

Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals

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ABSTRACT

For years, commentators have debated how to most appropriately allocate scarce medical resources over large populations. In this paper, I abstract the major rationing schema into three general approaches: rationing by price, quantity, and prioritization. Each has both normative appeal and considerable weakness. After exploring them, I present what some commentators have termed the “moral paradigm” as an alternative to broader philosophies designed to encapsulate the universe of options available to allocators (often termed the market, professional, and political paradigms). While not itself an abstraction of any specific viable rationing scheme, it provides a strong basis for the development of a new scheme that offers considerable moral and political appeal often absent from traditionally employed rationing schema.

As I explain, the moral paradigm, in its strong, absolute, and uncompromising version, is economically untenable. This paper articulates a modified version of the moral paradigm that is pluralist in nature rather than absolute. It appeals to the moral, emotional, and irrational sensibilities of each individual person. The moral paradigm, so articulated, can complement any health care delivery system that policy-makers adopt. It functions by granting individuals the ability to appeal to an administrative adjudicatory board designated for this purpose. The adjudicatory board would have the expertise and power to act in response to the complaints of individual aggrieved patients, including those complaints that stem from the moral,

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religious, ethical, emotional, irrational, or other subjective positions of the patient, and would have plenary power to affirm the denial of access to medical care or to mandate the provision of such care. The board must be designed to facilitate its intended function while creating structural limitations on abuse of power and other excess. I make some specific suggestions on matters of structure and function in the hope of demonstrating both that this adjudicatory model can function and that it can do so immediately, regardless of the underlying health care delivery system or its theoretical underpinnings.

I. INTRODUCTION

Health care is not cheap. Far from it; in 2009, health care spending in the United States consumed a projected \$2.5 trillion or 17.3% of the gross domestic product (GDP).¹ In the same year, the average American spent \$923 in “out of pocket” health care expenses.² While the cost of America’s consumption is high relative to the rest of the world, the excessive and growing cost of health care is a global problem. In 2006, total health care spending amounted to 15.8% of the GDP of the United States, 10.0% of the Canadian GDP, 11.0% of the French GDP, and 8.1% of the Japanese GDP.³ Those numbers have been steadily climbing. In 1980, the respective percentages of GDP were 8.7%, 7.0%, 7.0%, and 6.5%.⁴ Recent estimates suggest that total health care spending in the United States will reach a staggering 19.3% of GDP, or nearly \$4.5 trillion, by 2019.⁵ The same estimates suggest that 2019 per capita expenses will reach \$13,387 and out of pocket consumer expenses will reach \$1390 (a 50% increase from 2009 out of pocket levels).⁶ Many commentators have declared that if limits are not placed on access to health care (limiting access being the preferred or most direct means of limiting consumption), health care expenditures can easily reach 100% of GDP in industrialized nations, even without accounting for wasteful expenditures.⁷

Just as medical resources are costly, so are they scarce. This relationship between cost and scarcity is not merely coincidental; they each cause the other. As scarcity increases without a corresponding reduction in demand, rudimentary price theory dictates that price will increase. Multiplied over a

¹ CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2009-2019, tbl.1 (2010), <http://www.cms.hhs.gov/nationalhealthexpenddata/downloads/proj2009.pdf> [hereinafter PROJECTIONS].

² *Id.* at tbl.3.

³ ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), OECD HEALTH DATA 2009 (2010), <http://stats.oecd.org/Index.aspx?DatasetCode=HEALTH> [hereinafter OECD HEALTH DATA].

⁴ *Id.*

⁵ PROJECTIONS, *supra* note 1, at tbl.1.

⁶ *Id.*, at tbl.3 (all figures adjusted for inflation).

⁷ *See, e.g.*, Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1459 (1994) (referring to GNP, rather than GDP); Volker H. Schmidt, *Models of Health Care Rationing*, 52 CURRENT SOC. 969, 971 N.6 (2004).

population, these conditions result in decreased access to care and ultimately the death or suffering of individuals who are denied access. These social repercussions threaten to further commodify access to health care, placing increasing upward pressures on demand, thus further increasing price and decreasing access. We find ourselves caught in a violent spiral of price escalation and adverse health consequences.

In light of these trends, many who have commented on the subject of rising health care prices recommend the imposition of limits on health care consumption; in other words: rationing. Needless to say, health care rationing makes many people uncomfortable. Consider an article in the *American Spectator* that referred to rationing plans as “health care fascism.” It recommended a “national, populist, grassroots movement” to fight centralized rationing and offered its readers the following stark warning: “Unless this is stopped, many of you reading this article right now will one day suffer death-by-liberalism, when the government bureaucracy decides that the health care you need is not worth the cost, or puts you in a waiting line where death will arrive before treatment.”⁸

The *American Spectator’s* populist movement was clearly mobile by the summer of 2009. During the summer congressional recess, many members of congress went home to convene “town hall meetings” to discuss health care reform with their constituents. I decided to attend one such meeting hosted by Senator Ben Cardin, junior senator from Maryland, on August 10, 2009. I left the meeting inspired, although not by Senator Cardin’s words, as it was impossible to hear them from the other side of the brick and stone auditorium in which Cardin was speaking. The meeting started at 7PM but, according to a security officer present outside the meeting, capacity had been reached by about 5PM. Those who came thereafter were not permitted inside. When I arrived at about 6:30PM, naively expecting to be seated, I was overwhelmed by the energy of the people standing outside inspired to participate in the process of lawmaking. By my estimation, there were 1000 people convened outside under the hot Baltimore sun. About 40% of them were carrying placards, sporting a bull horn, or had adopted some other means of clearly making their views known. The atmosphere was that of a rock concert – simultaneously chaotic and peaceful. Everyone was talking about health care, rationing, economics, and other such topics that six months prior did not occupy the public square. Everyone had an opinion and few were afraid to argue. I listened as people debated the meaning of “rationing” or whether providing “health care for everyone” was tenable or desirable. They were all highly motivated. Interestingly, at least 70% of the assembled were there in opposition to “ObamaCare.” While I cannot say that everything that I heard was intelligent, I can say that the assembled, those excluded from their senator’s speech, cared about their country, were concerned about the actions of their representatives in Washington, and strongly desired to manipulate the development of this social/political issue.

What explains this populist uprising? Further, when did health care policy become so exciting? Certainly much of the protest revolved around

⁸ Peter Ferrara, *Repeal Health Care Fascism*, AM. SPECTATOR, Feb. 25, 2009, at 1, <http://spectator.org/archives/2009/02/25/repeal-health-care-fascism/>.

economic policy. People were concerned that excessive spending would harm the future economic and political stability of the country. But that objection, which is present every time government proposes the enactment of an expensive project, appears to be secondary. The primary objection, evidenced by the language of the *American Spectator* and the rhetoric used by the protestors standing outside town hall meetings across the country, was one grounded in liberty. Virtually nowhere is a violation of personal autonomy more closely felt than in depriving the individual the right to make personal health care decisions. It appeared that the people were not willing to surrender their liberty interests in choosing a course of treatment for themselves and their families. Most of them did not seem to object to health care delivery reform per se, just in a type of reform that limited their ability to make decisions regarding personal and familial health. If so, meaningful and comprehensive health care reform that adequately assures the public that it will have some degree of control over the results of health care allocation decisions might be politically feasible. Regardless, health reform efforts that do not adequately assuage public concerns have become a legal and political quagmire.⁹

Health care reform efforts are complicated by the absence of simple solutions. If it were possible to place physicians or patients in charge of allocating scarce medical resources, the problems of medical allocation could be addressed more easily. For example, rather than developing complex systems to promote the proper consumption of medical resources, governments could simply grant groups of physicians access to a certain quantity of resources and ask them to allocate resources appropriately and efficiently. Unfortunately, the realities of health care economics preclude simple solutions. Physicians, for example, must navigate a complex network of conflicting interests, many of which are at odds with society's interest in efficient resource allocation. They include the need to avoid medical malpractice liability; the need to satisfy repayment requirements, such as requirements imposed by private insurance companies and government programs; and other overt and discrete financial incentives that promote consumption, including direct compensation for services rendered¹⁰ and kickbacks from pharmaceutical representatives for product promotion.¹¹ Nor

⁹ See *infra* text accompanying notes 79, 127-128; see also, e.g., Stephanie Condon, *Scott Brown Win Shakes Up Health Care Fight*, C.B.S. NEWS, Jan. 20, 2010, http://www.cbsnews.com/8301-503544_162-6119035-503544.html (noting that Massachusetts' 2010 election of Republican Scott Brown to the U.S. Senate to fill the late Senator Ted Kennedy's seat was "a repudiation of President Obama's health care reform package" and that the significance of his election "was difficult to overstate."); Complaint, Commonwealth of Virginia v. Sibelius, No.3:10-cv-188 (E.D. Vir. filed Mar. 23, 2010); Complaint, State of Florida v. U.S. Dep't. of Health & Human Servs., No. 3:10-cv-91 (N.D. Fla. filed Mar. 23, 2010).

¹⁰ Physicians receive payment for services rendered regardless of whether the services were actually necessary or even marginally helpful. This creates an incentive to treat even where treatment is excessive or wasteful.

¹¹ I acknowledge that, notwithstanding these concerns, there are good reasons to trust physicians and that granting them the responsibility to ration care might yield some significant benefits. By focusing only on the reasons not to trust physicians, this paper suggests that there are no legitimate responses to the stated concerns—an unfortunate consequence necessitated by the limited scope of this paper. On balance, I believe that the arguments in favor of trusting physicians ultimately fail and that a grant of great authority to physicians is

can patient groups be expected to efficiently allocate resources. Patients, as a class, lack the information necessary to evaluate the full breadth of their options, the expected effectiveness of any given treatment, the total social costs¹² associated with their treatment options, the efficacy of their providers, or the relative quality of their results. They must rely upon their physicians to make allocational decisions for them, and are thus subject to all of the biases that physicians face. Nor can health insurance contracts efficiently allocate resources by actualizing individual preferences. Contracts are often negotiated by a third-party, typically an employer under the current American model,¹³ who then passes that contract (often unilaterally)¹⁴ to the consumer.¹⁵ The long-term interests of employers are necessarily different from the interests of employees,¹⁶ thus calling into question whether a contract negotiated by an employer, even if formally adopted by the employee, can be expected to represent the employee's interests.

Notwithstanding the absence of simple solutions to health reform due to numerous conflicting incentives and the political quagmire that permeates health care rationing, it remains necessary to impose comprehensive limitations on health care access. The government has the tools necessary to ration¹⁷ care and has no choice but to do so or to pass that responsibility to the private sector. It is impossible for any government to finance care commensurate with its demand because the potential demand (the desire) for medical care is virtually boundless despite external constraints such as the inability of many consumers to pay.¹⁸ The two simplest methods of limiting access are to (1) appropriate a certain fixed percentage or amount of the annual budget for health care spending and place no other limits upon

likely to result in an allocation at odds with public policy. Further analysis is beyond the scope of this paper.

¹² "Social costs," refer to government subsidies and the increased costs occasioned by increased consumption and thus higher prices for everyone.

¹³ A 2005 survey revealed that of the 108 million Americans aged nineteen through sixty-four who have private health insurance, 100 million of them received their insurance through an employer. SARA R. COLLINS, *SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 2* (2006), available at, <http://www.commonwealthfund.org/> (enter the report title into the search field) [hereinafter *SQUEEZED*]. It is unclear what percentage of the 100 million hold insurance contracts with private insurance companies and what percent have contracts for coverage with employer self-funded plans.

¹⁴ Health insurance contracts, even if the product of negotiation, are often stipulated to the employee. Employees are generally presented with one or two such contracts and told to 'take it or leave it.' In the United States, federal tax exclusions create significant incentives to 'take it,' despite that the contract might be inefficient and insufficient. One recent survey found that an amazing 46% of people aged nineteen to sixty-four with employer based insurance received just one insurance "option." For those employed in firms of less than twenty people, that number rises to 75%. *SQUEEZED*, *supra* note 13, at 6.

¹⁵ Note that while the employer negotiates the contract and often pays part or all of the insurance premium, the employee is actually the financially responsible party. The employer reduces the wages that it would be willing to pay the employee to cover the costs of insurance. See Ezekiel J. Emanuel & Victor R. Fuchs, *Who Really Pays for Health Care?: The Myth of "Shared Responsibility"*, 299 *JAMA* 1057, 1057 (2008).

¹⁶ The employer is less interested in the long-term health of the employee and so may be less motivated to bargain for preventative medical care. The employer is also less interested in end-of-life care and high-cost catastrophic care (patients needing such care are probably less likely to return to work or to be productive following treatment and recovery).

¹⁷ The term "ration" in this paper is defined broadly, as Part II will illustrate.

¹⁸ Schmidt, *supra* note 7, at 969.

consumption,¹⁹ or (2) adopt a completely unregulated market in which price constraints are the exclusive limiting factor. To my knowledge, neither option has been adopted in modern health care delivery systems. In the former case, it would be bizarre to allocate resources completely without regard to the needs of the patient being granted or denied those resources. In the latter case, price would likely spiral out of control, which would create severe negative distributional effects and would cripple the host economy.²⁰ A third, relatively simple, alternative would be to ration care without the knowledge of the patient via *ad hoc* rationing.²¹ While some physicians currently engage in *ad hoc* rationing on a case-by-case basis, it appears to be logistically impossible to institutionalize *ad hoc* rationing and expand it so that it independently solves the problem of excessive consumption. For the remainder of this paper, the term “rationing” refers to purely institutional, rather than to *ad hoc* rationing. Thus, for the purpose of this paper, it is assumed that when a patient is denied access to health care, she has full knowledge of the general reasons for her denial.

If government fails to satisfactorily ration care in light of virtually boundless demand, private insurers will have to ration by creating incentives to limit consumption. If they fail to do so, they will cease to exist. As the Supreme Court famously remarked in 2000, no managed care organization can survive without rationing tactics because “[t]he essence of [managed care] is that salaries and profits are limited by the [managed care organization’s] fixed membership fees.”²² The problem of fixed revenue renders fatal the failure to effectively address limitless demand. Indeed, “inducement to ration care goes to the very point of any [managed care] scheme.”²³ Accordingly, managed care organizations enter relationships with physicians that incentivize the physician to limit the treatment he provides to his patients.²⁴ The need for providers (government and private insurance) to ration care and the desire for patients to consume care create an irresolvable

¹⁹ At a high degree of abstraction, this approximates the scheme initially adopted by the United Kingdom. See discussion *infra* Part II.C.

²⁰ See *supra* notes 1-7 and accompanying text.

²¹ The ability of medical providers to limit access to care via *ad hoc* rationing is virtually plenary because it occurs without detection by the patient and cannot easily be regulated or controlled by traditional government mechanisms. For example, physicians might provide less-effective, and less-expensive, care (“rationing by dilution”). Schmidt, *supra* note 7, at 972. They might discharge patients from the hospital earlier than otherwise desirable or find other ways of minimizing the length of treatment (“rationing by termination”). *Id.* They might even simply decide not to provide a given option due to cost considerations without even making that option known to the patient (“bedside rationing”). Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 709 (1994). For an anecdotal example of bedside rationing, which resulted in the death of an author’s mother, see M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 919 (2002). Hospitals might restrict access to patients by telling them that other, less-expensive, facilities are better equipped to provide care (“rationing by redirecting”). Schmidt, *supra* note 7, at 972. Additionally, they might triage their patients to provide care first to those in less-urgent need (“utilitarian rationing”). *Id.* See also Iserson & Moskop, *infra* note 52, at 279. Or they might artificially limit the number of devices available, thus artificially limiting access (“rationing by quantity”). See Nicolas S. Ward & Mitchell M. Levy, *Rationing and Critical Care Medicine*, 35 CRITICAL CARE MED. S102, S102 (2007).

²² *Pegram v. Herdrich*, 530 U.S. 211, 220 (2000).

²³ *Id.* at 221.

²⁴ *Id.* at 234.

tension that lies at the heart of rising costs and skyrocketing prices. The objective of this paper is to address that tension.

In his landmark 1994 work, Einer Elhauge described four conceptual paradigms that are intended to provide the universe of possible theoretical approaches²⁵ to ration health care resources as a means of controlling costs: the market,²⁶ professional,²⁷ political,²⁸ and moral paradigms.²⁹ He defines the “moral paradigm” negatively: “What unites the various positions [that together constitute the moral paradigm] is not their uniformity but their insistence that allocation decisions should be derived from moral analysis, rather than dictated by market forces, professional judgment, or political accountability.”³⁰ As his language implies, he adopted this negative definition as a means of synthesizing many various positions that on the surface have nothing in common other than the negation of the other three paradigms.³¹ In truth, the various positions of the moral paradigm have a great deal in common. They all adopt moral reasoning as a tool for rationing health care and generally assume that the adoption of moral reasoning is not merely good policy, but that it is an imperative. Elhauge’s conception is thus far too narrow. By reconceptualizing the moral paradigm as an imperative, rather than as a distinct philosophical approach to rationing, this paper articulates a

²⁵ Thinking in terms of four discrete paradigmatic structures is analytically helpful as it keeps us cognizant of the universe of possibilities. Welfare economics, for example, is often limited to a discussion about the various methods of maximizing utility. That fact often obscures other important objectives because the inquiry initiates at a level that is too narrow. We might get better policy by first inquiring which of the paradigms are best suited for addressing the issue at hand.

²⁶ Generally, the market paradigm appeals to market efficiency as a means of determining how health care dollars ought to be spent.

²⁷ The professional paradigm places the onus of medical allocation on the medical profession; the theory being that appeal to their expertise and professional judgment, coupled with the self-imposed ethical Hippocratic-type limitations on medical decision-makers, is an effective and neutral means of achieving equitable rationing. Considering the various conflicting interests that physicians face in the normal course of their practice, an adoption of the professional paradigm in its pure form is probably unwise. *See supra* note 11 and accompanying text.

²⁸ The political paradigm looks to political accountability as a means of controlling costs. This approach, taken in its pure form, seems particularly ill advised as it is at least as likely that the political process would be used to increase, rather than decrease, acute-care medical spending. This is so because it implicates the “public choice” problem of political decision-making. When medical providers expend great government resources to save one patient, they do so at the detriment of every taxpayer. The beneficiaries of additional care (the individuals in need of immediate care) are motivated and able to organize (at least, their families are) while those who are at risk (the public at large) are diffuse, anonymous, and relatively disinterested. It is not surprising that the political paradigm has had little appeal. *But see generally* Elizabeth C. Price, *The Evolution of Health Care Decision-Making: The Political Paradigm and Beyond*, 65 TENN. L. REV. 619 (1998) (arguing that the political paradigm was in fact the primary mechanism of health care delivery in the United States at the time she wrote her paper).

²⁹ Elhauge, *supra* note 7, at 1452.

³⁰ *Id.* at 1453.

³¹ Elhauge’s principal argument was that the moral paradigm, while attractive in many ways, is both impractical and indeterminate in the context of health care, and is thus not a viable option absent external limitations. Elhauge, *supra* note 7, 1457-65. While I find his arguments convincing as they are articulated, they rest on this unnecessarily narrow conception of the moral paradigm.

new application of the moral paradigm that might help resolve the problem of rationing medical care.

This paper argues that the moral paradigm is both *useful* to the creation of good public policy and *necessary* to the extent we desire a solution that is politically salable. Essentially, it argues that the moral paradigm demands greater process for those who are denied access to medical care and that we design our institutions responsible for rationing to incorporate this call for greater process. The moral paradigm thus need not provide a substantive approach to rationing, such as by negating “non-moral” approaches. It serves merely to complement various approaches to rationing by incorporating a system of administrative adjudication into the rationing process.

Part II of this paper will introduce three principal methods of rationing (distinct from Elhauge’s philosophical paradigms) and will illustrate the problems with each of them. Part III will further develop the moral paradigm, articulate my reconceptualized pluralist version of the moral paradigm (the “new moral paradigm”), and articulate a moral argument for inserting a process-based element into rationing. Part IV will propose the creation of an administrative adjudicatory board that grows directly out of the process argument. The objective is to use the moral paradigm as an overlay on any rationing scheme. The adjudicatory board can oversee health care delivery and rationing efforts to deal with the problems of scarcity and unquenchable demand in a manner consistent with the new moral paradigm. In particular, Part IV will articulate the need for discretionary individualized decision-making rather than the adoption of universal bright-line rules as an answer to the rising price of health care. Part V will consider the structure and function of the administrative adjudicatory body proposed in this paper – suggesting some of the powers that ought to be granted to adjudicators and the structural limits that ought to be placed upon the adjudicatory process – in order to ensure efficacy and reduce the risks of abuse of power.

II. THE PROBLEM OF RATIONING

Richard Lamm summarizes the argument for the necessity and inevitability of rationing: “[W]hile our resources as a nation are finite, our health demands are infinite.”³² Governments and commentators have developed a number of rationing schema in response to this necessity and inevitability. This Part describes the three idealized mechanisms of rationing health care that together describe nearly every rationing scheme and articulates some of the normative or ethical problems occasioned by each of them.

³² Richard D. Lamm, *Rationing of Health Care: Inevitable and Desirable*, 140 U. PA. L. REV. 1511, 1512 (1992). Some other important works on the topic include Elhauge, *supra* note 7, Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597 (1992), Hall, *supra* note 21, and Robert M. Veatch & Carol Mason Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15 (1992).

Lamm identified four “basic methods of rationing”: rationing by (1) price, (2) quantity, (3) chance, and (4) prioritization.³³ In lay parlance, “rationing” means “rationing by prioritization,” which is a rigorous scheme in which health care decisions are set forth by way of precommitment.³⁴ For example, HHS has published a proposed distribution of scarce vaccine following the onset of pandemic influenza that delineates various “priority groups” to sequence vaccine distribution.³⁵ This sequencing is rationing by prioritization, which is just one of the three major forms of rationing. (I will not deal explicitly with rationing by chance for its only practical application is in the strong version of the moral paradigm, discussed below.)³⁶ The next Section describes these three approaches to rationing.

A. THREE APPROACHES TO RATIONING

1. Rationing by Price

Rationing in the United States is accomplished primarily by price.³⁷ Market-based systems, defined generally, allocate resources to those who are most willing to pay for them. In so doing, those who are unable to pay are priced-out of the market; they are denied access to the goods they desire. Markets create an effective means of rationing medical care by excluding certain people from the marketplace, thus limiting consumption against the will of the consumer. This is rationing by price.

The millions of Americans without health insurance and without sufficient funds to cover the costs of their care are subject to price rationing.³⁸ The millions of Americans who live in rural areas with insufficient access to specialists and resources necessary to travel long distances to get the care they need also suffer from price rationing.³⁹ Additionally, a surprisingly large number of people subject to price rationing fit in neither of those categories. An interesting study published in 2004 found that 3.2% of respondents with income over 400% of the federal poverty level reported postponing needed medical care or entirely declining to seek care due to cost concerns within the

³³ Lamm, *supra* note 32, at 1518.

³⁴ Many call this “allocation” rather than “rationing.” See Michael D. Reagan, *Health Care Rationing and Cost Containment Are Not Synonymous*, 9 POL’Y STUDIES REV. 219, 223 (1989). I have argued previously that the distinction between the two is subterfuge because “[b]oth processes center upon a decision to deny proper and necessary medical treatment to real people, even if at the time of the decision those people are anonymous and the decision is largely theoretical.” Meir Katz, Note, *Bioterrorism and Public Law: The Ethics of Scarce Medical Resource Allocation in Mass Casualty Situations*, 21 GEO. J. LEGAL ETHICS 795, 795 n.2 (2008). Accordingly, I make no attempt to distinguish between those terms in this paper.

³⁵ U.S. DEP’T OF HEALTH & HUMAN SERV., HHS PANDEMIC INFLUENZA PLAN, available at <http://www.hhs.gov/pandemicflu/plan/appendixd.html> (last visited Jan. 28, 2009); see also Katz, *supra* note 34, at 803-05.

³⁶ See *infra* Part III and the discussion on John Taurek, starting with text accompanying note 135.

³⁷ Lamm, *supra* note 32, at 1518.

³⁸ *Id.* at 1511.

³⁹ See *id.* at 1518.

twelve months prior to the survey.⁴⁰ A similar study demonstrated that 5.1% of responding patients with an annual income over \$70,000 refrained from the consumption of recommended health care due to cost.⁴¹ These data suggest that price rationing imposes significant burdens on a large number of middle-class Americans.⁴² Indeed, “[i]n the United States, 61% of adults *with health insurance* currently report difficulty paying their medical bills” and “29% of adults, or someone in their household, avoided medical treatment, cut pills, or did not fill a prescription in the [year prior to the survey] because of cost.”⁴³

Not only is the number of affected middle-class Americans large, it is growing. The Commonwealth Fund revealed that, from 2001 to 2007, the number of people reporting a decision not to go to a doctor, or to skip a recommended medical test, or to fail to see a specialist when needed, or to fail to fill a prescription despite knowledge of a medical problem rose from 29% to 45% for the entire population; from 21% to 35% for the population insured the entire twelve months prior to the survey; and from 14% to 29% among those with an annual income over \$60,000.⁴⁴ With the onset of severe global recession in late 2008, we can expect the figures in Commonwealth Fund’s 2009 survey (which will likely be released in 2010) to continue their upward trend.⁴⁵

⁴⁰ Robin M. Weinick et al., *Who Can’t Pay for Health Care?*, 20 J. GEN. INTERNAL MED. 504, 505-06, TBL.1 (2004). Moreover, 5.8% of respondents between 200% and 400% of the federal poverty level reported delaying or refraining from treatment due to cost. Also surprising is the percentage of college graduates who reported delaying or refraining from treatment: 4.6%. Additionally, 6.1% of all respondents and 5.2% of college graduates did not fill prescription medicine in the twelve months prior to the survey also due to cost. *Id.*

⁴¹ See Ali R. Rahimi, *Finacial Barriers to Health Care and Outcomes After Acute Myocardial Infarction*, 297 JAMA 1063, 1065 TBL.1 (2007). The table reports that 5.7% of those with financial barriers had an annual income over \$70,000. It also reports that there were 442 respondents claiming financial barriers. 5.7% of 422 respondents is approximately 25.19 people. The table also indicates that 19.6% of all respondents received an income over \$70,000, which works out to approximately 489.61 people. Dividing 25.19 by 489.61 equals approximately 0.051 (or 5.1%). *Id.*

⁴² The data comes from telephone surveys, perhaps limiting somewhat our ability to extrapolate from them conclusions regarding the entire population. See Weinick et al., *supra* note 40, at 507; Rahimi, *supra* note 41, at 1071.

⁴³ See Rahimi, *supra* note 41, at 1063, 1069-70 (emphasis added) (citing a joint study by USA Today, Kaiser Family Foundation, and Harvard School of Public Health).

⁴⁴ SARA R. COLLINS ET AL., LOSING GROUND: HOW THE LOSS OF ADEQUATE HEALTH INSURANCE IS BURDENING WORKING FAMILIES 15-16, FIGS. 17-18 (2008), available at, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Losing-Ground--How-the-Loss-of-Adequate-Health-Insurance-Is-Burdening-Working-Families--8212-Finding.aspx> (click “Fund Report”) [hereinafter LOSING GROUND].

⁴⁵ We can only assume that decisions to forgo needed medical treatment positively correlate with decreasing wealth. Data from the most recent American recession (in the early 1990s) is likely unhelpful because that recession was much shorter, narrower, and less severe than the 2008-2009 recession. The most recent comparable recession was in the early 1980s. Data from that recession, if available, would also likely be unhelpful for that recession pre-dates significant changes to the health care sector that are beyond the scope of this work. Additionally, because health care inflation out-paces general inflation, see Sean Keehan et al., *Health Spending Projections Through 2017: The Baby-Boom Generation is Coming to Medicare*, 27 HEALTH AFF. W145, W146 EX. 1 (2008), data on health economics that is not recent is less likely to yield conclusions that are still relevant, unless that data is adequately adjusted for the current rate of health care inflation.

2. Rationing by Quantity

Lamm suggested that rationing by quantity (setting limits on access to certain high-cost care by artificially limiting the quantity of that care available for consumption) might be conceptualized as “last-dollar rationing” as opposed to rationing by price, which is “first-dollar rationing.”⁴⁶ First-dollar rationing programs prevent access to initial treatment while last-dollar rationing programs focus on limiting access over time. If the objective of rationing is to maximize public health, controlling total expenditures is more congruous with that objective than is excluding a class of individuals from coverage entirely (provided that the disfavored class is not statistically less likely to recover or otherwise a less desirable class to treat for reasons of health policy). Rationing by price grants the wealthy access to procedures that promise little marginal benefit relative to the cost of treatment and excludes the poor from low-cost high-value procedures that undeniably improve both public and individual health. In stark contrast, rationing by quantity favors procedures that maximize public health relative to their costs.⁴⁷

In theory, limits on quantity need not be tied to assessments on cost effectiveness. The government could ration by setting very bright lines for total consumption without involving itself in the details. For example, health care consumption could be fixed at 10% of GDP without additional limitation. Under such a scheme, people who get sick in the beginning of a fiscal year will be favored over those who get sick in the end of a fiscal year for no other reason than getting sick at the wrong time. Rationing by quantity, performed so crudely, is clearly irrational. Once the budget for health care consumption is fixed, it becomes necessary to inquire how the fixed dollars ought to be spent. Accordingly, rationing by quantity is linked to, and generally preceded by, assessments on cost effectiveness.

The federal government’s decision in early 2009 to appropriate \$1.1 billion for cost effectiveness research and to develop an advisory council designated to issue reports on cost effective medicine might be the first step towards the adoption of a rationing by quantity scheme in the United States.⁴⁸

⁴⁶ Lamm, *supra* note 32, at 1518-19 (quoting Jeffrey C. Merrill & Alan B. Cohen, *The Emperor’s New Clothes: Unraveling the Myths About Rationing*, 24 INQUIRY 105, 106-07 (1987)).

⁴⁷ *See id.*

⁴⁸ A section of the American Recovery and Reinvestment Act of 2009 (“Act”) (commonly known as the “stimulus bill”) created the “Federal Coordinating Council for Comparative Effectiveness Research” (“Council”). American Recovery and Reinvestment Act of 2009 § 804, 42 U.S.C.A. § 299b-8 (West 2009). The Act stipulates that the Council’s role is advisory only, explicitly declaring that the Council has no power to “mandate coverage, reimbursement, or other policies for any public or private payer” and that none of the Council’s reports “shall be construed as mandates or [binding] clinical guidelines.” *Id.* Rather, the purpose of the Council is to “foster optimum coordination of comparative effectiveness and related health services research conducted or supported by relevant Federal departments and agencies.” *Id.* To that end, the Act appropriates \$1.1 billion for “comparative effectiveness research.” American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, div. A, tit. VIII, Healthcare Research and Quality. 111 H.R. 1, 62-63 (2009). The presumptive goal of that research is to reduce health care spending by rendering spending decisions more cost-efficient.

Rationing by quantity need not be centralized. For example, private insurance contracts impose some form of rationing by quantity.⁴⁹ They limit access to certain types of treatments on the theory that the costs of treatment exceed the likely benefits, and thus the beneficiary would not be willing to pay the increased premium for the additional benefit (a theory of consent). Even if we assume that this contractual relationship is truly consensual,⁵⁰ that does not imply that rationing is not taking place. The two parties are agreeing *ex ante* to ration care by limiting access to certain types of treatment (and thus quantity) should the beneficiary ever desire that type of treatment in the future.

The fact that insurance contracts and centralized rationing systems often completely exclude certain types of treatment does not render them any less vehicles of rationing by *quantity*. In these cases, the frequency of consumption is reduced from 100% down to 0% (a very blunt method of quantity reduction). The phrase “rationing by quantity” is valuable because it tolerates more subtle approaches to quantity limitations, such as limiting access to physical therapy or mental health treatment to a certain number of visits per year. It also incorporates a broader view of health policy. Even where a particular person is completely denied access to health care, describing that exclusion as a limitation on quantity is valuable because it focuses on national and global health care consumption rather than the narrow implications for just one patient.

3. Rationing by Prioritization

Finally, rationing by prioritization attempts to rank patients for treatment according to need or some other rubric, rather than by limiting quantity. Rationing by prioritization and rationing by quantity are closely related but different. Rationing by quantity focuses primarily on limiting access to certain types of *treatment* while rationing by prioritization focuses primarily on limiting access for certain types of *people*. If those people are defined by their medical condition (AIDS patients, for example) the line between rationing by prioritization and rationing by quantity is blurred. There is little functional difference between denying all treatment for AIDS patients (rationing by prioritization) and denying access to AIDS medication (rationing by quantity). The two are nevertheless analytically distinct, deserve separate analysis, and present different problems.⁵¹

Prioritization methods aim to provide medical care to particular patients rather than others on the theory that doing so will maximize public health or the ends of some other policy objective. An obvious and uncontroversial example of prioritization is the vaccination of soldiers, even at great expense and with a vaccine not available to the civilian public, before deploying them in an area of the world that has a high concentration of a particular contagion. These soldiers are placed at risk of significant harm for reasons largely beyond

⁴⁹ See *infra* text accompanying notes 72-77.

⁵⁰ Consent is true in theory alone. See *supra* notes 13-16 and *infra* notes 72-77 and accompanying text.

⁵¹ These problems are addressed *infra* Part II.C-II.D.

their control, thus providing a moral basis for prioritization. Vaccination is also appropriate on utilitarian grounds because soldiers who are not vaccinated provide a much shorter expected service to their country than do soldiers who are vaccinated. Accordingly, vaccinating these soldiers is likely to provide great societal gains per unit of investment as compared with a similar vaccination of the civilian population.⁵²

The term “triage” is today most commonly associated with efforts by hospitals to queue emergency room patients for treatment. It is generally uncontroversial because it provides a rule of priority rather than a rule of exclusion, except where the patient has no reasonable hope of recovery.⁵³ In contrast, the “rationing by prioritization” envisioned by this paper is a prioritization for the purpose of exclusion, and is thus far more controversial.

Using prioritization as a rule of exclusion is not analytically simple and the proper construction of such a prioritization scheme is not obvious. The problem is exacerbated because the methods available to policy-makers are nearly infinite. Here are a few potential viable examples, in no particular order: (1) utility (providing access in a manner designed to increase aggregate utility); (2) public health (providing access in a manner designed to increase aggregate public health (which is not necessarily coextensive with utility)); (3) nationality; (4) global productivity (particularly where extended illness or death is likely, we could provide treatment to those who are likely to be most productive – typically teenagers and young adults – after the emergency has past); (5) temporal priority (“first-come, first-served”; awarding resources to those who make themselves available soonest presumably either on the assumption that they are the most enthusiastic about treatment or as a means of adopting chance as the prioritizing factor); (6) enthusiasm (perhaps as evidenced by willingness to pay or to labor for the resources); (7) guilt or responsibility (disfavoring those who engage in dangerous behavior (e.g. smoking) on the theory that they will continue to impose health care costs on society after recovery); (8) age (prioritize the young on the theory that they have more to lose).

In light of the stunning variety of approaches to prioritization, this method of rationing is very difficult to characterize. Because the various methods of prioritization can be combined or graduated, prioritization is an extremely broad tool. In general, prioritization schemes all share a willingness to address consumption by appeal to some stated standard or policy objective.

⁵² Rationing by prioritization has a long history in war theaters. It was instituted no later than the eighteenth century by French military surgeons. Kenneth V. Iserson & John C. Moskop, *Triage in Medicine, Part I: Concept, History, and Types*, 49 ANNALS EMERGENCY MED. 275, 276-77 (2007). During World War II, for example, American physicians rationed scarce penicillin by supplying it to patients with gonorrhea, rather than patients with war wounds. The United States adopted a policy of treating those who could most quickly and “with the least expenditure of time and resources” return to the battlefield and assist directly in the war effort. *Id.* at 277.

⁵³ These situations are generally known as situations of “medical futility.” I have written about medical futility at length elsewhere. See Meir Katz, *When is Medical Care “Futile”? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care* (unpublished manuscript, on file with author).

B. RATIONING BY PRICE

Rationing by price,⁵⁴ the use of market systems to ration medical care, is endemic to the health sector and represents very poor health policy. Considerable data demonstrates that the lack of sufficient medical insurance yields reduced health care consumption, even where consumption is socially desirable and where non-consumption produces significantly poorer results.⁵⁵

Many commentators attempt to prove that the price rationing system prevalent in the United States is deficient by appealing to rather surprising statistics (for example, life expectancy in the United States, seventy-eight years, ranks just forty-fifth in the world and U.S. infant mortality rate is more than double that of Singapore, Sweden, and Japan).⁵⁶ These statistics prove little because simple statistical comparisons do not properly consider conflating factors. For example, a low life expectancy in the United States might be due more to a high homicide rate, poor nutrition, or a sedentary culture, than to ineffective health care.

Rather, data from empirical experiments – carefully designed to demonstrate such deficiency, and structured to avoid the articulation of false positive results – is necessary to support the claim that forced or coerced reductions in consumption of health care produce undesirable results. The empirical literature on the subject is broad and cannot be briefly

⁵⁴ Introduced *supra* Part II.A.

⁵⁵ See Malcolm Gladwell, *The Moral-Hazard Myth: The Bad Idea Behind Our Failed Health-Care System*, NEW YORKER, Aug. 29, 2005, available at http://www.newyorker.com/archive/2005/08/29/050829fa_fact. It is extremely well documented that insufficient medical insurance yields under-consumption. A few representative examples follow. A 2005 study found that 20% of adults with insurance deductibles of \$1000 or more delayed or declined to receive recommended cancer screening tests, compared with just 5% of adults with deductibles under \$500. (p R 0.05) (There was no correlation between high insurance deductibles and the decision to forgo lower-cost medical procedures, such as blood pressure screenings and dental exams, suggesting that the decision to forgo cancer screenings was primarily a financial one.) SQUEEZED, *supra* note 13, at 15; see also *id.* at 32 n.1. A 2007 study found adults aged nineteen through sixty-four with one or more of four named chronic conditions ((1) high blood pressure, (2) heart disease, (3) diabetes or (4) asthma, emphysema, or other lung disease) were more likely to visit the emergency room or seek admission into a hospital if they were uninsured. Specifically, 19% of patients with adequate medical insurance needed to visit the emergency room or be admitted to a hospital, compared with 43% of those who reported being uninsured at any time in the twelve months prior to the survey. *Rising Health Care Costs: Implications for the Health and Financial Security of U.S. Families: Hearing on High Health Care Costs: A State Perspective? Before the S. Comm. on Finance*, 110th Cong. 12-13, 28 fig.15 (2008) (statement of Sara R. Collins, Assistant Vice President, The Commonwealth Fund), <http://www.commonwealthfund.org/Content/Publications/Testimonies/2008/Oct/Testimony--Rising-Health-Care-Costs--Implications-for-the-Health-and-Financial-Security-of-U-S--Fami.aspx> (click “Testimony”) [hereinafter COMMONWEALTH TESTIMONY]. Another study found that 81% of insured diabetics reported that they were able to keep their diabetes under control as compared with just 63% of the uninsured. Further, 41% of insured blood pressure patients reported control over their blood pressure as compared with just 21% of the uninsured. *Id.* at 29 fig.16.

⁵⁶ See, e.g., Ezekiel, J. Emanuel, *What Cannot be Said on Television About Health Care*, 297 JAMA 2131, 2131 (2007); TOM DASCHLE, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 3-42 (2008). The Emanuel paper stated that the American infant mortality rate is 0.57%. Emanuel, *supra* at 2131. I am not confident that this figure is accurate. The Organization for Economic Cooperation and Development reported that the infant mortality rate in 2005 was 0.69%. OECD HEALTH DATA 2008, *supra* note 3.

summarized.⁵⁷ Instead, I provide below brief summaries of two empirical studies that I find particularly persuasive.⁵⁸

One interesting empirical study inquired whether the existence of a \$1000 cap on prescription drug benefits for certain sixty-five-or-older Medicare beneficiaries was closely correlated with differential outcomes between those patients and similarly situated patients whose prescription drug benefits were complemented by their former employers (that is, the second class was subject to no limitation as a result of the \$1000 cap).⁵⁹ Researchers found that those subject to the cap suffered relative to the other group;⁶⁰ the patients who had to pay for their own prescription drugs suffered from an increased death rate of about seven per 1000 people each year.⁶¹ Importantly, the research suggested that the cap actually created a net *cost*, rather than a net savings.⁶² Another study demonstrated that among patients who experience a dramatic change in their health status (due to severe trauma, for example), the uninsured patients performed significantly worse than those with insurance shortly after their dramatic change in health status.⁶³

⁵⁷ There is indeed a considerable body of research on the effects of uninsurance on health. See, e.g., Rahimi et al., *supra* note 43, at 1069 (finding that certain cardiac patients without health insurance faced “worse quality of life, and poorer overall physical and mental function,” were 50% more likely to be readmitted to a hospital with cardiac complications); David W. Baker, et al., *Loss of Health Insurance and the Risk for a Decline in Self-Reported Health and Physical Functioning*, 40 MED. CARE 1126 (2002); David W. Baker, et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 NEW ENG. J. MED. 1106 (2001); Peter Franks, et al., *Health Insurance and Mortality: Evidence from a National Cohort*, 270 JAMA 737 (1993); Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured*, 60 MED. CARE RES. REV. 3S (2003) [hereinafter *Consequences*]; INSTITUTE OF MEDICINE, *CARE WITHOUT COVERAGE* (2002); Helen Levy & David Meltzer, *What do we Really Know About Whether Health Insurance Affects Health*, in HEALTH POLICY AND THE UNINSURED (2005); Paul D. Sorlie, et al., *Mortality in the Uninsured Compared With That in Persons With Public and Private Health Insurance*, 154 ARCH INTERNAL MED. 2409 (1994). Much of it, however, is imperfect due to selection bias between those with and those without insurance. In other words, “prior health may have affected both the general measures of the subsequent health change and the baseline health insurance status,” thus undermining the claim that observed correlation between uninsurance and poor health indicated causation. The articles that I have described in the body of the paper are less susceptible to that criticism. Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, 297 JAMA 1073, 1074 (2007) [hereinafter *Unintentional Injury*].

⁵⁸ I discuss why I find them persuasive *supra* note 57.

⁵⁹ John Hsu et al., *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENG. J. MED., 2349, 2350 (2006).

⁶⁰ Research showed a significant difference in noncompliance between the two groups. Those with the \$1000 cap failed to comply with their drug treatment plan about 5% more often. See *id.* at 2354 tbl.2. Those with the cap saw a 4% increase in emergency room visits and a 2% increase in non-elective hospital admissions. *Id.* at 2355 tbl.3. These figures, and those in the body of the text, are all statistically significant and were subject to regression analysis.

⁶¹ 3.05% of those not subject to the \$1000 cap died each year. That number increased to 3.73% for those with the cap. *Id.* The difference between those figures is 0.68%. The 95% confidence interval is 0.30-1.07%. *Id.* at 2356

⁶² Patients with the cap saw a 9% cost increase due to greater use of the emergency room visits and a 14% increase from increased non-elective hospital admissions. *Id.*

⁶³ *Unintentional Injury*, *supra* note 57, at 1080. The study clearly demonstrated that the uninsured were less likely than the insured to receive recommended follow-up care. *Id.* at 1077. 92.1% of the insured were able to stay out of the emergency room as compared with

Both empirical studies involve situations of unambiguous medical need. Given such need, we might assume that the patients would efficiently use whatever resources they could to ensure recovery where the price of recovery was less than the costs of long-term harm occasioned by failure to recover. Instead, both studies indicate that patients who lack the ability to pay, either because they did not have health insurance,⁶⁴ or because they were subject to a cap on insurance benefits, either did not find the resources necessary to facilitate their recovery or misunderstood the importance of getting treatment. These observations corroborate the claim that price rationing subjects those who cannot afford the care they need to long-term suffering and non-recovery for no particular reason and with little social gain other than satisfying the need to limit access to health care in some form or another.

Price rationing has a tendency to inspire perverse decision-making that is ultimately costly to the system. Consumers often do not know how to distinguish between non-emergent and emergent health conditions. Accordingly, they refrain from spending on both frivolous care and on genuinely useful care.⁶⁵ The results can be tragic and very expensive. Consider the following anecdote: Dee Dee Dodd tried to independently manage her insulin-dependent diabetes as a means of reducing her medical costs, visiting her doctor only occasionally. Her efforts failed. Her health deteriorated and, during one eighteen-month period, she needed to be rushed to the emergency room nearly monthly, ultimately requiring a several week stay in the intensive care unit. Dodd accumulated \$191,000 in unpaid medical bills and was not employable due to her physical condition. Her story is particularly interesting in light of what happened next. The local hospital realized that it would incur fewer unrecoverable costs over time by voluntarily providing Dodd with charity care. It gave her a \$3200 insulin pump, access to a specialist, and in-home counseling. In the following eighteen months, the hospital *saved* an estimated \$86,580.⁶⁶

Price rationing is clearly a flawed solution to a major social problem. I believe the major flaw, however, is external, rather than fundamental, to price rationing. As currently in use, price rationing is extremely blunt. It need not be so. Price rationing could be instituted with a human override – a safety valve – that permits (or mandates) coverage where access to care is socially desirable. Given such a safety valve, patients like Dee Dee Dodd would have

86.9% of the uninsured (p value < .001). *Id.* at 1079 tbl.4. Also of interest was the observation that among the insured patients, the number of patients who reported doing “significantly worse” after 3.5 months of treatment was greater than the number reporting the same after 7 months (from 10.1% down to 9.7%). *Id.* at 1080. Among the uninsured patients, the trend reversed (from 12.3% up to 13.2%), suggesting that the health of uninsured patients is more likely to deteriorate over time due to insufficient treatment. *See id.* The claim that uninsured patients do worse over time has been corroborated: “[R]esearch suggests that the progression from good to poor health resulting from lack of health insurance is *cumulative* and gradually leads to higher mortality rates for uninsured individuals over time.” *Id.* (emphasis added).

⁶⁴ Presumably, some uninsured patients can afford the costs of treatment. Indeed, many of the uninsured patients in this sample did pay for their care. The implicit assumption is that a *population* of uninsured patients is more likely on average to be unable to pay for necessary medical care than is a population of insured patients.

⁶⁵ *See* Gladwell, *supra* note 55 and accompanying text.

⁶⁶ Erik Eckholm, *To Lower Costs, Hospitals Try Free Basic Care for Uninsured*, N.Y. TIMES, Oct. 25, 2006, at A1.

access to relatively inexpensive care without needing to first accumulate \$191,000 in unpaid medical bills and risking death several times. In most cases, access would be governed by market forces, as the current American system generally operates.⁶⁷ In the minority of exceptional cases, the needs of public policy to grant access would trump market inaction either by forcing a provider to provide treatment at a reduced price or via government subsidization.

Where the provision of care produces a net cost savings, the application of the safety valve envisioned by this paper is uncontroversial. Indeed, Dodd's hospital employed such a safety valve voluntarily as a means of saving costs. The hospital was in a position to take this step because it fully internalized the costs of Dodd's care. (In other words, because the hospital was legally obligated to assume Dodd's future medical expenses, it had an economic incentive to figure out how to most efficiently provide treatment. Not surprisingly, it responded to that incentive.) Where costs are diffuse throughout the system, providers will not voluntarily offer care even where doing so creates a system-wide net savings because those providers stand to gain nothing in exchange. Under such circumstances, government should be able to force providers to provide care in exchange for a promise of full compensation. Shifting the costs onto a provider or group of providers will create market incentives to reduce costs.⁶⁸ This use of public funds to pay for such care should be unobjectionable because, by hypothesis, the health care system will save money as a result and will ultimately place less of a drain on public funds.⁶⁹ However, there are more complicated cases in which the social justification for the use of such a safety valve is based primarily on moral reasoning rather than economic efficiency. I articulate those moral arguments in Part III of this paper and develop the safety valve in Parts IV and V.

Some might argue that such a safety valve already exists in the United States via health insurance. Health insurance introduces a contemporaneous and ubiquitous form of rationing by quantity⁷⁰: rationing by contract. Contractual limitations to insurance coverage are not unique to the United States, but the support they have commanded in American statutory and case

⁶⁷ There are notable exceptions. For example, the Emergency Treatment and Active Labor Act (EMTALA), requires that emergency rooms "stabilize" a patient that presents himself before the emergency room, regardless of his ability to pay. 42 U.S.C.A. § 1395dd (West 2008). For background on EMTALA, see generally Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L. J. 463 (1996), and Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145 (2004).

⁶⁸ The provision of full compensation does not upset the incentives that this scheme attempts to create. While providers face no direct economic loss (assuming that the government actually makes the payments that it promises), they lose access to their capital for a time. Government repayment will not be instantaneous. The delay in the repayment process is the source of the incentive here. The more medical providers can reduce their costs, the less money they will have to lay out in anticipation of government reimbursement.

⁶⁹ This argument operates under the assumption that any care not provided by the private sector would otherwise eventually be provided by the government, typically via Medicare or Medicaid in the American system. If, in fact, the patient would have otherwise persisted (or perished) without the relevant medical treatment, this economic justification does not apply.

⁷⁰ See *infra* Part II.C.

law is remarkable.⁷¹ In theory, the contract serves as a vehicle for gauging individual interest in various forms of care by the *ex ante* consent of the insured. Insurance contracts operate by placing insurance companies (limited by the details of the contract), rather than consumers, in charge of making health care delivery decisions. In exchange for ceding control over health decisions, consumers are shielded from risk of illness and are thus more capable of “paying” for the coverage they desire at the time they want it. For contractarians, this might sound like utopia as rationing is occasioned by individual preference expressing itself as assent to contract and a commitment to pay annual insurance premiums commensurate with the desired degree of future medical coverage. Not surprisingly, the literature dealing with the contractarian approach to health law is voluminous. It is also beyond the scope of this paper.⁷² In brief, insurance contracts are unusual given that they are often negotiated not by the patient but by an employer whose interests often differ from the patient.⁷³ Not all insurance contracts even go through negotiation before being presented to an employee, such as contracts for an employer’s self-funded insurance plan. Further, nearly half of all employee-insureds are presented with an “option” of just one contract.⁷⁴ The absence of a proper negotiation or meaningful choice is exacerbated by the preemption provisions of the Employee Retirement Income Security Act (ERISA).⁷⁵ ERISA preemption largely protects insurance companies from state regulation, thus insulating them from political pressure to draft contracts that are more desirable to consumers.⁷⁶ Given the nature of these “negotiations”

⁷¹ To the extent that insurance contracts conform to certain guidelines, broad grants to the insurance company permitting the insurer to use its discretion have been fairly consistently upheld by the courts. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989); Timothy Stolzhus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INT’L & COMP. L. REV. 639, 706 (1998). But see *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002) (finding that ERISA does not preempt a state statute designed to limit the discretion of insurance companies).

⁷² As a window into the literature, the following dialogue is interesting: Hall, *supra* note 21; Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002); Bloche, *supra* note 21; Mark A. Hall, *Ideology and Trust: A Reply to Bloche*, 55 STAN. L. REV. 955 (2002). Indeed, many have argued that the contract is central to modern health law. See generally, e.g., Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1 (2008) (arguing that risk governance is the central principle in modern health law).

⁷³ See *supra* note 13 and accompanying text.

⁷⁴ See *supra* notes 13-16 and accompanying text.

⁷⁵ See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204 (2004). For a brief history leading up to the enactment of ERISA and the subsequent development of its preemption provisions, see Hunter, *supra* note 72, at 24-42.

⁷⁶ Perhaps this insurance model governed by a strict contractual paradigm made sense in a world in which insurance payment or non-payment did not govern treatment decisions. In 1974, when ERISA was enacted, the dominant form of physician compensation was a “fee-for-service” arrangement. “Under this model of health care delivery, a plan beneficiary . . . would visit the doctor of her choice, receive treatment, and then send the bill to her health insurer. If the insurer improperly refused to pay, the beneficiary could be made whole by commencing suit to recover” her costs. *Andrews-Clarke v. Travelers Insurance*, 984 F. Supp. 49, 58 (D. Mass. 1997). That model is no longer the dominant model of physician reimbursement. Under typical modern managed care systems, the insurance company serves as a gatekeeper prior to treatment. As a result, “the wrongful denial of benefits by an insurer – whether intentional, or the result of negligent medical decisions made during the utilization review process – will sometimes result in the beneficiary never receiving the treatment that she requires.” *Id.* at 59. One federal court sitting in 1997 made the above observations pertaining to the “repeated[]

and the casual manner in which employees generally “assent” to such contracts of adhesion (given that prospective employees often have no real choice, it is not surprising that employees will often not read health care contracts before accepting them),⁷⁷ the existence of such contracts should not be viewed as a morally significant consent to their terms. Even if one assumes, contrary to the above, that the contracts embody meaningful consent, it is unclear why the *ex ante* consent of the individual ought to sufficiently satisfy our collective moral concerns such that insurance contracts fill the need of the safety valve envisioned by this paper.

C. RATIONING BY QUANTITY

At the end of the prior Section, I mentioned the private health insurance market in the United States and described it as a contractual form of rationing by quantity.⁷⁸ To simplify my discussion about rationing by quantity, I will focus here on centralized rationing by government officials. Rationing by detached corporate executives is similar to rationing by detached government officials, with the caveat that corporate executives are primarily regulated by market forces while government bureaucrats are primarily

and arbitrar[y]” denial of medical treatment that the plaintiff’s husband “so desperately required” and without which he “suffered horribly, and ultimately died needlessly at age forty-one.” *Id.* at 52. That court, after concluding that it had “no choice” but to authorize the removal of the case from a state court to federal court and then to “slam the courthouse doors in her face and leave her without any remedy,” *id.* at 53, made the following rhetorical observation:

Although the alleged conduct of Travelers and Greenspring [the defendants] in this case is extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Does anyone care?

Do you?

Id. at 65. Over ten years have past since Judge William Young wrote this stinging criticism of the congressional failure to amend ERISA. Since then, the power of ERISA preemption has *increased* without congressional intervention. *See* Hunter, *supra* note 72, at 24-28.

⁷⁷ This analogy to contracts of adhesion is imperfect because where the contract is for insurance from a private insurance company (as opposed to a self-funded insurance plan, which is sometimes offered by very large employers), the contract has been negotiated by the private insurance company and the employer. The difficulty is that neither party in the negotiation properly represents the interests of the employee. Collective bargaining mitigates that problem somewhat by permitting a union to stipulate to an employer the contractual terms it finds acceptable. Still, the analogy to contracts of adhesion is acceptable because ultimately, the employee has very little say on the terms of the contract and has no individual power or ability to negotiate its terms. While the employee might in theory be able to request increased wages in lieu of health benefits, it is doubtful that most employees are aware of that option or that most employers will increase the wages by an amount sufficient to offset the lost value to the employee. Additionally, plans offered on the private market might be more expensive on balance. *See* SQUEEZED, *supra* note 13, at 7. In other words, the value to the employee of this imperfect insurance contract is greater than the value of anything the employee might receive by turning the contract down. That is precisely the dynamic in a contract of adhesion. In any event, it is clear that assent to the contract does not represent a statement by the employee that he believes the specific terms of the contract are efficient or even in his ultimate interests.

⁷⁸ *See supra* text accompanying note 70.

regulated by political forces. The distinction between those differing forces and influences are worthy of comment. But for the purposes of this paper, contract-based rationing by quantity is sufficiently similar to centralized rationing that I will hold those comments for another day.

The very practice of setting central limits on health care delivery removes medical decision-making from the hands of physicians and patients and places it in the hands of detached officials. The significance of this critique might not be apparent to many, particularly after reading my critique on rationing by price in the prior Section. Indeed, it is far from obvious that putting government officials in control of medical allocation is worse than extreme price rationing. The primary problem with centralized rationing of this kind stems from the fact that decisions are *centralized* and thereby bureaucratic. Allocators in that context attempt to achieve the best results for the population they service, generally with little regard for the implications of those decisions in individual cases. I believe that it is this detached nature of all quantity rationing programs (whether by the government, insurance companies, or any other power broker) that renders such rationing programs the object of public vitriol and condemned as morally objectionable.⁷⁹

Extreme rationing by quantity imposes significant deficiencies in vertical equity.⁸⁰ Vertical equity essentially demands differential treatment for those patients who are who are materially different from each other. A health care delivery system that does not make such distinctions and accordingly denies access to two people by defining them to be in the same class, despite dramatic and relevant differences between them, violates the principle of vertical equity. Failure to distinguish between two distinguishable people can be the fault of a rationing scheme that is not sufficiently nuanced but is more likely the function of a necessary feature of centralized rationing. A rationing scheme that is designed to operate at the level of government without case-by-case oversight would need to be infinitely complex in order to be sensitive to all relevant factors as they present themselves in individual cases. A scheme that approaches infinite complexity would be very difficult and expensive to develop and clearly not worth the costs. Out of necessity, any scheme actually adopted would fail to make morally necessary distinctions. Just as with price rationing, this problem can be avoided by inserting a layer of oversight – a safety valve – into the quantity rationing scheme.

Perhaps all regulatory standard setting suffers from violations of vertical equity. On the surface, my critique thus proves too much. I think the critique is nevertheless justified considering the nature of the regulatory decisions in question. When a decision quite literally means the difference between life and death, the stakes are higher and the need for equity is as well. When the lines drawn by decision-makers impose dramatically different results (a person immediately on one side of the line lives and a person immediately on the other side dies), what might be an acceptable breach of equitable standards to promote the function of modern government in the context of education or in the application of tax laws is not necessarily acceptable when human life hangs in the balance.

⁷⁹ See *supra* text accompanying notes 8-9 and *infra* text accompanying notes 127-128.

⁸⁰ I discuss the need for standards rather than bright-line rules below. See *infra* text accompanying note 149.

While I believe that this criticism is rather intuitive, it is useful to demonstrate some of the problems that face quantity rationing schemes. As I will point out, there are no pure quantity rationing systems in use. Instead, I appeal to a prominent impure example of rationing by quantity: the United Kingdom's National Health Service (NHS). When the UK decided to initiate this revolutionary experiment in 1946, it wanted to create a system that was "available to all people" and provided coverage for "all necessary forms of health care."⁸¹ The NHS was not intended to be a vehicle for medical rationing. Only three years into its operation, the NHS began to feel the pressure of unexpected demand. That demand necessitated a statutory exception to the program, enabling the NHS to directly charge patients for prescription drugs and eyeglasses.⁸² The British experiment thus "began a consistent story of providing exceptional service for the victims of accidents and emergencies; generally, a very good service for patients in urgent need of care; but less consistent service for others who often found themselves on long waiting lists"⁸³ or whose treatment was excluded from the system entirely.⁸⁴ In other words, they began to ration by quantity. While Prime Ministers Thatcher, Major, and Blair would later impose significant market-based reforms on the NHS,⁸⁵ the NHS remains useful as an example of rationing by quantity considering that it has dominated the UK's health sector since its development over sixty years ago and continues to set explicit limits on the use of care. Moreover, throughout the NHS's existence, private insurance never exceeded twelve percent population coverage.⁸⁶

Political realities made it difficult for the NHS to ration care; they avoided it as much as possible. One method of avoiding the difficult questions of how to ration care, while still rationing care, is to officially permit access to treatment but then not fund the supply of that treatment commensurate with reasonably anticipated demand. Accordingly, supply shortages of medical care are common in countries such as the United Kingdom and Canada that rely on centralized quantity setting.⁸⁷ They typically result in very long waiting lists

⁸¹ Christopher Newdick, *Resource Allocation in the National Health Service*, 23 AM. J.L. & MED. 291, 291-92 (1997) (quoting MINISTRY OF HEALTH, DEPARTMENT OF HEALTH FOR SCOTLAND, A NATIONAL HEALTH SERVICE (1944)).

⁸² *Id.* at 292.

⁸³ *Id.*

⁸⁴ *Id.* at 305.

⁸⁵ See generally Martin Gorsky, *The British National Health Service 1948-2008: A Review of the Historiography*, 21 Soc. HIST. MED. 437 (2008).

⁸⁶ *Id.* at 438. Although NHS is driven more by market forces than it was at its creation, the agency is also driven more by appeal to "scientific research and evidence" on the value for cost of various forms of medical treatment, and less by "decisions based on opinion or current practice." Simon Walker, et al., *The Role of NICE Technology Appraisal in NHS Rationing*, 81-82 BRIT. MED. BULL. 51, 51-52 (2007). It is thus an unusual market; it utilizes market forces but is governed by rules that, presumably, could never develop in a well-functioning market. It is, at best, unclear why consumers would opt for a system governed by scientific research and evidence to the extent that scientific research and evidence yielded conclusions not in their short-term personal interest. For such a system to develop under well-functioning markets, we would have to assume, counterfactually, that medical decisions governed by scientific data regarding value for cost actually provided greater short-term benefit to consumers than could decisions governed by popular opinion (the collective opinions of the consumers).

⁸⁷ Supply shortages in centralized systems such as the NHS might be exacerbated by the failure to sufficiently ration care, but are actually entirely predictable and unavoidable in any market in which a single party (or, as in the case of the NHS, multiple quasi-public actors all

for treatment. The UK apparently relied on waitlists excessively; they became so popular that significant political pressure against them mounted, initiating a campaign to reduce the waiting times to *just* eighteen weeks.⁸⁸ The official government website dedicated to the project states the following:

In the early 1990s waits of more than six months for a first outpatient appointment were not uncommon, and tens of thousands of people waited more than two years for an operation. But since December 2008, the longest should wait after being referred by your [general practitioner] until you start your treatment is 18 weeks – that is, unless you choose to delay treatment or there is a clinical reason why you should wait longer. Wherever possible, you will wait less than this, with the average wait being around eight weeks. Any hospital appointments, tests, scans or other procedures that you may need before being treated will all happen within this maximum time limit.⁸⁹

Using waitlists as a rationing device to limit the quantity of consumption can be a much more blunt tool than price rationing. Price rationing can be circumvented. People who have sufficient assets on which to borrow can finance their care with debt. Those who do not can request charity care or beg for or steal the money they need to finance their care. A person subject to quantity rationing via waitlists who needs accelerated access to care will generally not have access to it, unless the state recognizes the situation as an emergency and moves that patient to the front of the line. But one cannot always rely on a bureaucracy to recognize an emergency and then act quickly. For example, when excessive backlog requires emergency room patients to wait before seeing a triage nurse, that backlog can prove fatal.⁹⁰ Moreover, the existence of proper screening is not necessarily even helpful. If the government identifies an emergency but declines to allocate sufficient resources to address that emergency, the failure to allocate resources is no less fatal and is generally not reviewable by the courts.⁹¹ Rationing by quantity,

working for a single party) is the sole provider of goods in that market. A clear explanation of such “monopsonies” in the labor market is provided by WILLIAM M. BOAL & MICHAEL R. RANSOM, *MONOPSONY IN AMERICAN LABOR MARKETS* (2002), <http://eh.net/encyclopedia/article/boal.monopsony>.

⁸⁸ See National Health Service, 18 Weeks, <http://www.18weeks.nhs.uk/Content.aspx> (last visited Aug. 23, 2009).

⁸⁹ National Health Service, I’m a Patient, <http://www.18weeks.nhs.uk/Content.aspx?path=/What-is-18-weeks/patient> (last visited Aug. 23, 2009)

⁹⁰ One particular hospital attempted to address their problem by instituting a rule requiring all patients presenting themselves in the emergency room to be seen by a triage nurse within four hours. One day, the hospital fell behind on its goal and required patients to wait up to six hours. Stewart Fleming was sent by his physician to that emergency room along with a note demanding “immediate” care. It turned out that his body was being ravaged by an aggressive virus and he had very little time left. Stewart Fleming and his wife sat in their ambulance, watching Stewart’s body slowly deteriorate, not knowing what to do or whom to turn. By the time the mandatory six hours had expired, so had Stewart Fleming. Lynsey Haywood, *Dying Father Ignored for 6hrs*, THE SUN, Dec. 29, 2008, <http://www.thesun.co.uk/sol/homepage/news/article2077919.ece>.

⁹¹ See *infra* text accompanying notes 102-106.

when expressed as rationing by delay, is thus a highly flawed system that generally cannot be circumvented and is not often appealable.

In 1999, the NHS was supplemented with yet another layer of bureaucracy that has since become the cornerstone of centralized medical resource allocation in the UK. The National Institute of Health and Clinical Excellence (NICE) was officially designated to engage in cost-effectiveness research⁹² and to make rationing recommendations.⁹³

The way that NICE (acting for the NHS) recommends limits on quantity is by incorporating another form of rationing: rationing by prioritization.⁹⁴ Specifically, it attempts to measure health benefits by calculating quality adjusted life years (QALYs) (sometimes referred to as “quality of life years”). I will discuss rationing by prioritization more broadly below. The thrust of the QALY approach is to apply numerical data to medical decision-making so as to allocate resources to those procedures that maximize not just life-years, but those life-years that are most “livable,” most “human,” or most “enjoyable.” Those magical numbers are then used to set central limits on consumption (rationing by quantity). The QALYs are used to attach a number to the person in question and that number can be used by the bureaucrat-in-charge to decide whether treatment is worth the expense (whether this person’s life is worth the expense).

⁹² Walker, *supra* note 86, at 52. “NICE was initially established in England and Wales to help the NHS meet three continuing objectives: (i) to improve continually the overall standards of care; (ii) to reduce unacceptable variation in clinical practice; and (iii) to ensure the best use of resources so that patients receive the greatest benefit.” *Id.* The purpose of NICE is commonly articulated using language similar to the following: “[T]o make decisions, which support an *efficient* use of NHS resources – that is, the *maximization of population health* from available resources.” *Id.* at 54 (emphasis added); see also Keith Syrett, *Nice Work? Rationing, Review and the ‘Legitimacy Problem’ in the New NHS*, 10 MED. L. REV. 1, 11-12 (2002). That last line deserves repetition for it is both the purpose of and the primary problem with centralized rationing by quantity: The most “efficient use” of taxpayer resources is, apparently, to maximize “population health.” I find this assumption very troubling. It is not obviously true that the “most efficient” use of resources is to maximize total health where doing so almost certainly means that many are made worse-off in the process. Maximization of total health is very different from maximization of wealth; efforts in the UK to conflate the two should not be taken as anything other than either simple confusion or a politicized attempt to obfuscate the realities of the NHS experiment. There are no theoretical limits on the wealth that a person can achieve. Accordingly, there are no limits on the wealth that a society can achieve. The same is not true regarding aggregate health. A person cannot be more than 100% healthy. So too, a society cannot be more than 100% healthy. If so, maximization of societal health cannot be achieved by improving the lot of the most-healthy; the improvement of individual health experienced for each increasing unit of resources decreases exponentially as an individual’s health approaches 100%. Rather, a society trying to maximize aggregate health must focus materially all attention on the least-healthy (assuming that they have reasonable hope of recovery). Given limited resources, this approach necessitates the promulgation of rules that ignore and possibly even harm (if indirectly) the most healthy in society. This is a social engineering that results in harm to innocent individuals for doing nothing wrong other than having above-average health.

⁹³ NICE does not actually impose regulatory limits. It simply makes recommendations to NHS. Medications and treatments that are recommended by NICE must be made available to patients. Those medications and treatments not recommended by NICE are not thereby banned, but they are far less likely to be available. See Clare Sellars & Amanda Easey, *First Successful Legal Challenge to NICE Guidance*, 3 J. INTELL. PROP. L. & PRAC. 692, 692 (2008).

⁹⁴ See *supra* Part II.C.

NICE's efforts to engage in 'cost-effective' medicine has, in the past, created controversy.⁹⁵ For example, in 2005, Elaine Barber, then a forty-one-year-old mother of four, was denied access to Herceptin, a pharmaceutical believed necessary for treating her early-stage aggressive breast cancer. Treatment for one year was estimated at £20,000, an excessively large amount of money; enough money that the provision of treatment "could seriously affect the availability of care to other patients, including those with other cancers."⁹⁶ Treatment was denied for that reason and because there were concerns about the drug's safety⁹⁷ (a curious justification considering that NICE is not responsible for issuing guidance regarding the safety of pharmaceuticals).⁹⁸ An advocacy organization defended the decision: "The health service has a lot of competing cost pressures – waiting lists, drugs and staff numbers – and at each stage it has to make the best decision for patients. That may be paying for drug treatment, or it may be paying for extra doctors. You cannot have it all."⁹⁹ In other words, the need for society to contain its medical costs trumps the needs of Elaine Barber's four children to have a mother.

NHS's incorporation of priority rationing (via QALY analysis) into a quantity rationing scheme is not the result of happenstance. It is very difficult as a practical matter to design a system that achieves optimal coverage by focusing on treatment types exclusively (rationing by quantity), without also considering the implication of treatment on the patient. In theory, we could artificially limit the availability of AIDS medication or dialysis machines at some quantity and deny access to anyone who needs assistance after the pre-designated limit is reached, regardless of the various circumstances that become present in such future cases. Such a system would be easy to administer and easy for people to understand. It would also be highly undesirable. It successfully constrains consumption but does so without regard to equity, public health, utility, or any other factor. Additionally, where resources are available, to turn a person away who needs those resources for survival simply because the predetermined rules say so imposes an exceptionally high burden on that individual and should require a compelling justification. The NHS attempted to provide that justification by incorporating a policy factor into their analysis: the interest of increased life expectancy, discounted by the relative quality of that life. In the next Section,¹⁰⁰ I will address the use of QALY as a controlling factor and whether it was appropriate to adopt just one factor. I will also address the problems associated with choosing among the various factors that might be used to justify such decisions. In brief, it is doubtful that NHS's justification is sufficiently compelling to justify the extreme burdens that it imposes.

⁹⁵ Nick Triggle, *Why Some Drugs are Not Worth It*, BBC NEWS, Nov. 9, 2005, <http://news.bbc.co.uk/1/hi/health/4420584.stm>.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Inescapable Trade-Offs: Weighing up the Costs as Well as the Benefits from New Medicines is Vital*, ECONOMIST, Feb. 25, 2006, at 62.

⁹⁹ Triggle, *supra* note 95.

¹⁰⁰ See *infra* text accompanying note 110 and subsequent paragraphs.

The experience of the NHS, the adoption of a prioritization tool into the quantity scheme, and the story of Elaine Barber demonstrate two additional related points. First, Barber's initial denial of care was mathematical and automatic. Extraneous factors, such as the needs of her four children and the happiness she might have experienced from raising them (even if from a hospital bed), were irrelevant because they did not increase Barber's "quality of life," tautologically defined to exclude extraneous factors that might actually impact on her experienced quality of life. The QALY calculation, just as any priority rationing scheme, draws lines that are not universally agreed upon in order to perform sterilized calculations. Regardless of whether Barber should or should not have been entitled to the medication she desired, the fact that the denial issued without due consideration of its immediate implications is very troubling and reflects an objectionable normative decision.

Second, Barber's inability to resort to meaningful appellate processes renders her summary denial seemingly draconian. She did seek review, but was denied access by the British courts on the grounds that her case was unexceptional. Her counsel suggested that the needs of her children rendered her case an exception. The court responded: "The *non-medical* personal situation of a particular patient cannot . . . be relevant to the question [of] whether [the drug] should be funded. . . . [T]he only reasonable approach [is] to focus on the patient's clinical needs."¹⁰¹ In other words, the court found it *irrational* to consider the factors other than "medical" and economic factors. Tautologically, the consideration of personal factors is deemed irrational. How does the court know that only medical or economic factors are relevant or how to assess them? Moreover, leaving four children without a mother surely has severe medical and economic consequences, such as regarding the provision of care for those children. If anything here is irrational, it seems to be the court's myopia.

If the failure to consider all relevant factors were appealable to a court properly situated to consider the factors not accounted for in mathematical formulae, the administrative failure to address those factors would be less harmful. But, in the absence of a violation of substantive rights (including violations of due process), the traditional appellate process is generally unavailable for review of administrative allocational decisions.¹⁰² To my knowledge, the seminal case addressing the courts' willingness to question administrative allocation is *ex parte Collier*, decided by the Court of Appeal of England and Wales¹⁰³: In September 1987, a four-year-old boy with a hole in his heart who desperately needed open heart surgery was placed at the top of the waiting list for that operation; he expected that the necessary intensive care facilities would be available within a month.¹⁰⁴ By January of 1988, the

¹⁰¹ Christopher Newdick, *Judicial Review: Low-Priority Treatment and Exceptional Case Review*, 15 MED. L. REV. 236, 238 (2007) (quoting *R. (Ann Marie Rogers) v. Swindon Primary Care Trust and the Sec'y of State*, [2006] EWCA (Civ) 392, [79]-[81] (Eng.)).

¹⁰² For a concise look at judicial review in the NHS, see generally *id.*

¹⁰³ *R v. Central Birmingham Hosp. Auth., Ex parte Collier*, unreported decision (discussed in Newdick, *supra* note 81, at 302); Christopher Newdick, *The NHS in Private Hands? Regulating Private Providers of NHS Services*, 3 LAW & MED.: CURRENT LEGAL ISSUES, 1, 10 (2000); JUDITH HEDRICK, LEGAL ASPECTS OF CHILD HEALTH CARE 11 (1996).

¹⁰⁴ Newdick, *supra* note 81, at 302. It appears that a one-month wait for life-saving open heart surgery was considered normal and acceptable in the United Kingdom in 1987. See *id.*

surgery had been arranged and then cancelled on three separate occasions because no intensive care bed was available.¹⁰⁵ The Court of Appeal, asked to demand the operation by injunction, declared that it was “in no position to judge the allocation of resources by the [local administrator of the health delivery system]” and that “there is no suggestion here that the hospital authority have behaved in a way which is deserving of condemnation or criticism. What is suggested is that somehow more resources should be made available to enable the hospital authorities to ensure that the treatment is immediately given.” The court was not willing to make such demands on the system. Lord Balcombe declared it “undesirable” to compel treatment “without knowing whether or not there are other patients to whom [the requested] resources might more advantageously be devoted.”¹⁰⁶ Balcombe does not suggest who might be in a position to make that determination. If the answer is “no one,” a strong argument emerges for an additional adjudicatory mechanism capable of reviewing decisions pertaining to administrative allocation.

There is a great deal more to say about rationing by quantity. For example, it might be beneficial to discuss the centralized rationing system in Canada that is similar to the NHS¹⁰⁷ and the overtly political (and controversial) nature of allocation decisions by Oregon’s Health Services Commission.¹⁰⁸ But those discussions would be largely redundant. Essentially, they would generate two familiar points. First, rationing by quantity occurs only after the resolution of controversial moral questions regarding how and where to set limits. Such decisions are unlikely to receive broad acceptance and are often polemic. Second, given the general unavailability of appeal, rationing by quantity tolerates the implementation of draconian measures to solve the problem of rationing.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ My specific interest here is to discuss the problem that Canada faced with excessive waiting times and its decision to permit patients to purchase medical services on a private market, which contradicts the Canadian philosophy on health care delivery.

¹⁰⁸ Oregon’s centralized medical care system prioritizes certain medical procedures as a means of limiting supply. Procedures higher on the prioritization list are more likely to be funded. Procedures below a certain point on the list, 503 in 2009, are excluded from state coverage. The list that Oregon developed is fascinating. They place a severe head injury at 101, injury to internal organs at 88, ruptured spleen at 178, and a deep open wound in the neck at 91. Number 3 on the list is preventative services from birth until age ten and number 4 is preventative services for after age ten. Treatment for drug abuse is 5 and tobacco dependence is 6. Contraception management and sterilization are 7. Abortion ranks 41 and treatment for sexually transmitted diseases is 56. LINDA GORMAN, NAT’L CTR. FOR POLICY ANALYSIS, RATIONING CARE: OREGON CHANGES ITS PRIORITIES, (2009), *available at* <http://www.ncpa.org/pub/ba645/>. Whether you believe abortion is a socially desirable medical procedure or not, abortion cannot reasonably be ranked ahead of severe head injuries, injuries to internal organs, and deep open neck wounds! This list is explainable only by appeal to political considerations. Needless to say, there are a great many more procedures that rank below abortion and should not. For the complete 2009 list, see HEALTH SERVICE COMMISSION, PRIORITIZED LIST OF HEALTH SERVICES (2009), *available at* <http://www.oregon.gov/OHPPR/HSC/docs/Jan09Plist.pdf>. The 2010 priorities are virtually identical. HEALTH SERVICE COMMISSION, PRIORITIZED LIST OF HEALTH SERVICES (2010), *available at* <http://www.oregon.gov/OHPPR/HSC/docs/Jan10Plist.pdf>.

D. RATIONING BY PRIORITIZATION

The most common form of prioritization today is not commonly thought of as a form of prioritization. The method is descriptively known as “first-come, first-served” and is widely condemned by health scholars. Prioritizing those who come first to the hospital or the doctor serves no public health objective. Indeed, it might even be bad public health policy for it generally prioritizes those who are least likely to recover (assuming that the people who come first are those most sick). Moreover, the Centers for Disease Control and Prevention (CDC) has come out against “first-come, first-served” as a method of prioritization for distribution of vaccine against pandemic influenza on distributional grounds. It argued that these prioritizational systems place “certain groups – such as those who are less likely to be informed or those who have inadequate transportation – at a disadvantage.”¹⁰⁹

Market-based systems almost necessarily rely on “first-come, first-served” prioritization. He who is willing to pay the market price gains access to the resource. In a functioning market, if there are many people in line, rather than trying to decide whom to award the resource to, the supplier will simply raise the price and permit those who claim to want the resource to fight amongst themselves. He who is first willing to pay the higher price is the winner, even if the needs of public health and equity demand a different result.

QALY¹¹⁰ is another prioritizational mechanism in common use. Here, the objective is to prioritize those patients who have the most to gain from treatment. It is plainly utilitarian. “Gain” in this context is defined by a measure of the life expectancy differential as between the various options (typically, treatment or non-treatment) where that life expectancy is discounted by the expected “quality” of those years.¹¹¹ There are various methods of assessing QALYs, all purporting to maximize return on investment. The theory behind prioritizing young persons over the elderly is that “[d]eath seems more tragic when a child or young adult dies than an elderly person – not because the lives of older people are less valuable, but because the younger person has not had the opportunity to live and develop through all stages of life.”¹¹² But if that is the operative theory, some argue that it makes more sense to adopt a system that prioritizes people aged thirteen to forty (rather than granting the greatest priority to infants) because people in that age range “have more developed interests, hopes, and plans but [may] not have had an opportunity to realize them.”¹¹³ Or perhaps the range should

¹⁰⁹ KATHY KINLAW & ROBERT LEVINE, CTNS. FOR DISEASE CONTROL & PREVENTION, ETHICAL GUIDELINES IN PANDEMIC INFLUENZA 7 (2007). The CDC’s position is somewhat ironic. The federal agency that is dedicated to “prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats,” Ctrs. For Disease Control & Prevention, Our History - Our Story, <http://www.cdc.gov/about/history/ourstory.htm>. (last visited Mar. 6, 2010), in the United States finds the method of prioritization in most common use in the United States to be inappropriate considering its inequities.

¹¹⁰ “Quality Adjusted Life Years.” See *supra* text accompanying notes 94-100.

¹¹¹ Ezekiel J. Emanuel & Alan Wertheimer, *Who Should Get Influenza Vaccine When Not All Can?*, 312 SCI. 854 (2006).

¹¹² *Id.* at 855.

¹¹³ *Id.*

be eighteen to fifty? Or fifteen to thirty? Even if we decide that the use of QALY is appropriate,¹¹⁴ there are a great variety of options and choosing among them is very difficult. We can debate the appropriate age range forever and never reach a consensus. The problem with selecting an appropriate age range is not simply one of line-drawing that pervades law. We draw lines all the time, some of them quite arbitrary but necessary nonetheless. The problem is the exceptionally high burden associated with being on the wrong side of the line. If we set the favored age range as eighteen to fifty, many otherwise meritorious fifty-one-year-olds might die. If we set the range at twenty-one to fifty-five, those same people will live but some nineteen and twenty-year-olds will not. It is hard to imagine a more significant burden and a line-drawing problem with greater associated gravity. Given this exceptional gravity, the general necessity of line-drawing in the law cannot justify line-drawing here, absent an equally compelling justification.

¹¹⁴ The theory behind QALY starts with a very strong normative judgment about which there is a significant divide. It assumes that human life has defined value that is capable of entering into mathematical calculation. If we assume, instead, that the value of human life is infinite, we would necessarily reach different results. I consider this problem more explicitly in Part III of this paper. QALY makes an additional highly questionable normative judgment. It suggests that some years of human life are more valuable than other years of human life on the basis of an undefined and amorphous standard called "quality of life." The assumption is that a year spent suffering in a hospital room on a respirator is substantially without value. That argument presumes that the purpose and value of human life is known to health policy-makers and is frustrated when a person is in a state of suffering. Presumably, these policy-makers are assuming either that that human life is defined primarily by cognitive ability or that the purpose of life is to experience pleasure. The moral overtones to this decision are blatantly obvious. Very few sincere people believe that it is okay to harvest the organs of the comatose and almost no one lives his life exclusively to maximize pleasure. If humanity were defined by cognitive ability, our value would be numerically assessable by looking at IQ or SAT scores. If we really believed that life existed to maximize pleasure, we would be terribly unproductive as a society because we would all be too busy fulfilling our base desires. If indeed there is something more to life than cognitive ability and pleasure, is it so obvious that the "something more" is not achieved or advanced during periods of intense pain and suffering? Can it even be said conclusively and definitively that there is no value to pain and suffering in its own right?

Some might argue that while these are strong normative positions that cannot be defended, they are not controversial. We place dollar figures on human beings all the time out of necessity – for example, we grant specific monetary awards in wrongful death cases. It might appear that, given our long history of expressly valuing human life, it is appropriate to do so in a QALY analysis for the purpose of controlling health care costs. Appearances can be deceiving. Courts assign value to life in wrongful death cases, for example, because they have no other choice. For a court to declare human life of infinite value and thereby deny a wrongful death award on the grounds that an appropriate award cannot be determined by the court is functionally the same as ruling that human life is without value. Courts, by their nature, must decide such questions out of necessity – it is their responsibility – because the decision not to decide makes one party the winner in litigation and the other party the loser. Efforts to reduce the price of health care, while also necessary, do not fall within the jurisdiction of the courts. For the court, then, the necessity of determining wrongful death judgments is greater than the necessity of controlling medical consumption. While necessity does exist for policy-makers, it is not necessary to arrive at policy by first issuing myriad questionable normative decisions about human life and then assigning a dollar figure to that life as one way of controlling consumption. While that is one way to deal with the problem of rationing, it is not the only way and should not be performed absent true necessity. We must recognize that we are probably quite inept at determining the value of human beings. Sensitive to that shortcoming, we should refrain from doing it wherever feasible. Our inability to do this well necessitates a certain conservatism that seems utterly absent from the QALY approach.

In truth, the problem of satisfying this high standard precedes the question of how to structure QALY. Policy-makers must first decide which mechanism to use to set quantity limits. Why draw the line using age and quality of life (QALY)? What is the compelling justification for the use of QALY over any other means of quantifying or articulating the various benefits associated with the preservation of human life?¹¹⁵

A system constructed more rationally would continue to incorporate more and more interests (that is, priority factors such as QALY) into the analysis until the procedural costs of doing so offset any expected gains from the derivation of more perfect results. Stated using economic language, to the extent that the marginal benefits of incorporating additional interests into the analysis exceed the marginal costs of a more complex and finely tuned procedural system, those additional interests should be incorporated. The rationing scheme should first include those factors, interests, and procedural mechanisms that confer the greatest value (defined by their ability to make appropriate distinctions between people) relative to their costs and continue to add factors until the addition of additional factors is more costly than beneficial. Failure to perform this or a similar analysis, opting instead to just settle on one factor (such as QALY) is unprincipled absent a compelling policy justification on behalf of that factor, unless that single factor, standing alone, is determined to be the “best” among the virtually infinite options and permutations thereof.¹¹⁶ The selection of any one factor, standing alone, is likely subject to criticism for lack of rational adoption and insufficient nuance.¹¹⁷

But the “principled” approach outlined in the prior paragraph has its own problems. Even assuming that society had the competence and information necessary to calculate the various costs and benefits for each of the relevant factors (a hefty assumption), the number of those factors approaches infinity. The goal of quantifying the costs and benefits of each option is thus nearly impossible. To illustrate, I will list some of the factors that decision-makers will have to resolve *after* deciding to incorporate a utilitarian factor into the prioritization analysis (clearly, there are many non-utilitarian factors that decision-makers might want to consider and each of them will sit at the top of their own decision tree).¹¹⁸

Do we want to maximize recovery rates, minimize the rate of preliminary infection, or minimize the size of the infected population? Is “recovery” defined by the short-term absence of symptoms or by long-term survival? How relevant is patient satisfaction to general notions of “recovery” and public health? If we want to maximize patient satisfaction, should we devote more resources towards encouraging physicians to communicate with patients and less on increasing the availability or efficacy of treatment? Perhaps the proper goal is to minimize pain and suffering? When dealing with an aggressive and

¹¹⁵ I provide a list of eight such factors at the conclusion of Part II.A.

¹¹⁶ QALY, in particular, is quite controversial. It seems highly unlikely that NICE or any other governmental body can credibly argue that it chose QALY singularly because it, and only it, is the most efficacious and just means of allocating resources.

¹¹⁷ See *supra* note 114.

¹¹⁸ Most of these questions are being debated in the literature; there are obvious answers to none of them.

deadly contagion, should the objective be to minimize the length of recovery efforts (which would require that the worst-off be quarantined and permitted to die)? Should we focus our attention on preventative care (perhaps by primarily treating the healthy)?¹¹⁹ When we conceptualize public health maximization, should we focus on eradicating the narrow contagion or condition that is the subject of treatment or is it appropriate to think more globally? The latter approach would significantly disadvantage those with pre-existing chronic conditions such as diabetes, heart disease, and conditions brought on by smoking, for example.¹²⁰ Moreover, should we conceptualize maximal recovery on absolute terms or relative terms? If the latter, should we seek to treat the most sick (and thereby have the most to gain) or those who are most likely to recover (on the assumption that “recovery” is defined primarily by complete recovery, placing little relative value on partial recovery)?¹²¹ Perhaps we ought to disadvantage those who engage in unsafe behavior (for example, smoking, drinking, reckless driving, unprotected sex, riding a bicycle without a helmet, or perhaps even traveling to Israel, Northern Ireland, Iran, the inner-city USA, or any other potentially dangerous location) on the theory that healing those people now is likely to create less benefit in the future because those people are likely to continue their dangerous behavior?

If rational prioritization requires the adoption of various factors according to a cost/benefit analysis for the purpose of getting the most fine-grained procedure possible given the associated costs, and the selection of those factors requires close analysis of each of them, how should we proceed in light of the virtually infinite number of options? The necessity of making a decision does not justify the arbitrary selection of one or more of the factors at random if we can do better. Perhaps an unprincipled selection among the factors is inevitable, but that need not be the end of the analysis. We can respond to the problems of unprincipled selection via increased process. I will describe how in Part IV.

III. THE NEW MORAL PARADIGM

Throughout Part II, I articulated some of the problems with the three idealized approaches to rationing and argued that additional process might help to alleviate many of those problems. This Part is devoted to discussing the unifying theme behind each of those problems and explaining how process can help cure them.

¹¹⁹ Researchers analyzing a hypothetical virulent strain of influenza determined that “[v]accinating [eighty] percent of the children has nearly as high an overall effectiveness as vaccinating [eighty] percent of the entire population,” suggesting that in some sense it might be preferable to conserve resources and just vaccinate the children. Ira M. Longini, et al., *Containing Pandemic Influenza with Antiviral Agents*, 159 AM. J. EPIDEMIOLOGY 623, 627 (2004).

¹²⁰ See Norman Daniels & James Sabin, *Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers*, 26 PHIL. & PUB. AFF. 303, 319-320 (1997).

¹²¹ See *id.*

The “moral paradigm” is not an alternative method of rationing; it is a philosophy – an imperative – that argues for the inclusion of moral reasoning into medical rationing decisions.¹²² In its extreme form, the moral paradigm “denounc[es] as immoral any attempt to weigh health against mere monetary costs.”¹²³ It flows logically from the assumption that human life is infinitely valuable.¹²⁴ Political and professional mechanisms that limit access to life-saving or sustaining medical care are immoral under this view. Essentially, rationing itself is immoral where doing so results in human death or suffering.¹²⁵ The theoretical problems with such an approach are paramount. No doubt, they are the very reason that the market paradigm, via price rationing, has had so much success in American law and policy. There are certainly less extreme, more pragmatic versions of the moral paradigm. They do not necessarily share the same moral principles or assumptions and those who adopt various versions of the moral paradigm might share little in common aside from their insistence upon the use of moral reasoning. The moral paradigm is nevertheless useful – not because it dictates an idealized system or can necessarily answer substantive questions but because it dictates a *better* system, as I will explain.

Asking moral questions, even if they have no answer, is important because doing so will enable us to create a rationing scheme that is far more palatable to each of us individually. This is so because a scheme designed only after engaging in moral reasoning will be sensitive to each of our individual positions. No scheme will be able to *incorporate* every moral position, but can at least be *sensitive* to the moral positions of each person. The difference between a scheme that endeavors to achieve such sensitivity and one that does not is monumental. When the subjective spiritual, irrational, and emotional preferences of each person (defined here as “moral” preferences) are made relevant, that person becomes more than just a number or a statistic. She is rendered important; she is rendered human. She is given the dignity that befits her before it is decided whether she receives the treatment that she needs to survive. The choice is no less tragic and the consequences no less severe (indeed, those who are denied treatment are not less hurt or dead because someone somewhere considered the moral ramifications of denial),

¹²² See *supra* text accompanying note 30.

¹²³ Elhauge, *supra* note 7, at 1457.

¹²⁴ See the discussion on John Taurek, starting with text accompanying note 135.

¹²⁵ This conclusion is related to, but not necessitated by, the assumption that human life is infinitely valuable. If human life is infinitely valuable, the value of each year, hour, day, and second of human life is infinite as well. The value of the integral parts of something with infinite value is also infinite, assuming that the rules defining the whole and the parts are not different. In other words, while it is possible to conclude that the value of human life is infinite while the value of a human arm is \$3704.23 because the terms that define the value of an arm are not the same as the terms that define human life, it is not possible to conclude that the value of human life is infinite but the value of one year of life is finite. The value of a year of life is merely a component part of the value of life and is defined by the same terms in every respect. Continuing the analysis, if a year, day, hour, or second of human life is of infinite value, it is at best not obvious that the value of extending patient X’s life by three years is greater than the value of extending patient Y’s life by three seconds because both are infinite.

This does not mean that the question is indeterminate. Not all infinities are equal. It might well be true that the three years are greater than the three seconds, but that result does not flow from simple arithmetic. To make that determination, we must have some means to assess the difference that precedes mathematical analysis. See *infra* note 141.

but the likelihood of error, as defined through the eyes of the one person whose opinion really counts, is greatly reduced.

So conceptualized, the moral paradigm is relevant to everyone, not just those who adopt very strong or concrete arguments. This is so because everyone has subjective spiritual, irrational, and emotional preferences that would otherwise receive no consideration by policy-makers. Those preferences are relevant because they are part of what makes each person unique and special. To discount them would be to discount who these people are and would thus virtually guarantee that any rationing decision adverse to them would be based on normative decisions about which they disagree.

The “new moral paradigm” proposed in this paper is pluralist by design. Pluralism is necessary because it enables our system to be more moral in the eyes of the aggrieved party. Given that there is no mutually accepted perspective from which to view the moral questions and, consequently, no consensus on how to answer the very hard questions implicated by rationing, and because the burdens of rationing are so greatly and painfully concentrated against certain individuals, we ought to try to view the costs and the benefits of rationing through their eyes. Intellectual modesty, coupled by respect for humanity, suggests this result. If we recognize that we do not know the objectively correct approach to rationing, and have settled on our scheme of choice only out of necessity (in full knowledge that many reasonable people will disagree with our assumptions and conclusions), a meaningful respect for life counsels that we do our best to consider the extreme harm occasioned against individuals by adopting the moral positions of those individuals. To that end, the new moral paradigm further requires individualized adjudication, rather than centralized governmental or private sector rationing, because adjudication can consider the merits in each case and render decisions that are appropriate in light of all the relevant facts and circumstances. An exclusively centralized process that attempts to design rules that apply to all people without regard to individual circumstances and subjective spiritual, irrational, and emotional preferences, violates the dignity – indeed, the personhood – of the individual.

The new moral paradigm does not define rationing care for economic purposes as per se immoral. Nor does it consider invalid any attempt to rank people or forms of treatment with the hope of developing a health system that is more socially efficient. Rather, the new moral paradigm objects to rationing without giving due consideration to human dignity. The failure to properly consider the individual interests of the parties aggrieved by rationing is arguably the primary harm in rationing.

Rationing is necessary. Rationing *without respect and care* for those disadvantaged by the rationing scheme is not.¹²⁶ Perhaps this is the reason that many so strongly object to centralized rationing.¹²⁷ Under a price

¹²⁶ Certainly, not all rationing schemes that do not conform to the scheme proposed by this Article can be classified as “immoral” and I do not mean to suggest that they are all guilty of “[r]ationing without respect and care for those disadvantaged.” The point is that one cannot turn to the inevitability of rationing as an excuse to adopt an approach that, by hypothesis, fails to afford patients their due respect and care. Indeed, the entire point of the moral paradigm is to place moral reasoning into the rationing debate. As I will explain, I believe this can be done without first specifying what is to be deemed “moral” and what “immoral.”

¹²⁷ See *supra* text accompanying notes 8-9, 79.

rationing system, people are able to convince themselves that they remain in control of their medical decisions. Those who can afford the care they want are indeed in control of their fate. Those who truly cannot afford the care they need are not actually in control but have no one to blame and are thus able to view their fate as solely their problem. Centralized rationing, on the other hand, places someone else, who is detached and thus cannot view the world through the eyes of the patient, in control of medical decisions. That person or institution might be called upon to make moral or value-based decisions and will have to use their own moral code, rather than the moral code of the patient, to make rationing decisions.¹²⁸ In truth, under any rationing scheme, including rationing by price, individuals are permitted to suffer or die without a legitimate chance to have their voices heard, their moral positions considered, and their cases considered by an authority capable of reversing their fate where appropriate. This is the evil that is rationing.

Additional legal process can help. Legal process provides the safety valve that I mentioned throughout Part II. An appellate process can overlay any rationing scheme; it permits aggrieved patients to articulate their moral code or their personal interests that ought to be taken into account before an adverse decision is rendered against them. Such a program will be expensive, but for reasons that I will address in Part IV, will likely confer a net savings notwithstanding large start-up costs. Additionally, adjudication, as described, will be complicated to administer and demands the answers to many preliminary questions. Parts IV and V are devoted to addressing those tasks.

The demand for greater process ought to be entirely uncontroversial upon proper reflection on what happens when health care is rationed. Rationing often results in death. The immediate consequence: children are orphaned, spouses widowed (or widowed), and other dear parties left bereft. Rationing is thus conceptually related to capital adjudication. Obviously, no one is being punished and no particular person is targeted when health care is rationed, but the result is the same. Intuitively, we would condemn a society that is willing to impose capital punishment without granting the accused some reasonable procedural basis to gain protection. Why should similar procedural protections not exist when death is occasioned in the context of health care rationing? Is it because rationing is an omission rather than an action? Any first-year law student can see that a calculated decision by the government to withhold access to care is no less an action than is flipping the switch of an electric chair. Is it because the intent is not to punish but to build a better health system, which can only be done by restricting access to treatment? By that rationale, in the name of meaningful health reform, there should be no objection to the execution of all people who impose a net cost on society (perhaps because they are disabled or too old to work).

Although this argument appears strongest in cases where limitations on access to health care will result in death, it is applicable to cases in which limitations on access impose significant suffering or debilitation.¹²⁹ These are

¹²⁸ *See id.*

¹²⁹ Examples used throughout this paper tend to focus on death or possible death. That is for illustrative reasons only. It is easier to articulate the problems of rationing when the result of a poor decision is extreme and irreversible. However the arguments presented in this paper, as articulated in this paragraph, are not limited to such cases. For example, it should be easy to

restrictions on liberty and ought not to be treated differently from other egregious restrictions on liberty that impose excessive burdens on particular individuals. The Supreme Court of the United States reached a similar conclusion in *Goldberg v. Kelly*, holding that pre-deprivation evidentiary hearings are a constitutional requirement when welfare is to be terminated because, “welfare provides the means to obtain essential food, clothing, housing, and medical care.”¹³⁰ In other words, where the harm to the individual is particularly great, the Federal Constitution does not permit governmental bodies to act summarily to further the public interest. The denial of necessary health care is no less debilitating than the denial of welfare benefits. *Mathews v. Eldridge* would later expressly adopt a balancing test. That three-prong test should also come out in favor of granting pre-deprivation procedural protections for adverse health care rationing decisions.¹³¹

Before describing the procedural mechanism proposed by this paper, I think that it is appropriate to consider the range of moral perspectives that ought to be considered by a decision-maker. In general, I see no reason to artificially limit the range of moral positions, strong or weak, that deserve consideration. Where strong social interests or public policy requires the rejection of certain moral arguments – the infanticide of Peter Singer and Jonathan Glover, for example¹³² – those arguments will lose during the adjudicatory process. If so, there is no need to set jurisdictional-type limits. The range of adjudicable moral arguments is thus exceptionally broad. Peter Singer, for example, heavily discounts the value of human life – viewing humans no differently from animals – and thus develops surprising opinions

see how a situation of severe suffering, even if only temporary, could be subject to the analysis provided in this paper.

¹³⁰ *Goldberg v. Kelly*, 397 U.S. 254, 261, 264 (1970).

¹³¹ *Mathews v. Eldridge*, 424 U.S. 319, 326, 335 (1976). The three-factor test involves a consideration of (1) “the private interest that will be affected by the official action,” (2) “the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards,” and (3) “the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.” *Id.* at 335. As I have demonstrated throughout, the private interest is enormous. The risk of “erroneous deprivation” is dependant upon a definition of “erroneous.” A fair interpretation of the *Eldridge* decision would define a deprivation of health care without regard to objectively compelling moral objections as “erroneous.” The Government’s interest in reducing costs is strong and the fiscal and administrative burdens associated with the additional procedural protections that I propose are significant. While perhaps not readily intuitive, I believe that my proposal will actually serve to reduce costs for reasons articulated in Parts IV and V.

¹³² They argued that there is no conceptual difference between depriving an infant of a toy and killing that infant. Infants lack cognitive ability and, in their view, lack an important measure of humanity. In Glover’s words:

The objection to killing provides no argument against infanticide, for newborn babies have no conception of death so they cannot have any preference for life over death. The objection to infanticide is at most no stronger than the objection to frustrating a baby’s current set of desires, say by leaving him to cry unattended for a longish [sic] period.

Wesley J. Smith, *Does Human Life Have Intrinsic Value Merely Because it is Human?*, 13 TRINITY L. REV. 45 (2006); see also RAMESH PONNURU, THE PARTY OF DEATH: THE DEMOCRATS, THE MEDIA, THE COURTS, AND THE DISREGARD FOR HUMAN LIFE 175-87 (2006) (quoting GLOVER on page 181); PETER SINGER, PRACTICAL ETHICS 170-71 (2d ed., 1993).

about murder.¹³³ In direct contrast, the “strong version” of the moral paradigm argues that human life is infinitely valuable.¹³⁴ It too reaches some surprising results, some of which are summarized below. In the interests of the pluralism that this appellate procedure attempts to promote, both approaches should be presumed as legitimate as applied to the patient who subscribes to those views, notwithstanding the dramatically different results they produce.

To illustrate further the variety of views on the value of human life and how they might effect adjudication under the pluralistic model proposed in this paper, the following paragraphs develop the views articulated in a landmark work by philosopher John Taurek, likely an adherent of the “strong version” of the moral paradigm. In addition to developing an extreme position, his words also help to illustrate what “pluralism” means as I am using that term. Taurek initiates his discussion with the following question:

I have a supply of some life-saving drug. Six people will all certainly die if they are not treated with the drug. But one of the six requires all of the drug if he is to survive. Each of the other five requires only one-fifth of the drug. What ought I to do?¹³⁵

Presumably, most people would instinctively say that it is better to save five people than to save one. Alternatively, they might argue that it is worse to allow five people to die than to allow one person to die. Taurek asks “Worse for whom?”¹³⁶ From the perspective of the one person, his death is more meaningful and worse than the death of the other five because he values his own life more than he values the lives of the others.¹³⁷ Taurek points out that we would permit him to keep the drug for himself if he previously held it in

¹³³ See PONNURU, *supra* note 132.

¹³⁴ An earlier version of this article received criticism for failing to explain the logical basis of the apparent assumption by Taurek, *infra* note 135 and accompanying text, and others that life has infinite value. Frankly, I find this criticism surprising. I am not adopting Taurek in toto and my arguments in this Article are in no way dependant upon an assumption of infinite value. But even if one were to erroneously assume that my arguments are entirely dependant upon the infinite value presumption, that in no way implies an obligation to defend that presumption. While it may be possible to provide logical proof for the claim of infinite value (a matter well beyond the scope of this Article), the source of this presumption is very likely religious or highly theoretical and/or philosophical and exist in a realm outside of logical discourse. A person can believe (or perhaps even *know*) something to be true without being able to explain his views logically. In the context of an academic article, presumptions as such are valid, as long as they are properly identified as presumptions. The point I intend to make is not that life *is* infinitely valuable but that many people *believe* that it is so and the fact that they do draws them towards interesting conclusions that deserve consideration.

Perhaps my critic meant only that if there is no logical basis for their conclusions, and that they rest on an assumption that cannot be disproven, we need not address these conclusions or build policy around them. To him I ask: What is your logical basis for concluding that these assumptions are *wrong*? If, for example, those making the presumption of infinite value are making a religious or theological argument, a logical proof against them will have to start by logically disproving their religion and the sources of their revelation. I request instead that we inject a little intellectual humility into the debate, recognize that the positions of people with whom we disagree remain relevant notwithstanding our disagreements, and, more importantly, remain tolerant of those views that we do not understand. See generally Nomi Maya Stolzenberg, *‘He Drew a Circle that Shut Me Out’: Assimilation, Indoctrination, and the Paradox of a Liberal Education*, 106 HAV. L. REV. 581 (1993) (DEFINING TOLERANCE).

¹³⁵ John M. Taurek, *Should the Numbers Count?*, 6 PHIL. & PUB. AFF. 293, 294 (1977).

¹³⁶ *Id.* at 299.

¹³⁷ *Id.* at 300.

his legal and physical possession.¹³⁸ If so, why does he have less of a claim to the drug because the drug is now held by an anonymous third-party? Does the analysis somehow change if the anonymous third-party is the government? Taurek continues:

Here are six human beings. I can empathize with each of them. I would not like to see any of them die. But I cannot save everyone. Why not give each person an equal chance to survive? Perhaps I could flip a coin. Heads, I give my drug to these five. Tails, I give it to this one. In this way I give each of the six persons a fifty-fifty chance of surviving. Where such an option is open to me it would seem to best express my equal concern and respect for each person. Who among them could complain that I have done wrong? . . . If six objects are threatened by fire and I am in a position to retrieve the five in this room or the one in that room, but unable to get out all six, I would decide what to do in just the [same] way . . . Each object will have a certain value in my eyes. If it happens that all six are of equal value, I will naturally preserve the many rather than the one. Why? Because the five objects are together five times more valuable in my eyes than the one. But when I am moved to rescue human beings from harm in situations of the kind described, I cannot bring myself to think of them in just this way. I empathize with them.¹³⁹

Needless to say, flipping coins as a means of allocating scarce medical resources never gained a plurality. As Derek Parfit retorted in his response to Taurek, we cannot flip coins “[b]ecause we *do* give equal weight to saving each. Each counts for one. That is why more count for more.”¹⁴⁰ Parfit never really refutes to Taurek’s argument. (Incidentally, the claim that life is infinitely valuable does not necessitate the conclusion that each counts for one. Not all infinities are equal – one item of infinite value can be worth more than another item of infinite value.¹⁴¹ Accordingly, I suspect that Parfit’s characterization of Taurek’s argument is incorrect.) Instead, he rejected Taurek’s normative assumptions primarily on an intuitive basis and on the grounds that Taurek is violating traditional assumptions.¹⁴² But that approach is not responsive to Taurek’s argument precisely because Taurek sought to question the traditional approach to addressing these questions by asking us to change our perspective:

¹³⁸ That is, we would not require him to surrender the drug on the basis that doing so would save more people than it is able to save while in his possession. *Id.*

¹³⁹ *Id.* at 303, 306.

¹⁴⁰ Derek Parfit, *Innumerate Ethics*, 7 PHIL. & PUB. AFF. 285, 301 (1978).

¹⁴¹ This observation can be best demonstrated in the language of mathematics. The area under the curve $y=x^2$ is infinite ($x \rightarrow 0$). The area under the curve $y=(x/2)^2$ is also infinite ($x \rightarrow 0$). Nevertheless, at any point on the curve, x^2 will be greater or equal to $(x/2)^2$. For example, if we set x at 50, x^2 is 2500 and $(x/2)^2$ is 625. Similarly, if we set x at 0.5, x^2 is 0.25 and $(x/2)^2$ is 0.0625. Both curves are infinite and yet one is smaller than the other is. *See also supra* note 125.

¹⁴² *See generally id.*

For each of these six persons it is no doubt a terrible thing to die. Each faces the loss of something among the things he values most. His loss means something to me only, or chiefly, because of what it means to him. *It is the loss to the individual that matters to me, not the loss of the individual.* But should any one of these five lose his life, his loss is no greater a loss to him because, as it happens, four others . . . lose theirs as well.¹⁴³

When viewed from the perspective of the *victim*, is it in fact clear that there is a difference between the death of five people and the death of one? One hundred and one? Three hundred million (the approximate population of the United States)¹⁴⁴ and one?

Taurek's argument for flipping coins is conceptually similar to mine. He views the harm from the perspective of the injured because it is their loss that he finds most meaningful. Adopting the same pluralist reasoning, it would seem that where the specific interests (beyond the general desire to live in health) of the sick are unknown, Taurek would presumably favor a procedural system that discovers those preferences and seeks to honor them. While I am not advocating the use of a lottery, I find Taurek's general theoretical approach compelling¹⁴⁵ for the reasons provided throughout this Part as well as those articulated by Taurek above.

Notwithstanding its dramatic variety, the moral paradigm has much to offer health law and policy as society confronts the excessive and rapidly rising cost of health care. Even if we are incapable of resolving these very broad disputes, by having the discussion and thinking about difficult moral questions, we will be better suited to relate to the interests of individual patients and devise a system of rationing (defined to include its procedures) that achieves far more desirable results.

IV. CONSIDERING INDIVIDUAL NEEDS IN A SOCIAL SYSTEM

Rationing is both necessary and undesirable. There is no singular normatively or morally "correct" solution. Even if there were one, we would not necessarily be able to adopt it considering the formidable political limitations on health care reform efforts.¹⁴⁶ This Part suggests a process-based solution to these problems by appealing to the new moral paradigm articulated in Part II. Section A outlines that solution: a 'safety valve' that permits individuals to bypass the rationing scheme, whatever its contours, where the alternative is an intolerable breach of the victim's – or our collective – moral code. It replaces the traditional bright-line rules governing health care delivery with standards and places human beings at the center of bypassing those standards. Section B will then consider what might constitute a valid basis for exception to the rules.

¹⁴³ Taurek, *supra* note 135, at 307 (emphasis added).

¹⁴⁴ U.S. Census Bureau, U.S. & World Population Clocks, <http://www.census.gov/main/www/popclock.html> (last visited Feb. 12, 2010).

¹⁴⁵ See *supra* note 134.

¹⁴⁶ See *supra* text accompanying notes 8-9.

A. BRIGHT-LINE RULES AND THE EMERGENCY ROOM

Apparently first articulated by Aristotle, that society must be governed by the ‘rule of law, not of men’ to preserve governance by reason is now widely acknowledged.¹⁴⁷ Aristotle argued that resorting to equity is appropriate only in light of the failure of law and only in specific cases. Further, “[t]o adopt and to live according to rules is right, not because rules have good consequences or because a legal order is dictated by the categorical imperative, but because to create and to live under a legal order honors the virtue of justice.”¹⁴⁸ Bright line rules are also much simpler to develop and enforce, thus significantly reducing procedural costs. Indeed, bright-line rules have considerable appeal. They also have a tendency to be grossly over-broad or under-inclusive (perhaps both simultaneously). As a result, they impose significant costs on society in the form of departures from the objectively correct result (borrowing an analogy from criminal law, they can be thought of as causing “false convictions” and “false acquittals”) and violations of vertical equity.¹⁴⁹ Bright-line rules can also be affirmatively dangerous for their ability to cabin the thought process of judges and lawyers into formal boxes detached from the world around them. In that spirit, it is not uncommon to see courts shun bright-line rules, stating that “practical attention to substance rather than doctrinaire reliance on formal categories should inform” judicial analysis.¹⁵⁰ Where the cost of error is very high and the fear of detaching adjudicators from the world in which they adjudicate is particularly significant, such as where the consequences are death or significant suffering, the need for standards rather than bright-line rules is heightened.

In light of the need for greater process and use of standards rather than rules, any effort to reform health care should be preceded by the creation of an administrative adjudicatory board properly designated to question administrative allocational decisions and to grant access to care as it believes necessary. A discussion on the structure of the adjudication is reserved for Part IV. The objective behind the creation of this administrative body is to give patients the opportunity to tell their stories and allow adjudicators to hear all the relevant factors – many of which might not otherwise play a role in the rationing scheme – before issuing a final decision. Adjudicators on the board should have full power to mandate the provision of care in individual cases, without upsetting the underlying rationing scheme.

Persons existing under a system of price rationing who need particular treatment to avoid significant suffering or the possibility of death would be able to go to the adjudicatory board and *request* that the board mandate the

¹⁴⁷ See Kyron Huigens, *The Dead End of Deterrence, and Beyond*, 41 WM. & MARY L. REV. 943, 1033 (2000).

¹⁴⁸ *Id.*

¹⁴⁹ See *supra* text accompanying note 80.

¹⁵⁰ See *Thomas v. Union Carbide Agr. Prod. Co.*, 473 U.S. 568, 587 (1985).

provision of care. This is not (necessarily) centralized medicine or rationing by quantity or prioritization. Patients and physicians operating under a price rationing regime remain in control of medical decisions, to the extent of the patient's ability to pay and to the degree that his preferences are not already supplanted by contractual relationships with insurance companies. This adjudicatory approach merely permits the government to mandate treatment in particular cases and shift fiscal responsibilities, at least in part, to another party (typically to the government itself, but possibly to private parties, as explained in Part IV). With the government available to supplement the payment of medical fees in extreme or unusual cases, or cases in which the denial of treatment would greatly violate the personal moral code of the patient, treatment can be made available via this administrative body.

A similar safety valve should be available to oversee centralized rationing systems such as the one employed by the United Kingdom's NHS. People forced to wait a dangerously long time for medically necessary care would have a legal recourse specifically designed for and competent to address such problems.¹⁵¹ The potential victims of centralized limitations on quantity or prioritization, such as Elaine Barber and her four children,¹⁵² would gain from a direct appellate avenue. Patients denied care would not be relegated to exercising political pressure, perhaps by gaining a voice in the media, to gain a hearing if a meaningful opportunity to appeal existed.

In adjudication, the patient will be able to tell her story and reveal her moral code. If the patient believes that her life is of infinite value and that it is immoral to place a dollar figure upon it, let her state her positions before we assume them. Notwithstanding the apparent claims of Peter Singer and John Taurek,¹⁵³ no policy-maker can know for certain how to value (or not value) a human being. We make assumptions that are based in reason and logic, but might not be objectively correct. If so, the subjective positions of the patient cannot be presumed less valid than our own and should be taken at least as seriously. As I argued in Part II, intellectual modesty, respect for human life (regardless of its relative value or "quality"), and the inequitable distribution of harm suggest that the subjective positions of the patient actually matter a great deal *more* than the positions of the decision-maker. While her declaration that she views her life to be infinitely valuable cannot be dispositive of the question, her position can at least inform the board's analysis. Similarly, if a patient places moral value on pain and suffering, she should have the opportunity to communicate her position before we discount her remaining life years according to their expected quality in a QALY analysis. By bringing the patient before an adjudicatory board, we are able to use her moral code, not ours, as we decide whether or not to make treatment available. Rather than guessing, why not just ask?

The strongest argument against my proposal – requiring decision-makers to supplant their own theories in favor of those of the patient – starts from a position of moral relativism. The theory would be that there is no objective truth and that the decisions of policy-makers, if founded in reason, are just as "correct" as any other reasonable decision. The needs of expediency, the

¹⁵¹ I refer to *Ex parte Collier*. See *supra* text accompanying note 103.

¹⁵² See *supra* note 97 and accompanying text.

¹⁵³ See *supra* text accompanying notes 132-144.

argument might go, would require that we adopt the decision-maker's assumptions. Relativism, however, need not yield that result; pluralism can also tolerate relativism. If there is no correct answer, the policy-maker's decision is, by definition, not more correct than the position of the patient. Given that the patient has a great deal more to lose than the decision-maker, we ought to listen very carefully to what the patient has to say.

Additionally, the patient might lie. She might conveniently discover a moral philosophy or a series of compelling personal circumstances just prior to her adjudication that might compel an adjudicator to grant her access to treatment. Further, even if the patient is entirely honest, she is likely to frame her moral arguments in a way that makes her claims more meritorious, even if not entirely representative of her true beliefs. The adjudication of her claims will have to be sensitive to these realities. I go into great detail suggesting how to neutralize such problems in Part III.B. I address various other potential pitfalls throughout the balance of this Article.

Granting patients access to a formal hearing to address a denial of treatment presents four significant distinct advantages. First, it will improve upon any rationing scheme that we employ by incorporating the values and beliefs of individuals directly into the system. Individuals will be judged according to their moral code or philosophical outlook and will thus be in the best position to cope with an adverse decision. Adverse decisions will be no less tragic, but will at least lack the draconian character that permeates them at present. It also makes rationing decisions more moral from the perspective of the aggrieved party and thus more normatively desirable because the decisions will be sensitive to the subjective beliefs and positions of *each* person at the time she stands before the board. Second, it will counter the tendency of bright-line rationing schematics to be both over-broad and under-inclusive. It is quite difficult to articulate a scheme designed to accommodate a massive population that is also fine enough to be sensitive to subtle distinctions between people and situations. Case-by-case adjudication does precisely that. Third, this approach gives rationing moral legitimacy via increased procedural protections. Even if the process results in a reversal for a very small percentage of cases, the fact that process exists and that people have the ability to have their voices heard makes the adverse decisions in the balance of the cases (even if that is 99% of the cases) more morally justified. Fourth, it renders any rationing scheme more politically viable and thus more likely to be adopted to the extent that people believe that the adjudicatory appeals process will be both available to them and responsive to their needs. Meaningful and mutually beneficial change in health law and policy is thus more likely. It also makes aggressive reform more palatable in the short term. Thus, even if adjudication proves to be very expensive (that is, without regard to the moral and social benefits that should be seen to offset the economic costs), adjudication would provide significant political capital by enabling quick and meaningful reform of the health sector. The economic benefits associated with quick and meaningful reform will likely be large and will more than compensate the costs associated with adjudication. The political benefits from adjudication will not be short-lived either. Adjudication grants continuing moral legitimacy and a sense of security that will enable health reform to progress well into the future.

B. ACCESS, ADJUDICATION, AND THE NEW MORAL PARADIGM

The availability of hearings cannot influence any sort of reversal if the substantive limits of those hearings do not tolerate reversal. Further, the right to a hearing does not guarantee that the petitioner will actually receive one. Were the adjudicatory board to grant every request for a hearing that it received, its existence would frustrate health care reform by making the process exceedingly unwieldy and expensive. Undoubtedly, certain requests for hearings should be denied. Additionally, limits on the discretion of adjudicators must be put into place because, were these hearings to proceed entirely at the whim of the adjudicators, we would expect some adjudicators to grant treatment for nearly every patient who faces death, significant suffering, loss of limb, insanity, and many other conditions likely to pull emotional strings. Other adjudicators will likely deny coverage in even the most meritorious cases. The inequity inherent in adjudication as such is paramount, plainly undesirable, and would tend to undermine the purpose of instituting adjudication in the first place. Indeed, erratic decisions would potentially violate fundamental legal constraints,¹⁵⁴ such as those imposed by the Due Process Clauses of the Federal Constitution.¹⁵⁵

In response to the above concerns, this Section discusses how a patient might gain access to the adjudicatory board and considers some of the factors that adjudicators might look to when deciding whether to grant a hearing and whether to mandate treatment. The discussion that follows is not exhaustive; it is a working list.

1. Threshold Requirements.

It does not make sense to grant a hearing to every patient who wants one. While doing so might make the victims of rationing feel better, and thus make the rationing process more palatable, the expense of doing so would be too great. Accordingly, patients must be required to demonstrate the substantive merits of their claim (akin to the requirement in civil litigation that plaintiffs demonstrate the existence of a *prima facie* case through their pleadings).¹⁵⁶ Placing this burden on patients (or their surrogates) will prevent many of them from filing for a hearing. It will also assist the board in their duties by

¹⁵⁴ *Cf.* *Kolender v. Lawson*, 461 U.S. 352, 357-59 (1983) (particularly discussing penal statutes); *Smith v. Goguen*, 415 U.S. 566, 575-76 (1974) (“Where inherently vague statutory language permits such selective law enforcement, there is a denial of due process.”); *U.S. v. Reese*, 92 U.S. 214, 221 (1875) (“It would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and leave it to the courts to step inside and say who could be rightfully detained, and who should be set at large.”).

¹⁵⁵ U.S. CONST. amend. V. (“No person shall be . . . deprived of life, liberty, or property, without due process of law”); U.S. CONST. amend XIV, § 1 (“ . . . nor shall any State deprive any person of life, liberty, or property, without due process of law”).

¹⁵⁶ This screening process implicates some institutional design questions that I address *infra* note 183 and accompanying text.

requiring the patient to do much of the initial work. As I will explain in greater detail momentarily, most of the adjudication will be consumed by fact-finding. If patients are obligated to provide the facts that they have available to them, the operating costs of the board will be greatly reduced and the board will be in a better position to competently assess the merits of the patient's argument very early in the hearing process.

The duty to disclose should be accompanied with a duty of candor, akin to the requirement placed on patent petitioners before the Patent and Trademark Office (PTO or Office). As described in the patent regulations:

Each individual associated with the filing and prosecution of a patent application has a duty of candor and good faith in dealing with the Office, which includes a duty to disclose to the Office all information known to that individual to be material to patentability as defined in this section. . . . [N]o patent will be granted on an application in connection with which fraud on the Office was practiced or attempted or the duty of disclosure was violated through bad faith or intentional misconduct. [The regulation then discusses the types of relevant information that must be disclosed.]¹⁵⁷

A violation of the duty of candor is deemed "inequitable conduct" and can render the patent unenforceable.¹⁵⁸ Inequitable conduct is defined as material misrepresentation or omission (which includes: (1) an affirmative misrepresentation of material fact, (2) the failure to disclose material information, or (3) the submittal of false material information) coupled with intent to deceive.¹⁵⁹ Intent, under appropriate circumstances (such as where the petitioner had knowledge of the relevant facts and their materiality and makes no good faith explanation for its failure to disclose), can be inferred.¹⁶⁰ Unenforceability of the patent is a rather severe remedy. It is justified because the PTO is incapable of reviewing each detail in every patent application against the entry body of "prior art" that might disqualify the patent application. The PTO needs help from its applicants and their honesty is ensured via the threat of this severe penalty. Patent applicants are aware of the ramifications of violating their duty of candor and thus have a presumptively sufficient incentive to be more forthright.

The corollary to patent unenforceability in the present discussion is the summary reversal of any administrative decision to demand care. If the board granted a patient access to life-saving medication on the basis of materially misleading information, the board operating under equitable rules similar to those that govern patent enforcement would have to kill the patient. For obvious reasons, this harsh approach is not appropriate in this context. Still, a very severe penalty, such as the assessment of severe economic penalties, years

¹⁵⁷ 37 C.F.R § 1.56 (2000).

¹⁵⁸ *Praxair, Inc. v. ATMI, Inc.*, 543 F.3d 1306, 1313, 1328 (Fed. Cir. 2008).

¹⁵⁹ *Id.* at 1313 (quoting *Cargill, Inc. v. Canbra Foods, Ltd.*, 476 F.3d 1359, 1363 (Fed.Cir.2007)).

¹⁶⁰ *See id.* at 1315, 1318 (inferring intent from the degree of materiality of the information, actual or constructive knowledge, and the absence of a good faith explanation for failure to disclose).

of community service, or perhaps even time in prison,¹⁶¹ is appropriate and would likely be sufficient to ensure compliance with the duty of candor.

2. Fact-Finding.

As a presumptive matter, the standards used for adjudication ought to be relative to the various harms caused by denial. Foremost in any discussion about access to medical care are the potential negative implications on the health and wellbeing of the patient. Death is a far more significant burden to place on a patient than is the denial of access to cosmetic intervention, for example. It would seem that treatment requests to preserve life should be preferred over less “important” or vital procedures, such as cosmetic surgery. One approach might be to draw up a list of services, similar to the approach adopted by Oregon, ranking various forms of treatment and being more lenient regarding those at the top of the list.¹⁶² But, as I noted in my brief (footnoted) discussion on Oregon’s system, the prioritization of services is very likely to be influenced by political motivations and is therefore of questionable utility.¹⁶³ Further, bright-line prioritization suffers from many of the problems I have discussed throughout this paper and ought to be avoided. Indeed, the judicial institutionalization of prioritization would compound, rather than solve, the problems with rationing addressed throughout this paper.

Moreover, it is quite far from obvious that cosmetic surgery ought to always be considered a low priority. If someone suffers severe trauma to the face resulting from a violent attack or a fire that renders his face unsightly, cosmetic surgery might be the only means to start the victim on the path to emotional, social, and economic recovery. It is perverse to deny this victim access to cosmetic surgery on the theory that cosmetic surgery is somehow “unimportant.”

If we cannot make seemingly obvious distinctions between the treatment of potentially fatal conditions and superficial conditions, how is it possible for this entire process to be effective? How can we permit adjudicators to consider the totality of the circumstances while placing meaningful restrictions on their discretion to get uniform results and to curb the effects of emotional appeal? I think the answer lies in forcing the adjudicators to ask difficult and uncomfortable questions about the ramifications of a negative outcome on both the patient and those who depend upon her (those who would be severely affected by her incapacity). For example, adjudicators might inquire whether the patient will be able to keep her job, whether her spouse and family will continue to support her, and whether her financial security, and that of her family, will be materially affected. In short, rather than just considering the immediate medical effect of a denial of treatment, adjudicators will have to consider the long-term effects on the patient and on

¹⁶¹ Penal remedies would very likely have to proceed through the criminal court system with trial by jury and the other protections granted to criminal defendants. A further discussion on criminal procedure and constitutional law is beyond the scope of this paper.

¹⁶² See *supra* note 108 and accompanying text.

¹⁶³ *Supra* note 108.

those close to the patient. Needless to say, this type of probing analysis will require extensive questioning and aggressive fact-finding. The process will undoubtedly be highly emotional. Given the time-sensitive nature of many of the petitions that might come before adjudicators, they will have to gather information at a rapid pace, making it much more difficult for adjudicators to act sensitively towards patients and their families. Perhaps it seems perverse to force these patients (and their surrogates) through an administrative gauntlet to determine whether they will live or die.¹⁶⁴ While certainly painful, I view these emotional impositions as an advantage rather than as a basis for criticism of the adjudicatory system that I propose. By making the process emotionally difficult for the patient and family, many people who would otherwise request an exception to their adverse decision if all they needed to do was check a box and perhaps pay a small fee, will prefer to avoid the fact-finding process and simply accept their treatment denial as final. Those who choose to petition the board will be those who have the strongest desires and the greatest need.

Perhaps this fact-finding approach is subject to criticism for unfairly selecting the emotionally strong over the emotionally weak. It seems to me that, in general, those who have a very strong desire to recover would be willing to go through an emotionally trying adjudicatory process, even if they find the process exceptionally difficult. Selection on the basis of individual emotional strength should thus be limited. Moreover, if the adjudicatory process permits surrogates to argue on behalf of the patient, the remaining potential deleterious effects of insufficient emotional stamina are likely to be mitigated. Because it is necessary that surrogates be permitted to stand in the place of patients that are confined to a hospital bed or are otherwise immobile or are inarticulate, permitting surrogates to argue on behalf of all patients, even where the patient is physically able to stand before the board and to gather information, is not a significant concession.

More importantly, this approach has the potential to promote callous behavior and might even violate human dignity whenever the denial of treatment is very likely to cause the patient to die or be rendered unconscious. The fact-finding approach would ask adjudicators to consider the long-term implications of a person's death or inability to communicate and interact with others. More precisely, it would ask the patient to think about and describe the implications of her own death or disability and explain to the board (and to herself) why anyone ought to care. When death or severe disability that renders the patient unable to communicate is at stake, the long-term implications are external to the person and thus ask the patient and the adjudicators to question whether the patient's incapacity would matter to any *other* person. Under this rubric, people with little responsibility and no

¹⁶⁴ The following sentences provide a partial reply to the criticism that this process is perverse and may serve to demean patients. I recognize that my response may not be satisfying to all readers. I am writing here to remind those readers that under my proposal, the entire process is optional. If the rationing system in place determines that a particular patient is to be denied treatment, that patient will then be in the position to choose between embarking on these appellate procedures or accepting her denial of treatment. Giving to those patients who are willing to fight through the proposed procedures for the chance to convince a panel that they ought to be entitled to treatment the option to do so is far better than denying all parties that option because the process seems demeaning to some.

dependants would be permitted to die or suffer, even where treatment would be relatively inexpensive. The elderly would be systematically disfavored as a class and would thus suffer disproportionately. To avoid these intolerable results, it seems a virtual necessity that the fact-finding inquiry would need to explicitly consider the *personal* and internal effects of non-treatment, including the subjective spiritual, irrational, and emotional preferences of the patient. In other words, the loss *to* the individual is significantly important.¹⁶⁵ This individualized approach to adjudication is central to the new moral paradigm.

Nevertheless, patients with many dependants (including non-relatives) will be advantaged over those with relatively fewer dependants. This is so not because people with children (or other dependants) are somehow more valuable than people without children, but because the loss to the children matters as well. Failure to make distinctions between patients with young children and patients without young children severely discounts the needs of those children. Because the children need parents, their existence and dependence render their parent (the patient) a more worthy petitioner.

In general, even where the emotive appeal for granting treatment is quite high, the adjudicatory board should be inclined to sustain a treatment denial where the impact of a denial appears to be relatively low. Still, the imposition of *per se* rules on the board, such as by mandating the denial of treatment where the impact of a denial does not reach an articulated threshold, would too frequently reach intolerable results. Indeed, it seems proper to demand care even when the impact of a denial is low when the costs of treatment are relatively low, the desired resources are readily available, and the marginal increase in consumption is likely to have only a negligible impact on increasing prices.¹⁶⁶

3. Testing Sincerity of Preference.

In addition to considering the impact of denial, the adjudicatory board should expressly consider the sincerity of the patient's desire for coverage. When confronted by a patient living under a legal régime that encourages the private purchase of insurance – such as in the United States – who has insurance that she knew or should have known would not be sufficient to cover her needs, the board will expressly consider why the patient lacks requisite insurance. If it is clear that the patient made a calculated decision not to pay premiums for a level of coverage that would have been presumed sufficient for her *ex ante*, the board should deny access to care almost without exception. This patient, through her actions, has declared that she was willing to accept the risks associated with medical incapacity rather than take the steps necessary to protect herself.¹⁶⁷ Her actions prior to getting sick have at

¹⁶⁵ This is a modification of John Taurek's argument. *See supra* text accompanying note 143.

¹⁶⁶ Clearly, where the provision of care costs less than the denial of care, care should be mandated. *See supra* notes 65-67 and accompanying text for a fuller discussion of this phenomenon (discussing the treatment of Dee Dee Dodd).

¹⁶⁷ Note that the objective here is to use the purchase of insurance as a proxy to determine the true preferences of the patient at the time she purchased her insurance. If various

least as much credibility as her claims now before the board that she desires treatment. Needless to say, it will rarely be clear from the evidence before the board why any patient lacks sufficient insurance coverage. When the board confronts a patient who had sufficient assets to purchase insurance and did not, a strong rebuttable presumption is created that the patient made a calculated decision not to purchase insurance. Where a patient did not have sufficient assets, but made significant discretionary expenses that are generally viewed in the surrounding culture as unnecessary or indulgent (assuming that she would have been able to purchase a presumptively adequate policy but-for those discretionary expenses), that too should create a rebuttable presumption against the patient. When a person with no health insurance purchases a fancy car or goes on an expensive vacation, she declares implicitly that her car or vacation is worth more to her than health coverage. Of course, if the vacation was necessary to preserve the patient's mental stability or reduce excessive stress levels, the inference that she values discretionary expenses more than health care vanishes. Assuming that the inference is reasonable, it makes little sense to mandate that the patient receive the care she desires when she did not sufficiently protect herself *ex ante*.

If the presumption is rebutted, or it is determined that the patient legitimately did not have sufficient resources to purchase care (or, in countries that do not encourage the purchase of private insurance, other relevant measures of desire are considered and satisfied), and in every case where sources of funding (such as private insurance) that were presumptively sufficient *ex ante* refuse to pay for care,¹⁶⁸ the board should impose a final hurdle upon the patient as a means of assessing sincerity. The board should calculate the extent to which the patient is able to reasonably pay (perhaps via an installment plan) and assess a fee against the patient in that amount. The patient's contribution for her care might be a negligible fraction of the total bill, but is materially important nonetheless. By agreeing to pay her "fair share," the patient is expressing, in a tangible way, her sincere desire for the coverage she requests by agreeing to suffer for it and also by sharing directly in the social costs associated with her treatment.

The assessed obligation should not render the patient unable to pay for vital services such as food, clothing, shelter, necessary transportation, utilities, other anticipated medical expenses, taxes and other similar assessments. The objective here is to gauge willingness to pay, not to bankrupt the patient or force her to subsidize the cost of her care in any meaningful way. The board should consider her need for funds to cover other non-discretionary costs, such as home maintenance expenses, the costs of private school tuition or

circumstances render the proxy unconvincing, such as where the insurance policy was provided by an employer and the patient did not know that she was supposed to read it or that she had the option to supplement the insurance with an additional policy, it is irrelevant to this discussion. Further, the fact that the insurance proved *ex post* to be insufficient is not relevant. The argument is simply that patients should be expected to make reasonable guesses given the information they had at the time they entered into their insurance contracts. If the patient purchased a policy that was subjectively reasonable given her anticipated needs as she understood them at the time of purchase, the inadequacy of the policy is not a meaningful proxy.

¹⁶⁸ See *id.*

private tutoring where subjectively important for religious or certain other personal purposes or for children with special needs, and for transportation expenses beyond the minimum necessary for transportation to work and school. In some cases, those other non-discretionary expenses will be no less vital and will need to be preserved. After all appropriate deductions are made, persons requesting previously denied care should be expected to pay a very large percentage of their remaining income (and perhaps some portion of their accrued assets) not necessary for these vital services.

4. Culpability and Incentives.

The board should additionally consider the patient's culpability. If the patient's medical condition is caused largely by her repeated consumption of cigarettes, there is good reason for the board to affirm a denial of care. The patient has made a choice that exposed her to significant risk and now wants everyone else to pay for it. That sort of subsidization creates incentives for future patients to act carelessly. It also seems to violate a pervasive normative ethical assumption pertaining to individual responsibility.

But all of this begs the question. If a patient is a thirty-year nicotine addict, how much of that addiction is due to a breach of individual responsibility and how much is due to deception by the cigarette companies before it became widely known that cigarettes are dangerous and addictive? It seems to me that the board should not get involved in assigning blame for past mistakes except where it is unambiguous that the patient is blameworthy. Culpability will likely be relevant in a very small minority of cases.

5. Deceit and Manipulation.

We would expect patients to manipulate their moral positions to achieve the outcome they desire before the board. This is particularly so if patients are able to appoint surrogates (some of whom will likely have experience arguing before the board) to argue on their behalf. They *must* be able to appoint surrogates because not all patients will have the physical ability to come before the board. Accordingly, we would expect the number of people claiming severe religious constraints or emotional harm to exceed true frequency. To guard against that, adjudicators will have to view such claims with particular skepticism (especially when articulated by a surrogate). Claims about religious belief will need corroboration. If a person claims to be a practicing member of an established religion, the panel would need to seek expert testimony establishing that the normative beliefs of that religious sect would be violated or undermined by the denial of treatment. A person claiming an adherence to a personal moral code (whether outside of established religion or as a supplement to an established *religious* doctrine) would need to have some other means of corroborating those claims, perhaps through the production of witnesses who heard the patient articulate her moral preferences prior to her illness (and where it can be assumed that her statements reflect true preference) or from reading the patient's prior writings to the extent that her writings can be assumed to articulate her true personal

preferences or sincere belief. Needless to say, the adjudicatory board will not be able to corroborate the legitimate moral, ethical, spiritual, emotional, and irrational claims of a good number of patients. While this is greatly unfortunate, simply taking the patient or surrogate at her word is unadministrable. I note additionally that the corroboration requirement suggested above raises some significant problems under the Free Exercise Clause¹⁶⁹ that are beyond the scope of this paper.¹⁷⁰ To my knowledge, a corroboration requirement has never been addressed in the context of health care rationing. The detailed rules promulgated by the Department of Defense to address the sincerity of conscientious objectors to military participation may provide adequate guidance in light of possible constitutional limitations.¹⁷¹ Nevertheless, ignoring all moral arguments, either as a means of mitigating any appearance of bias or to completely avoid inquiries into sincerity, is itself draconian and not a legitimate alternative solution.

To the extent that patients are able to corroborate their strongly held beliefs during the adjudicatory process, those beliefs can be incorporated into the panel's deliberations and used to fairly consider the relevant positions of the patient when rendering a decision regarding that patient. For a patient who believes that there is value to pain and suffering and defines that alternative as preferable to death, the board will use the patient's subjective definitions and assumptions when weighing the relative harm caused by a denial of various treatment options. Conversely, a patient who defines humanity and the value of human life by appeal to cognitive ability or the ability to experience pleasure should not be entitled to a course of treatment that will keep the patient alive, but severely debilitated and in pain.¹⁷²

¹⁶⁹ "Congress shall make no law . . . prohibiting the free exercise [of religion]." U.S. CONST. amend. I.

¹⁷⁰ See *Thomas v. Review Bd.*, 450 U.S. 707, 714-16 (1981) ("[R]eligious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection. . . . Courts should not undertake to dissect religious beliefs because . . . [they] are not articulated with the clarity and precision that a more sophisticated person might employ. . . . Particularly in this sensitive area, it is not within the judicial function and judicial competence to inquire [which of two people] more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation.").

¹⁷¹ DEPARTMENT OF DEFENSE, INSTRUCTION NO. 1300.06 at 4-6, 16 (May 5, 2007) (imposing on the petitioner a burden of producing "clear and convincing evidence" regarding the content and sincerity of belief, asking the petitioner to explain how his beliefs affect his actions, and asking the petitioner to demonstrate the consistency and depth of his convictions), *available at* <http://www.dtic.mil/whs/directives/corres/pdf/130006p.pdf>.

¹⁷² The possibility that this patient – a patient who previously adopted a moral system that values human life according to cognitive ability or the ability to experience pleasure, but now stands before the board begging for the opportunity to access treatment that will be painful and leave her with little ability to function as she did before – has simply changed her mind has not escaped me. Indeed, the fact that this patient is before the board asking for a course of treatment that seems to contradict her moral code suggests that she might have had a genuine change of heart as death began to stare her in the face. It is also possible that she does not trust her doctors and thinks that if she gets the treatment that she requests, she will have a complete recovery in a period of months. Or perhaps stress prevents her from thinking clearly and she persists in a state of confusion. It will often be impossible to discern whether her requests accurately mirror her true preferences at the time she makes her request. While this is a significant problem, it does not justify the current system in which medical resources are allocated without any attempt to discern a patient's moral, religious, ethical, emotional, irrational, or other subjective positions. When it is difficult to determine what those preferences or beliefs are, perhaps because there is reason to believe that they have changed

V. THE ADJUDICATORY BOARD

This Part contemplates the structure and function of the adjudicatory board. While my arguments to this point relate to health care delivery in any country operating under any rationing scheme, this Part necessitates a focused discussion assuming a fixed context and framework. I will argue that the adjudicatory board envisioned in this paper be formed under United States law as a special court of equity jurisdiction to review particular questions of fact, as defined below.¹⁷³ Section A discusses the powers that the board will need to have to function competently and effectively. Section B will address the structure of the board and attempt to design the board such that its powers and discretion will be inherently limited in order to prevent abuse of power, excessive sympathy towards patients, and capture by health care providers and insurance companies. I include this Part not to close discussion or suggest that no other design is appropriate. The objective is rather to demonstrate both that this adjudicatory model can exist and that it can exist now, regardless of the underlying delivery system that the board will oversee. To that end, this Part aims to delineate at least one possible structure and show how it solves some predictable problems.

A. A DISCUSSION ON THE NECESSARY POWERS OF THE ADJUDICATORY BOARD

1. A Two-Step Process

To be effective, the adjudicatory board must have the ability to review denial of medical treatment for any reason and by any party. Specifically, the board must have jurisdiction regardless of whether care is denied by a private insurance company pursuant to a legal and binding insurance contract, the government pursuant to its clearly defined rationing scheme, and/or resulting

over time, the board will be in the difficult position of using the information that it has and coming to a conclusion.

¹⁷³ Whether the court be formed as an Article I court, *see generally* N. Pipeline Constr. Co. v. Marathon Pipe Line Co., 458 U.S. 50 (1982), or as an Article III court is a question that I reserve. I believe that either construct will satisfy the demands of the United States Constitution provided that questions outside this court's jurisdiction (most significantly, underlying questions of law) remain under the jurisdiction of the standard Article III courts. If this "adjudicatory board" is formed as an Article III court, presumably the only potential bar to jurisdiction is whether the equitable questions before the court properly "aris[e] under" the Federal Constitution. U.S. CONST. art. III, § 2. Under *Osborn v. Bank of the U. S.*, 22 U.S. 738 (1824), there seems to be no doubt that the arising under test is met. *Cf.* Carlos M. Vazquez, *The Federal 'Claim' in the District Courts: Osborn, Verlinden, and Protective Jurisdiction*, 95 CAL. L. REV. 1731 (2007). If the "adjudicatory board" is formed as an Article I court, it would have to survive the tests created by the Supreme Court to determine whether jurisdiction properly rests with the proposed Article I court. To explore those tests, which are well beyond the scope of this paper, see generally *Granfinanciera, S.A. v. Nordberg* 492 U.S. 33 (1989); *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833 (1986); N. Pipeline Const. Co., 458 U.S. 50; James E. Pfander, *Article I Tribunals, Article III Courts, and the Judicial Power of the United States*, 118 HARV. L. REV. 643 (2004).

from the patient's inability to pay. When an insurer denies insurance benefits for medically necessary treatment and the patient is unable to pay the physician or hospital out of pocket, the patient will be able to gain administrative review of the insurance company's decision without having to navigate the court system or be responsive to prevailing local contract law. A decision in her favor might require the insurance company to pay for coverage despite that the contract does not require payment.¹⁷⁴ Similarly, an uninsured patient who satisfies the board that her lack of insurance is not due to a lack of legitimate desire for care¹⁷⁵ would be able to request that the board mandate that the government pay for medical treatment. The board will thus wield considerable power over the transfer of money in a very large sector of domestic economies around the world (currently about 17% of the United States GDP)¹⁷⁶ and will issue decisions that implicate the economic interests of many parties. Where the patient is insured, the reversal of the insurance company's decision would make an otherwise administrative proceeding an adversarial one. This renders the adjudication very complicated, necessitating the involvement of many different parties with varying interests. Much of the adjudication would have nothing to do with the merits of the patient's request. This patient would have to sit indefinitely as parties fight over who is going to pay for her treatment while she waits for the board to issue a decision that directly implicates whether she will live or die.

To avoid prolonged and complex litigation in this context, adjudication should proceed in two steps. In the first step, the board will consider whether to mandate the provision of care. If the board denies care, the adjudication is complete. If the board mandates care, physicians would be required to immediately render care (particularly if the patient's medical condition could deteriorate over time) even before the board considers how the physician will be reimbursed. The second phase of adjudication would be exclusively about compensation and would not involve the patient at all. In a typical case in the United States, the second phase would generally look like an adversarial proceeding between the insurance company and the government. The loser pays most (less any portion paid by the patient)¹⁷⁷ of the patient's medical expenses.

This, however, creates potential jurisdictional problems. Were the board to issue a decision in favor of the government on legal grounds, the decision would necessarily be subject to appeal to the jurisdiction's civil courts.¹⁷⁸ To grant the board jurisdiction over legal issues (such as questions regarding the validity or proper interpretation of the contract and the applicability of intervening state or federal regulation) would be inefficiently duplicative and would tie up the administrative process. It would be more efficient to deny the board jurisdiction over purely legal claims. Further, to expect the adjudicators, who must be proficient in economics, moral philosophy, and health policy, to also be sufficiently proficient in law such that they are able to conduct a trial and conclusively decide issues pertaining to state contract law

¹⁷⁴ Shortly, I will more explicitly discuss the question of who ought to pay.

¹⁷⁵ See *supra* Part IV.B.3.

¹⁷⁶ See *supra* note 1 and accompanying text.

¹⁷⁷ *Supra* Part IV.B.3.

¹⁷⁸ See *supra* note 173 and accompanying text.

is probably asking too much. Rather, the adjudicatory board should be permitted to mandate payment by the insurance company only to the extent demanded by equity and the new moral paradigm.¹⁷⁹

If an insurance company is, as a matter of law, obligated to provide benefits for a particular treatment, the patient, or the government in her stead (if it would be obligated to pay the patient's expenses if the insurance company does not), would be able to adjudicate her legal claims through the traditional court system. In fact, the "second phase" of the adjudication would probably occur in the civil courts much of the time. In such a scenario, after the conclusion of phase one of the adjudication before the board, a complaint would be filed in civil court to determine whether the insurance company is responsible to pay for coverage. Presumably, the board would enter some sort of a preliminary judgment against the government and the government would have to file a complaint against the insurance company to require the insurance company to pay. Alternatively, the board itself could act as the nominal plaintiff and file in civil court a complaint against the government, the insurance company, and any other third-party that might be responsible to pay. While denying the board jurisdiction over legal questions creates the potential efficiency problems associated with forcing parties to litigate concurrently in two forums, any loss of judicial efficiency is likely to be minimal because the moral and personal interest questions that the board must address will turn on very different facts and issues than the legal questions pertaining to payment that would be addressed in phase two by a civil court.

2. Maintaining Market Stability

The board should exercise its equitable power to mandate payment by private parties very rarely. If insurance companies anticipated potentially limitless liability, many would respond by exiting the private insurance market. The remainder would likely raise insurance premiums significantly to cover increased costs. This would destabilize insurance markets, price many more people out of those markets, and alter health care delivery dramatically and in a manner that might not be desirable. For private insurance markets to remain stable, the risk to insurance companies will need to be predictable and limited.

Notwithstanding these fears about market stability, the board must have the option to mandate payment at its sole discretion sitting as a court in equity.¹⁸⁰ If the administrative board could mandate payment only in specific

¹⁷⁹ For example, if a patient is denied access by his insurance company, the board might explicitly consider the moral relevance of the insurance contract. If it is factually true that the patient was not involved in the contract negotiations and merely accepted it from his employer, and if it seems clear to the board that no patient negotiating the contract would have agreed to a particular exclusion (or if the custom in the industry is to grant coverage for the excluded item), the board would reasonably find the insurance company at least partially liable. The theory would be that the insurance company engaged in bad faith by presenting a contract that no one would want, knowing that it would not be read.

¹⁸⁰ There is virtually no question that an Article III court can constitutionally be granted these powers, provided that other questions not within the jurisdiction of this Article III court are within the jurisdiction of other Article III courts. If the "adjudicatory board" be structured

and narrow circumstances, that fact would likely be far more disruptive to the health care delivery system than would the threat of untold liability. If insurance companies knew how to avoid the imposition of liability and knew that patients would be able to receive the care that they need at the government's expense, insurance companies would have a reduced incentive to compete for employers based on the quality of their plans and those employers would have reduced incentive to bargain for increased coverage on behalf of their employees. When circumstances for a particular employee are particularly dire, the employee will likely have access to care through the adjudicatory process. If so, there is much less value in entering contentious negotiations over specific exclusions and limitations. Employers will also be less likely to incur the expenses associated with shopping for competitor insurance plans. Accordingly, insurance companies will likely increase their exclusions and limitations to reduce their operating costs and increase profit margins at the expense of the government. To prevent this, and to keep insurance markets competitive, insurance companies must know that they will be held liable at the sole discretion of the adjudicatory board if they engage in socially undesirable behavior. A healthy insurance market will thus require both that the insurance companies are aware that the board has plenary discretion to create liability and that it generally will not exercise that discretion except under predictable, but relatively broad circumstances.

3. The Board as an Agent in Health Care Reform

The adjudicatory board's most significant power would be granted to it only indirectly: the power to control the price of health care. If major health care reform is instituted, the likely primary objective of such reform will be to reduce health care costs.¹⁸¹ If the adjudicatory board grants coverage in a large number of the cases it hears, that could undermine the government's efforts to control costs and thus the price of coverage. The board must remain cognizant of that fact and act accordingly. It seems unlikely, however, that the presence of this board will cause significant net prices increases. With sufficient procedural controls (which I discuss in the next Section), we would expect relatively few claims to be granted. Moreover, the presence of the board grants the government more political capital and the moral freedom necessary to enact desirable health care delivery reforms. Accordingly, the adjudicatory board complements, rather than detracts from, reform efforts. Thus, in

as an Article I court, I am not aware of a case directly on-point. There is broad authority for the proposition that administrative findings of fact are not subject to appeal provided that constitutional Due Process protections (beyond the scope of this paper) are properly observed. *See Crowell v. Benson*, 285 U.S. 22, 92-94 (1932) (holding that administrative factual findings are to be granted deference); *Sheldon v. Sill*, 49 U.S. 441, 448-49 (1850) (holding that Congress has plenary power to limit the jurisdiction of the lower federal courts); *supra* note 173. The types of questions presented before this court would plainly be questions of fact rather than questions of law.

¹⁸¹ *See supra* notes 8-24; *see also generally* DASCHLE, *supra* note 56.

addition to creating a more moral system of allocation,¹⁸² the adjudicatory board also generates a net cost savings.

B. INSTITUTIONAL DESIGN AND PROCEDURAL CONTROLS

The adjudicatory board must have plenary power to mandate the provision of health care and must function in individual cases without being bound by precedent. Those two characteristics have the potential to lead to abuse and thus frustrate the purpose of the board. To be effective, the board's design must incorporate significant procedural controls. This Section suggests some such controls.

1. The initial screening – during which the petitioner must submit evidence demonstrating the existence of a prima facie claim for treatment¹⁸³ – should be heard by an adjudicator with full administrative responsibilities rather than a magistrate specifically appointed for that purpose. The screener will have a great deal of discretion and little supervision. Should the screener deny a case, the denial of treatment will likely be final as there will presumably be no one else for the patient to turn to. The patient will, of course, have the opportunity to submit additional documents, evidence, and testimony as necessary, but her fate will ultimately rest with the screener. In order to promote uniformity, effective, and fair screening, the adjudicators should serve as screeners on a rotating basis.

2. Each case should be heard by a panel of adjudicators rather than just one. Individual adjudicators that have no precedential constraints and who are subject to limited review will be free to act as they chose. Independent adjudicators sitting on a panel are able to supervise each other and are thus each less likely to abuse their authority.

3. The initial screener should not be one of the adjudicators who ultimately sit on the panel that hears the case. This is desirable because the patient has already successfully convinced the screener that her case has merit. Additionally, the screener might be biased as a result of his prior interactions with the patient as she gathered her evidence and submitted her petition.

4. Because emotion will likely play a significant role in many of these decisions, patients should be required to convince a large number of adjudicators. Convincing two out of three people is probably too likely to be the result of emotional bias.¹⁸⁴ If three intelligent people on a panel of five – each with considerable experience and expertise in this area – can agree that the patient's case is meritorious, it seems less likely that their good judgment has been compromised by emotion alone. If these panels are at all analogous

¹⁸² See *supra* Parts III & IV.A.

¹⁸³ I introduced the screening process *supra* note 156 and accompanying text.

¹⁸⁴ This is not to suggest that emotional costs are irrelevant. Indeed, high emotional costs likely implicate many of the factors discussed in Part IV.B. of this paper. Emotion alone, however, should not be dispositive primarily because emotion will be present in nearly every case that comes before the board. A larger panel is less likely to be swayed by emotion and thus better equipped to make wise and just decisions.

to juries in criminal trials – and there is good reason to assume that they are not¹⁸⁵ – we might be inclined to adopt a very large panel of, say, twelve adjudicators. Larger panels would benefit from greater diversity of thought and would be more likely to reach better-reasoned outcomes.¹⁸⁶ Larger panels would, however, require more resources and would tend to undermine the overriding goal of this entire discussion: to reduce the price of health care. Their deliberations would also tend to extend the process of adjudication, further increasing the costs of additional process. The gains that the adjudicatory board might achieve can quickly be lost through demands of excessive process, including by insisting on very large panels. I suspect that a panel of five is probably sufficient and therefore optimal.

Note that by barring the screener from the adjudicatory panel, we are effectively requiring the patient to convince four out of the six adjudicators who consider her case. To the extent we fear that the adjudicatory board is more likely to grant treatment when it should deny than it is to deny when it should grant, this insistence on a panel and an effective 2/3 requirement might be helpful.

5. Decisions by the panel should generally be reviewable only at the discretion of a majority of the members of the adjudicatory board who did not sit on the panel or serve as the case screener. For example, if we imagine that the entire board has fifteen adjudicators, six of them have already considered the case. A majority of the remaining nine adjudicators would have to agree to hear an appeal and then all fifteen would sit *en banc*. The purpose of this is primarily to limit appeals. The adjudicatory process will be rather difficult for those involved and protracting it with a lengthy review procedure exacerbates the problem. Further, patients that are denied treatment by the panel of five will, as a rule, appeal to the whole board if that option is available to them. The availability of review will tremendously increase costs and make the operation of the adjudicatory board more cumbersome. By imposing limitations on the availability of *en banc* review, truly objectionable decisions will be reversed without dramatically tying up the resources of the panel or drawing out the adjudicatory process in every case ending with an adverse decision.

6. Notwithstanding the above, where the board suspects abuse of discretion, excessive and improper grants or excessive and improper denials,

¹⁸⁵ Individual jurors suffer from prejudice that we like to assume is not present among adjudicators. Where prejudice exists, larger numbers are desirable to ensure less bias in the results. Additionally, jurors, unlike adjudicators, are often not permitted to take notes during deliberations and must thus rely more heavily on their memories. Greater numbers are likely to result in better recall of the facts. See *Ballew v. Georgia*, 435 U.S. 223, 232-35 (1978). Perhaps most importantly, at least for jury panels of six and for all federal criminal juries, the Supreme Court has ruled that the Federal Constitution requires unanimity. See *Apodaca v. Oregon*, 406 U.S. 404, 410-12 (1972); *Johnson v. Louisiana*, 406 U.S. 356, 363 (1972). This fact dramatically alters the nature of negotiations among jurors and strains the attempt to compare jurors and adjudicators. See *Ballew*, 435 U.S. 223, 432-35.

¹⁸⁶ See *Ballew*, 435 U.S. at 234-37. *Ballew* quoted some studies showing that large jury panels were more likely to acquit than were smaller panels and that the fear of wrongful acquittals counseled against making the panels excessively large. One such study found that the optimal panel would be a jury of between six and eight members. *Id.* at 234. I do not believe this to be relevant for the analysis appears to turn on the unique features of jury deliberation. See *id.* at 236.

or other improper activity by an adjudicator, the whole board should be able to review, *sua sponte* (by a majority vote of uninterested adjudicators), any decision by a screener or a panel or any other action by an adjudicator and should have plenary authority to remove an adjudicator from the board or reverse any of his decisions by a majority vote of the uninterested adjudicators.

7. Aside from the entire board's ability to remove adjudicators and to review decisions, no review of the actions of individual adjudicators or of the entire board (including decisions to remove adjudicators or reverse prior decisions) should be available, except by traditional courts to the very limited extent required by background jurisdictional laws (such as those imposed by the Federal Constitution).¹⁸⁷ This is necessary to insulate the adjudicators from politics. If the adjudicators were subject to political pressure, as would be the case if they were subject to removal by the president or impeachment by the legislature, there is concern that they might adulterate their decisions to remain in political favor or to maintain quotas (for example, by ensuring that a certain percentage of cases that come before them get denied). If congressional impeachment is to be available, it would need to be used very sparingly and contain all the rigor of a traditional impeachment and subsequent trial.¹⁸⁸

8. Notwithstanding the desire to insulate the board from politics, appointments to the board should be made by the president and confirmed by the Senate, consistent with the Appointments Clause of the Federal Constitution.¹⁸⁹ The appointment process will necessarily inject a measure of politics into the board, but that can be countered with the use of other procedural controls, such as the unavailability of review (above) and the use of a series of staggered terms (below). It is hard to imagine an alternative reasonable but apolitical method of choosing the members of the board.

9. Adjudicators will need to be well-versed in health economics and the health sector generally. They should be obligated to demonstrate their proficiency in these areas via examination or a degree from a recognized university. They will need to have a very strong demonstrated background (presumably by examination) in moral philosophy to be able to relate to and anticipate the arguments being made by petitioners. Prerequisite to Senate confirmation, they should be required to receive instruction in comparative religion and psychology and supplementary instruction in any discrete areas on which they were tested and did relatively poorly. The adjudicators ought to be attorneys to ensure sufficient competence in dealing with administrative, adjudicatory, and social structures as well as the ability to operate within a purely legal framework,¹⁹⁰ possibly including within the civil courts.¹⁹¹ Because the board will have no jurisdiction over legal issues, proficiency in any

¹⁸⁷ See *supra* notes 173 & 180.

¹⁸⁸ See U.S. CONST. art. I, § 2, cl. 5; U.S. CONST. art. I, § 3, cl. 6-7.

¹⁸⁹ U.S. CONST. art. II, § 2, cl. 2.

¹⁹⁰ Presumably, the adjudicators need not be practicing attorneys. Perhaps it is not even necessary that they be a member of any state bar. Successfully completing three years at an accredited law school likely provides the background knowledge necessary to meet the requirements described in the text.

¹⁹¹ See *supra* paragraph following note 179.

particular area of the law is unnecessary. Rather, the board should have an office of legal counsel to advise the members of the board as appropriate.

10. To retain the continuity of the board, and to minimize the influence of any one president over the composition of the board, the adjudicators either should serve for life¹⁹² or should have long terms with staggered expirations. If the terms expire, they should be renewable so that adjudicators do not feel entitled to abuse the system at the conclusion of their terms without fear of reprisal. Terms should be no shorter than nine years to ensure that the term of each newly-appointed or renewed adjudicator expires during the presidency of a different president, further insulating the adjudicator from politics. To ensure that term expirations remain staggered, some appointments will necessarily be for terms longer than nine years.

Senator Tom Daschle argued in his book about health reform that an advisory board should be created similar to the one I suggest here. He modeled his board after the Board of Governors of the Federal Reserve System (commonly known as the Federal Reserve). I incorporate Daschle's discussion by reference.¹⁹³

11. The first president to preside over the board will necessarily have to appoint all members of the board at once. Even if the members have terms of different lengths, if the shortest term is nine years, the influence of that one president over the health sector will be profound. Accordingly, only one-quarter of the first president's appointments should serve the traditional minimum nine years. The remaining three-quarters of the board, while also passing Senate confirmation, will have terms that expire¹⁹⁴ simultaneously with the conclusion of that president's administration. The next president to come into office will find at least three-quarters of the board vacant. He will be entitled to appoint the next one-quarter of the board and will be able to fill any additional vacancies caused by the removal or expiration of an adjudicator appointed by the prior president with adjudicators who serve no less than nine years. Starting with the fourth president, all appointments to the board will be for no less than nine years.

12. To prevent capture by medical providers and health insurance companies, adjudicators should be barred from hearing cases that directly involve former employers (perhaps defined as those employers for whom the adjudicator worked in the five years prior to joining the board). Adjudicators should be barred from accepting cash or other gifts, including charitable donations made at the request of the adjudicator, from anyone who is likely to appear before them or is associated with anyone who might appear before them. Noncompliance should subject the adjudicator to mandatory removal

¹⁹² A necessity if the court be formed as an Article III court. *See supra* note 173.

¹⁹³ DASCHLE, *supra* note 56, at 169-80.

¹⁹⁴ Judges of Article III courts must have life tenure. U.S. CONST. art. III, § 1. If the adjudicatory board be formed as an Article III court, the judges admitted for terms shorter than life tenure would be appointed for an office other than "judge." Accordingly, only one-quarter of the court would be staffed by actual judges. This creates some interesting questions on the authority of non-judges to sit in an adjudicatory fashion alongside judges. To my knowledge, such questions have never been addressed. I suspect that the court would be properly constituted provided that at least one judge, who will be nominally responsible for the case, sit on every case and that the statute granting the court jurisdiction be drafted in a manner that tolerates such a scheme.

by the board. A specific cause of action should be created subjecting former adjudicators to jurisdiction in the civil courts for forfeiture of the value of goods received or donated by request of the adjudicator. Finally, members of the board should be barred from going to work in the health care industry, whether for a private company or for government, for the five years following their departure from the board. This is important to prevent board members from being particularly generous to particular insurance companies, physician groups, or ranking government officials in the hope of receiving a comfortable job at that employer after leaving the adjudicatory board.

13. The annual budget of the board would likely need to proceed through congressional appropriations. The appropriations process might subject the board to undesirable political pressure. To further insulate the board from politics, adjudicators must have a fixed salary throughout their tenure. Limits on appropriations would affect caseload only and would thus have a limited personal effect on adjudicators. We can limit the risk of congressional backlash and the resulting high caseloads by requiring Congress to appropriate funds for the board at least two years in advance, with the caveat that adjustments within two years of the start of the relevant fiscal year may only increase appropriations, and never by more than 10%. Any retaliation against the board would have no effect on caseload for at least two years. Adjudicators would be able to plan in advance, the executive might be able to appoint more adjudicators, and Congress would have time to reconsider its decision. The 10% limit is important to prevent Congress from appropriating \$1 initially in the knowledge that it will have time to make appropriate adjustments in the year that the money will be spent, thus circumventing this two-year requirement.

VI. CONCLUSION

Providing medical treatment to those who want it has considerable emotive appeal. At the same time, it remains impossible to entitle every person to all desired medical care. Rationing care is necessary. There are three generalized mechanisms to health care rationing – rationing by price, quantity, and prioritization – that are all accompanied with considerable moral difficulty. In light of this difficulty, this paper proposes the incorporation of a moral imperative, the “new moral paradigm,” into rationing decisions. It permits rationing to proceed by ensuring individual patient access to a board of independent adjudicators who have the power and competence to incorporate the patient’s moral code and emotional or irrational preferences into a review of the denial of coverage. While the board will sustain initial denials of access to care in most cases, the existence of meaningful access to appellate procedures is valuable for it enables the patient to express her moral positions so that society is able to review a denial from the perspective of the person to whom the denial matters most. This makes it both less likely that socially intolerable denials will occur and more likely that the results of the rationing scheme will be acceptable to as many people as possible. It also provides comfort to those not sick by ensuring that should they truly need care, they will not be denied access to it without a hearing.

This adjudicatory model thus provides a valuable contribution to health care reform efforts because it minimizes the potential harm from poor policy and makes it easier for those unhappy with prevailing proposals to accept them. It also improves each of the proposals by providing a safety valve that prevents them from reaching morally objectionable results. Moreover, the details of this proposal can be enacted now and will be available in the future, regardless of subsequent changes to prevailing health care delivery mechanisms. Finally, it validates, reinforces, and protects the humanity of each person even in the face of the most tragic of choices.