount considered morally obligatory, the amount a self-interested citizen behind the veil of ignorance wants to be sure he can get, the amount that responds to important social externalities, societal resource constraints, and a host of other factors. The funding structure is also a complex compromise that must balance social norms of fairness against incentive effects and political influence. Inevitably, the result satisfies no one completely.

This difficult task is certainly easier when all participants share the same conceptual framework, but in a pluralistic society this does not happen. Philosophical debates about rights can distract attention from the more important work of discovering the common policies different conceptual frameworks can support. Epstein argues that the decent minimum is well-nigh indefinable at a philosophical level. Perhaps he is right, but so what? It is difficult to define at a philosophical level the extent of a nation's obligation to the families of soldiers who die for their country, or for that matter, the appropriate layout of an interstate highway system. We do not use this as an excuse to leave these matters to private charity. Instead, we use the political process to find a practical compromise we can all live with.

THE IMPORTANCE OF THE RATIONING ISSUE

One important theme does emerge from Epstein's discussion of policy contradictions. This theme is the failure of the United States to come to terms with the rationing issue. The debate about a right to health care is irrelevant, but the rationing debate is not. Although acceptance of a societal moral obligation to guarantee care has long been implicit in health policy, it has not been accompanied by an appreciation of the necessity for limits on beneficial care in both private and public insurance.

Epstein is correct to flag our flawed social response to scarcity as a key issue for health policy.[73] His examples show what happens when people try to make health policy in an environment in which the public does not understand the rationing issue and can be manipulated easily by interest groups.[74] Under these conditions, rationing cannot be openly dis-

73. *See id.* at xi.
74. *See, e.g., id.* at 174-81.

cussed and equitable and efficient non-price rationing systems developed; at the same time, people are not willing to provide the open-ended funding that unlimited entitlements require. The outcome is contradictory policies that make no sense on equity or efficiency grounds. Many of his examples also illustrate the fundamental truth that discharging societal obligations requires societal funding and a national perspective. It cannot be done on the cheap by unfunded regulation or legislation, because ordering individuals or organizations to meet societal obligations without societal funding is unfair and doesn't work.[75]

In the end, however, *Mortal Peril* is part of the problem, not part of the solution. The book fails to deliver either a solid philosophical discussion of health care rights, a cogent analysis of existing health policy, or a reasoned argument for a private market-based health care system. The author seems to encourage people to see rationing as inevitably about letting people die, when actually it is much more about reducing marginally beneficial care across the board, in ways that would have little impact on patient well-being. The book's harsh tone[76] reinforces the public belief that taking scarcity into account in health care is incompatible with a humane and generous society, instead of essential to it. As a result, the book is more likely to hinder than to help progress toward public understanding of the key issues in health policy.

75. Asking them very nicely to do it voluntarily would not work, either, however.

76. For a final example of this tone, note Epstein's opinion on how to prevent "free-riding" by people who do not buy insurance, assuming they will receive free care in the event of illness:

> [T]he other unspoken alternative is *not* to supply that care in time of necessity at public expense. If so, the alleged external cost disappears, even if some people die or are injured. Yet if that bad outcome happens more than once or twice, the inability to obtain the care in time of need will lead many young adults to think twice before going without health insurance .... Social Darwinism is a bit too unfashionable in modern circles of thought.

Id. at 127.