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Source: *The Hastings Center Report*, Vol. 26, No. 6, In Search of the Good Society: The Work of Daniel Callahan (Nov. - Dec., 1996), pp. 12-14
Published by: The Hastings Center
Stable URL: http://www.jstor.org/stable/3528746
Accessed: 20/07/2009 13:30

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does not, however, yield an account of fine-grained principles we can use in rationing contexts.

4. See "The Goals of Medicine: Toward a Sustainable Future," (draft of February, 1996).

5. See John Rawls, *Political Liberalism* (New York: Columbia University Press, 1993), esp. lecture 6; Joshua Cohen, "Deliberation and Democratic Legitimacy," in *The Good Polity*, ed. Alan Hamlin and Phillip Petit (Oxford: Blackwells, 1989), pp. 17-34; Cass Sunstein, *The Partial Constitution* (Cambridge: Harvard University Press, 1993), esp. chaps. 1 and 6.

6. Norman Daniels, "Growth Hormone Therapy for Short Stature: Can We Support the Treatment/Enhancement Distinction?" *Growth, Genetics, & Hormones* 8 (1992, Supplement 1): 46-48; James E. Sabin and Norman Daniels, "Determining 'Medical Necessity' in Mental Health Practice," *Hasting Center Report* 24, no. 6 (1994): 5-13. ■

Ezekiel J. Emanuel

Where Civic Republicanism and Deliberative Democracy Meet

Is there a relationship between defects in our medical ethics and the reason the United States has repeatedly failed to enact universal health coverage? I will begin to suggest an answer to this question by clarifying the locus of allocating decisions. The allocation of health care resources can occur on three levels. The social or, in the economist's language, the macro level entails the proportion of the gross national product (GNP) allocated to health care. The patient, or micro, level entails determining which individual patients will receive specific medical services; that is, whether Mrs. White should receive this available liver for transplantation. Finally, there is an intermediate level called the service or medical level that entails determining what health care services will be guaranteed to each citizen. These socially guaranteed services have been called "basic" or "essential" medical services or what the President's Commission designated as "adequate health care." Clearly, these three levels are connected. A larger proportion of the GNP going to health care permits coverage of more services. Similarly, as demonstrated by the end-stage renal disease program, providing specific services to a wider range of patients causes upward pressure on the proportion of the GNP going to health care and/or reduces the range of services covered as part of basic medical services. Despite these connections, these three levels are conceptually distinct.

The fundamental challenge to theories of distributive justice for health care is to develop a principled mechanism for defining what fragment of the vast universe of technically available, effective medical care services is basic and will be guaranteed socially and what services are discretionary and will not be guaranteed socially. Such an approach accepts a two-tiered health system—some citizens will receive only basic services while others will receive both basic and some discretionary health services. Within the discretionary tier, some citizens will receive few discretionary services, other richer citizens will receive almost all available services, creating a multiple-tiered system.

Underlying the repeated failure of attempts to provide universal health care coverage in the United States is the failure to develop a principled mechanism for characterizing basic health services. Americans fear that if society guarantees certain services as "basic," the range of services guaranteed will expand to include all—or almost all—available services (except for cosmetic surgery and therapies not yet proven effective or proven ineffective). So rather than risk the bankruptcy of having nearly every medical service socially guaranteed to all citizens, Americans have been willing to tolerate a system in which the well insured receive a wide range of medical services with some apparently basic services uncovered; Medicare beneficiaries receive fewer services with some discretionary services covered and some services that intuitively seem basic uncovered; Medicaid beneficiaries and uninsured persons receive far fewer services.

On this view, the reason the United States has failed to enact universal health coverage is not primarily political or economic; the real reason is ethical—it is a failure to provide a philosophically defensible and practical mechanism to distinguish basic from discretionary health care services. What is the reason for this failure of medical ethics?

There are two opposing explanations. One explanation points to the inherent limits of ethics. Some philosophers, such as Amy Gutmann and Norman Daniels, argue that we lack sufficiently detailed ethical intuitions and principles to establish priorities among the vast array of health care services. Every time we try to define basic services our intuitions "run out." As Gutmann once wrote:

> I suspect that no philosophical argument can provide us with a cogent principle by which we can draw a line within the enormous group of goods that can improve health or extend life prospects of individuals . . . The remaining question of establishing a precise level of priorities among health care and other goods is appropriately left to democratic decision-making.[1]

Taken at face value, this moral skepticism is extremely dangerous; it suggests that there can be no principled mechanism to define basic health care services and, therefore, that the efforts to ensure universal access will always founder on the fear that guaranteeing any health care to all citizens means guaranteeing all available services. It suggests we should just give up on a just allocation of health care resources because we can never succeed.

The second explanation holds that the problem with defining basic health services is not a general lapse of ethics, but a specific lapse of liberal political philosophy that informs our political discourse, including the allocation of health care resources. The problem is that priorities among health care services can be established only by invoking a conception of the good, but this is not possible within the framework of liberal political philosophy. Liberalism divides moral issues into three spheres: the political, social, and domestic. It then holds that within the political sphere, laws and policies cannot be justified by appeals to the good. To justify laws by appealing to the good would violate the principle of neutrality and be coercive, imposing one conception of the good on citizens who do not necessarily affirm that conception of the good. But without appealing to a conception of the good, it is argued, we can never establish priorities among health care services and define basic medical services. This is Dan Callahan's view with which I agree:[2]

> . . . there can be no full discussion of equality in health care without an equally full discussion of the substantive goods and goals that medicine and health care should pursue . . . [U]nless there can be a discussion of the goals of medicine in the future as rich as that of justice and health has been, the latter problem will simply not admit of any meaningful solution.

Fortunately, many, including many liberals, have come to view as mistaken a liberalism with such a strong principle of neutrality and avoidance of public discussion of the good. Some think the change a result of the critique provided by communitarianism; others see it as a clarification of basic liberal philosophy. Regardless, a refined view has emerged that begins to create an overlap between liberalism and communitarianism. This overlap inspires hope for making progress on the just allocation of health care resources. This refined view distinguishes issues within the political sphere into four types: (1) issues related to constitutional rights and liberties; (2) issues related to opportunities, including health care and education; (3) issues related to the distribution of wealth such as tax policies; and (4) other political matters that may not be matters of justice but are matters of the common good, such as environmental policies and defense policies. While there still may be disagreement about the need for a neutral justification for rights and liberties, there is consensus between communitarians and liberals that policies regarding opportunities, wealth, and matters of the common good can only be justified by appeal to a particular conception of the good. As Rawls has put it:

> Public reason does not apply to all political questions but only to those involving what we may call "constitutional essentials."[3]

More expansively, Brian Barry has written:

> Examples of issues that fall outside [the principle of neutrality include] two distinct kinds of items. One set of items (tax and property laws) contains matters that are in principle within the realm of "justice as fairness" but are subject to reasonable disagreement about the implications of justice . . . The other set . . . contains issues that in the nature of the case cannot be resolved without giving priority to one conception of the good over others . . . There is no room for a complaint of discrimination simply on the ground that the policy by its nature suits those with one conception of the good more than it suits those with some different one. This is unavoidable.[4]

Thus, it seems there is a growing agreement between liberals, communitarians, and others that many political matters, including matters of justice—and specifically, the just allocation of health care resources—can be addressed only by invoking a particular conception of the good.

We may go even further. Without overstating it (and without fully defending it) not only is there a consensus about the need for a conception of the good, there may even be a consensus about the particular conception of the good that should inform policies on these nonconstitutional political issues. Communitarians endorse civic republicanism and a growing number of liberals endorse some version of deliberative democracy. Both envision a need for citizens who are independent and responsibile and for public forums that present citizens with opportunities to enter into public deliberations on social policies.

This civic republican or deliberative democratic conception of the good provides both procedural and substantive insights for developing a just allocation of health care resources. Procedurally, it suggests the need for public forums to deliberate about which health services should be considered basic and should be socially guaranteed. Substantively, it suggests services that promote the continuation of the polity—those that ensure healthy future generations, ensure development of practical reasoning skills, and ensure full and active participation by citizens in public deliberations—are to be socially guaranteed as basic. Conversely, services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic and should not be guaranteed. An obvious example is not guaranteeing health services to patients with de-

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mentia. A less obvious example is guaranteeing neuropsychological services to ensure children with learning disabilities can read and learn to reason.

Clearly, more needs to be done to elucidate what specific health care services are basic; however, the overlap between liberalism and communitarianism points to a way of introducing the good back into medical ethics and devising a principled way of distinguishing basic from discretionary health care services. Perhaps using this progress in political philosophy we can begin to address Dan's challenge, begin to discuss the goods and goals of medicine.

References

1. Amy Gutmann, "For and Against Equal Access to Health Care," *Milbank Memorial Fund Quarterly* 59 (1981): 542-60.

2. Ezekiel J. Emanuel, *The Ends of Human Life* (Cambridge, Mass.: Harvard University Press, 1991), chap. 4.

3. John Rawls, *Political Liberalism* (New York: Columbia University Press, 1993), p. 214.

4. Brian Barry, *Justice as Impartiality* (New York: Oxford University Press, 1995), pp. 144-45. ■

Bruce Jennings

Beyond Distributive Justice in Health Reform

The moral imagination most congenial to professional and policy elites in America—even in this apparently "conservative" moment of recentering national politics a few notches to the right—is the perspective of liberal individualism, in either its rights-based or utilitarian guises. The liberal tradition also remains intellectually dominant in the most influential work of ethical theory in Anglo-American analytic philosophy. Thus for understandable theoretical as well as practical reasons, liberal individualism has dominated the discourse of bioethics, child of the late sixties, patient's rights advocate of the seventies, and proponent of universal access to medical services—a.k.a. "just health care"—in the eighties and nineties. When Daniel Callahan argues that neither the language of liberalism generally nor the discourse of justice in particular will be sufficient to guide medicine and the health care system into the next century, he cuts the field of bioethics to the quick.

Callahan is concerned primarily with the fact that this liberal focus has led us to neglect substantive questions about the goals of medicine and its service to the human good. While agreeing with him about that, I want to steer the discussion along a different path. What is most striking to me about the contribution bioethics has made to discussions of health care reform is that the moral and political problem of health policy has been framed almost exclusively as a problem of *distributive justice.* This conceptual orientation has determined the kinds of moral questions posed and the kinds of policy solutions sought by bioethicists. It has been our signal contribution to the social construction of reality in health affairs.

It is time to reconsider what bioethics has built and to draw up some new architectural plans. The lens of distributive justice does not provide the discernment we need to guide systemic change in an aging society, or in an era of chronic illness and behaviorally related health risks. Future gains in the health of the population will not be made primarily by redistributing (even more equitably) access to medical services and technologies. In sum, the most significant structural and epidemiological problems to tomorrow's health are not distributive problems properly addressed by a discourse of justice. They are political problems best addressed by a discourse of citizenship. They are problems of community, solidarity, and mutual responsibility that require a new kind of civic bioethics.

Posing a contrast between a discourse of distributive justice and a discourse of civic solidarity is an unfamiliar way of talking about these issues and requires some explication. This contrast is not meant to suggest that concerns of justice and the allocation of scarce resources have no place in a civic framing of health reform. Nor is it true that the perspective of distributive justice is entirely devoid of any notions of democratic governance, community, and mutual responsibility. The difference between the two orientations lies primarily in the way health and health care are understood as human goods and as social practices. There are three aspects of this difference that I want to put on the table for further discussion.

First, the distinction I am drawing between seeing health reform as a problem of distributive justice and seeing it as a problem of civic reconstruction grows out of the broader tension in American political culture between the liberal and the civic republican traditions. The former centers on the protection of individual rights and interests and on the pursuit of personal conceptions of the good; the latter focuses on the problem of creating a self-governing community that makes possible the pursuit of a good in common that no individual member of the community can realize or appropriate alone.

It is no accident that distributive justice is the touchstone of politics and ethics in a liberal society