Health Care Reform

Ethics and Politics

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Chapter Nine

A Cooperative Beneficence Approach to Health Care Reform

Rory B. Weiner

Introduction

Over ten years have passed since President Clinton's failed attempt to reform the United States' health care system. In its wake, federal and state governments have tried to increase access to health care incrementally by passing a new layer of patchwork quilt programs and regulations,[1] and pinning their hopes on the increased expansion of managed care plans and free-market forces.

1. For example, in 1997, Congress created, under title XXI of the Social Security Act, the State Children's Health Insurance Program to provide funds to states to expand health insurance coverage for children. Other examples include the Health Insurance Portability and Accountability Act of 1996, codified at 42 U.S.C. § 300gg *et seq.* (2000), which aims at remedying problems related to employees with pre-existing medical conditions losing health insurance when changing jobs; the Newborns' and Mothers' Health Protection Act of 1996, codified at 29 U.S.C. § 1185 (1999), 42 U.S.C. §§ 300gg-4, 300gg-51 (2000), which prohibits, *inter alia*, a health plan from denying mothers and newborns at least 48 hours in a hospital after a vaginal delivery and 96 hours after a cesarean; the Mental Health Parity Act of 1996, codified at 29 U.S.C. § 1185a (1999), which proscribes group health plans offering mental health benefits from setting annual or lifetime dollar limits on mental health benefits that are lower than those for medical and surgical benefits; the Women's Health and Cancer Rights Act of 1998, codified at 29 U.S.C. § 1185 (2000), which requires health coverage for all stages of reconstructive surgery after mastectomies, including surgery necessary for symmetrical appearance.

The states have also passed legislation to expand access to health care. See Fred Heeling, "The Expanding Scope of State Legislation," *Journal of the American Medical Association* 276 (1996): 1065. See generally, National Health Law Program, *1997 Manual on State and Local Responsibility for Indigent Health Care*, available at www.healthlaw.org (regularly updated).

These strategies have failed miserably. Despite a short-term hiatus in health care inflation and in the uninsured rolls during the economic boom of the late 90s, increases in health care spending and the numbers of uninsured persons has returned with a vengeance. In 2001, the United States' health care spending grew by 8.7 percent to $5,035 per person, and overall spending reached $1.4 trillion.[2] The number of uninsured and underinsured persons increased to over 42 million[3] and 31 million,[4] respectively, making about 73 million Americans inadequately insured.[5]

By contrast, countries that provide universal health insurance spend significantly less than the United States. In 2000, for example, the United States spent $4,631 per person, while Germany spent $2,748, Canada $2,535, Japan $2,012, and the United Kingdom spent $1,763.[6] Although critics of this comparison point out, correctly or not, that other countries ration care by limiting elective procedures, expensive medical intervention, and instituting long waiting lists,

2. By 2010, health care spending will reach $2.6 trillion or 15.9 percent of the gross domestic product (*1997 Manual on State and Local Responsibility for Indigent Health Care*, 193). Moreover, what consumers paid for health care, although stable for a few years, rose by 8.3 percent in 2000 across all health plans types, the largest increase since 1993 [Katherine Levit et al., "Health Care Spending in 1998: Signals of Change," *Health Affairs* 19, no. 1 (2000): 124; and Jon Gabel et al., "Job-Based Health Insurance in 2000: Premiums Rise Sharply while Coverage Grows," *Health Affairs* 19, no. 5 (2000): 144–51].

3. See Center on Budget and Policy Priorities, www.cbpp.org/9-30-02health.htm, analyzing data from the Census Bureau's September 30, 2002 release of data from its Current Population Survey. For data on the trend of the increasing uninsured throughout the 1990s, see Health Insurance Association of America, *Source Book of Health Insurance Data* (Washington, DC: HIAA, 1998), 2.

4. See Gail Shearer, "The Health Care Divide: Unfair Financial Burdens," *Consumer Union* (Washington, DC, 2000): 14. Available at www.consumerunion.org/pdf/divide.pdf. Here the "underinsured" is defined as a person who has private health insurance, yet runs the risk of incurring out-of-pocket expenses (not including premiums) that exceed 10 percent of his or her income in the event of catastrophic illness [Shearer, 14, citing Pamela Farley Short and Jessica S. Banthin, "New Estimates of the Underinsured Younger than 65 Years," *Journal of the American Medical Association* 274, no. 16 (1995): 1302–6].

5. The uninsured include about 8.5 million children. See Center on Budget and Policy Priorities. For data on the trend of increasing uninsured throughout the 1990s, see Health Insurance Association of America, *Source Book of Health Insurance Data*.

6. Gerard A. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Price, Stupid, Why the United States is So Different from Other Countries," *Health Affairs* 22, no. 3 (2003): 91.

these differences in per-person spending actually suggest that such problems would dissolve if these other countries decided to spend as much as the United States on health care. Put another way, if the United States adopted a "system" similar to any one of these other countries and spent just as much as it does now, it might insure everyone without substantially limiting care to anyone.

Why Health Insurance Matters

The importance of having adequate health insurance cannot be overstated. The overwhelming evidence conclusively shows that having health insurance is "an essential component of access to quality health care or to health outcomes."[7] Persons who lack health insurance confront numerous short-term and long-term health, medical, and financial problems.[8] The research on the consequences of inadequate health insurance has consistently made the following findings:[9]

- The uninsured are less likely to have a usual source of care outside the emergency room.
- The uninsured often go without screening and preventive care, which results in poorer health and increased rates of premature death.
- The uninsured often forego or delay needed medical care, which has been found to be particularly dangerous for those with chronic health problems such as heart disease, diabetes, and asthma.
- The uninsured are sicker and die earlier than those with health insurance, making lack of insurance the sixth leading cause of death.

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7. Institute of Medicine, *Care Without Coverage: Too Little Too Late* (Washington, DC: National Academy Press, 2002), ix, chap. 2. See also Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington, DC: National Academy Press, 2001), chap. 1. Also see Office of Technology Assessment, *Does Health Insurance Make a Difference?—Background Paper*, OTA-BP-H-99 (Washington, DC: U.S. Government Printing Office, September 1992), 2.

8. I am not suggesting that lacking health insurance means that a person receives no medical care. In 2001, for example, "uninsured Americans received about $35 billion worth of uncompensated care . . . through a patchwork of hospitals, clinics, physicians, government programs, and private funding" [Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?," *Health Affairs* 22, no. 3 (2003): 13 (available on line at www.healthaffairs.org/WebExclusives/Hadley_Web_Ecl_021203.htm)]. What the evidence shows is that the care that the uninsureds receive is lower in quantity and quality and often times delayed for too long.

9. See, generally, Institute of Medicine, *Care Without Coverage: Too Little Too Late* and *Coverage Matters: Insurance and Health Care.*

- Medical care costs more for the uninsured, and these higher costs cause higher health care costs for the U.S. health care system.[10]

Debating Universal Health Insurance

Despite the overwhelming connection between inadequate health insurance and the above-described health consequences, as a society, we continue to debate whether we should adopt a universal health insurance system.[11] As always, our current debate includes, in part, a perennial moral question: Is access to health care a basic moral right, which the federal government must enforce by enacting the appropriate legislation, or a praiseworthy moral ideal, which it ought to encourage vis-à-vis individual and community volunteerism, but it is under no moral obligation to enact any specific legislation?[12]

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10. *Families USA* (2004): 20–22; see also Institute of Medicine, *Care Without Coverage: Too Little Too Late*, 86–87; see also Karen Donelan, Robert J. Blendon, Craig A. Hill, Catherine Hoffman, Diane Rowland, Martin Frankel, and Drew Altman, "Whatever Happened to the Health Insurance Crisis in the United States? Voices from a National Survey," *Journal of the American Medical Association* 276, no. 16 (1996): 1346–50; J. S. Weissman, C. Gastonia, and A. M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268, no. 17 (1992): 2388–94; R. G. Roetzheim et al., "Effects of Health Insurance and Race on Early Cancer Detection," *Journal of the National Cancer Institute* 91: 1409–15 as cited in *Uninsured in America: A Chart Book* (Washington, DC: Kaiser Family Foundation, May 2000); Office of Technology Assessment, *Does Health Insurance Make a Difference?—Background Paper*; Jack Hadley, Earl Steinberg, and Judith Feder, "Comparison of Uninsured and Privately Insured Hospital Patients," *Journal of the American Medical Association* 265 (1991): 374–79.

11. For purposes of narrowing the discussion, I am assuming that we can have a debate about guaranteeing universal health insurance independently of (and prior to) deciding the level of benefits that this insurance coverage would provide.

12. Many people believe this "moral" question is a legal or a political one as well (or even entirely). For purposes of this chapter, I treat it as a moral question only. I assume, without defending, that ethics is prior to and should inform politics, e.g., legislation [Joel Feinberg, *Harm to Others*, vol. 1 of *Moral Limits to the Criminal Law*, 4 vols. (New York: Oxford University Press, 1984); R. M. Hare, *Essays on Political Morality* (Oxford: Clarendon Press, 1989), chap. 8; John Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971); Robert Nozick, *Anarchy, State, and Utopia* (New York: Basic Books, 1974), ix; Michael Sandel, *Liberalism and the Limits of Justice* (Cambridge: Cambridge University Press, 1982); but cf. Michael Bayles, *Principles of Legislation* (Detroit: Wayne State University Press, 1978), 38–42]. For an analysis of how health care advocates could use state constitutional law to defend a universal legal right to health care, see Rory B. Weiner, "Universal Health Insurance under Equal Protection Law," *Western New England Law Review* 23, no. 2 (2002): 327–79.

Generally, moral arguments that attempt to answer this question take one of three forms. The first is a rights approach. According to a rights approach, individuals have a positive moral right to some decent level of health care and the federal government must protect that right by enacting some kind of universal health insurance legislation.[13] The second is a charity approach. According to the charity approach, individuals do not possess a positive moral right to health care. They only have negative rights which protect them from others doing them harm. Thus, the government is never permitted to force anyone by law to participate in any health care planning; its role is limited to protecting citizens from harm by others.[14] The enforced charity approach is the third theory. According

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13. How a moral theorist defends a positive moral right to health care varies greatly. Some moralists use a strict egalitarian conception of justice to derive this right [Robert M. Veatch, "What Is a 'Just' Health Care Delivery?," in *Ethics and Health Policy*, ed. R. M. Veatch and R. Branson (Cambridge, MA: Ballinger, 1976), 127–53; Gene Outka, "Social Justice and Equal Access to Health Care," in *Ethics and Health Policy*, 79–98; Amy Gutmann, "For and Against Equal Access to Health Care," in *Search for Equity*, ed. R. Bayer, A. Caplan, and N. Daniels (New York: Plenum, 1983), 43–67]. Others use a communitarian conception of justice [Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983), 86ff.]. Others have a pluralistic conception of justice [Charles J. Dougherty, *American Health Care* (Oxford: Oxford University Press, 1988)]. Still others use natural rights arguments [Joseph M. Boyle, Jr., "The Concept of Health and the Right to Health Care," *Social Thought* 3, no. 3 (1977): 10–15]. Others use arguments from enlightened self-interest [Larry Churchill, *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone* (Cambridge, MA: Harvard University Press, 1994)]. Still others use Rawls's liberal egalitarian conception of justice, "justice as fairness," which remains the most powerful theory for defending positive rights [Rawls, *A Theory of Justice*; see Ronald Green, "Health Care and Justice in Contract Theory Perspective," in *Ethics and Health Policy*, 111–26 and "The Priority of Health Care," *Journal of Medicine and Philosophy* 8 (1983): 373–80; Norman Daniels, "Rights to Health Care and Distributive Justice: Programmatic Worries," *Journal of Medicine and Philosophy* 4 (1979): 174–91 and *Just Health Care* (Cambridge: Cambridge University Press, 1985)].

Buchanan provides a brief review of some of the above-mentioned less systematic approaches to defending a right to health care [Alan Buchanan, "Health-Care Delivery and Resource Allocation," in *Medical Ethics*, ed. R. Veatch (Boston: Jones and Barlett, 1989), 293–327], whereas Dougherty provides a summary of how utilitarianism, egalitarianism, libertarianism, and contractarianism might derive a right to health care (Dougherty, *American Health Care*, chaps. 3–6).

14. The charity approach relies on a libertarian conception of justice that Robert Nozick made popular in *Anarchy, State, and Utopia* and which H. Tristram Engelhardt, Jr., defends and uses to reject a moral right to health care [*The Foundations of Bioethics* (New York: Oxford University Press, 1986) and *The Foundations of Bioethics*, 2nd ed. (New York: Oxford University Press, 1996), especially chap. 8]. An early use of this type of libertarianism in health care reform debates was made popular by Robert

to the enforced charity approach, health care is a morally fundamental collective good, and strictly voluntary arrangements for securing it will succumb to common barriers to successful collective action, e.g., the free-rider problem and the assurance problem.[15] Because enforcement is necessary and sufficient for achieving this collective good, the government has prima facie justification to enact the appropriate legislation.[16]

Sade ["Medical Care as a Right: A Refutation," *New England Journal of Medicine* 285 (23) (1971): 1288–92]. Although Nozick changed his views slightly [*The Examined Life* (New York: Simon and Schuster, 1989), 286–87], those who use libertarian arguments to argue for the primacy of markets in the distribution of health care, and against any government interference with those markets, rely on his original libertarian arguments.

15. The free-rider problem occurs when some people drop out of collective action because they believe that because their contribution to the overall project is insignificant, it would be better for them if they "free-ride" on the contributions of others. For example, a free rider will enjoy access to health care that collective action provides, but will not contribute to its success. The assurance problem occurs when some people drop out of the collective action because they believe that others will not participate. Hence, they believe their own participation is futile. Without assurance that others will work with them, these people believe that they ought to work on other projects where the outcome of their efforts is more certain. For a discussion of these two problems with respect to enforcing collective beneficence see Allen Buchanan, "The Right to a Decent Minimum of Health Care," *Philosophy and Public Affairs* 13 (1984): 55–78.

16. See Allen Buchanan, "The Right to a Decent Minimum of Health Care" and "Health-Care Delivery and Resource Allocation," in *Medical Ethics*, 293–327. For deeper theoretical arguments that Buchanan's position presupposes, see his "What's So Special About Rights?," *Social Philosophy and Policy* 2 (1984): 61–83 and "Justice and Charity," *Ethics* 97 (1987): 558–75. Other writers who use non-rights-based principles to argue for universal health care include John Moskop, "Rawlsian Justice and a Human Right to Health Care," *Journal of Medicine and Philosophy* 8 (1983): 329–38 and James F. Childress, "A Right to Health Care?," *Journal of Medicine and Philosophy* 4 (1979): 132–47. They argue that social ideals of decency and humanitarianism, not rights or charity, ought to be the focus of our ethical debate and used, if necessary, to create a legal right to health care. Mark Siegler argues that the use of rights is ambiguous and deleterious to the doctor-patient relationship ["A Right to Health Care: Ambiguity, Professional Responsibility, and Patient Liberty," *Journal of Medicine and Philosophy* 4 (1979): 148–57]. Peter Singer and Beauchamp and Fadan use non-rights-based utilitarian arguments [Peter Singer, "Freedoms and Utilities in the Distribution of Health Care," in *Ethics and Health Policy*, 175–93; Tom L. Beauchamp and Ruth R. Faden, "The Right to Health and the Right to Health Care," *Journal of Medicine and Philosophy* 4 (1979): 108–31]. The President's Commission does as well [President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care*, vol. 1, report, vols. 2 and 3, appendices (Washington, DC: Government Printing Office, 1983)].

A Closer Look at the Enforced Charity Approach

The enforced charity approach aims to challenge three assumptions that underlie the debate between the rights approach and the charity approach: (1) that justifying universal health care legislation necessarily requires establishing an antecedent moral right to health care; (2) that only securing moral rights justifies using governmental coercive power; and, importantly, (3) that making progress toward health care reform requires a convincing defense of a right to health care.[17] Thus, the enforced charity approach aims to avoid the debate among competing conceptions of justice (Rawlsian versus libertarian, for example) without conceding that no arguments exist to support universal health care legislation.

Although I will support its strategy, the enforced charity approach is too weak to justify universal insurance legislation. The enforced charity approach assumes that we can justify coercing people to participate in collective charity only because it assumes that those people are genuinely benevolent and wish to participate, but that their beneficent actions are undermined by the actions (or

Beauchamp and Childress also argue that individuals have a moral right to health care because the government should protect us from the threats of disease like it does from fire or crime, and, echoing Daniels in *Just Health Care*, because meeting health care needs is necessary for guaranteeing fair equality of opportunity [Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 3rd ed. (New York: Oxford University Press, 1989), 176ff.]. They believe that their moral arguments are extensionally equivalent with the Engelhardt's two-tiered policy solution (*The Foundations of Bioethics*, 2nd ed., chap. 8).

Leonard Fleck argues that the President's Commission relies on Engelhardt's libertarian argument for its conclusions [Leonard M. Fleck, "Just Health Care (I): Is Beneficence Enough?," *Theoretical Medicine* 10 (1989): 167–82]. Engelhardt uses a principle of limited beneficence to justify creating a legal right to some minimum level of health care for all. Although Engelhardt's conclusions resemble the President's Commission's (and Buchanan's), his arguments do not. Engelhardt's view is an example of the charity approach because his argument *is not neutral* with respect to whether or not justice guarantees individuals a moral right to health care. Engelhardt's libertarian theory of justice explicitly rejects such a right. For a critical analysis of Engelhardt's principles of bioethics and their application to health care policy, see Rory Weiner, "Beyond Forbearance as the Moral Foundation for a Health Care System: An Analysis of Engelhardt's Principles of Bioethics," in *Reading Engelhardt: Essays on the Thought of H. Tristram Engelhardt, Jr.*, ed. Brendan Minogue, Gabriel Palmer-Fernandez, and James E. Reagan (Dordrecht: Kluwer Academic Publishing, 1997), 113–38.

17. Buchanan, "Health-Care Delivery and Resource Allocation," 322; "What's So Special About Rights?".

inactions) of other persons.[18] Yet, imagine arguing for enforcing collective efforts to end racism and sexism only among the genuinely nonracist and nonsexist, or enforcing collective efforts to reduce industrial pollution only among the genuinely nonmaleficent. We justify enforcing these collective aims not merely to ensure coordination among the nonmaleficent, but to secure what the efforts' underlying moral principles prescribe.[19]

Similarly, to use a principle of beneficence to justify enforcing a universal health care system, we must defend a principle of beneficence that makes cooperating for the benefit of others obligatory. This principle must justify a level of beneficence that we can reasonably require from everyone, independently of whether each person is genuinely beneficent, and especially because many individuals are not. This principle would prescribe duties that individuals have in cooperative efforts as a moral requirement, and not merely as a charitable (voluntary) ideal. Thus, it would require each able person to cooperate in beneficent efforts, and its legal enforcement would be grounded in the moral importance of its content and not merely in the practical importance of its coordination.

My aim, then, is to advance the enforced charity approach one step further by offering some arguments for amending both the theory underlying and the practice associated with the principle of beneficence. I will defend what I call "a principle of cooperative beneficence," which prescribes some cooperative beneficent behavior as obligatory, such as cooperating in a plan that guarantees universal health insurance. Moreover, I will derive from the principle of cooperative beneficence principle three subprinciples to evaluate different health care plans. Although I will not evaluate any specific current policy or plan, I will show how to use these subprinciples as guidelines to evaluate competing proposals.

Part 1: The Principle of Cooperative Beneficence

The principle of cooperative beneficence (PCB) is an extension of the widely accepted duty of individual beneficence. Individual beneficence requires one to make a sacrifice for the benefit of another provided that the sacrifice does not pose an unreasonable risk to one's self or undermine one's existing duties of

18. Buchanan, "The Right to a Decent Minimum of Health Care," 73.

19. One might argue that in those cases, individuals have rights against others not to discriminate, or not to pollute, which provides us with a good reason to enforce coordination. However, my point is that the reason that they have rights is a function of the underlying moral rules, "Don't discriminate" or "Don't pollute," and enforcing these rules not only coordinates nondiscrimination or nonpollution goals, but it also functions to express the moral importance of each.

equal or greater weight.[20] The paradigm case is still the one Peter Singer presented: should you rescue a child who has fallen in a shallow pond and is in danger of drowning if doing so only costs you a dry cleaning bill? Presumptively, the answer is "yes" because compared to the loss of life, this cleaning cost is insignificant.[21] Although more prevalent in continental Europe and Latin America,[22] a handful of American states have enacted "good Samaritan" laws, which require

20. Both deontologists and consequentialists support a duty of individual beneficence. Regarding deontologists, see Immanuel Kant, *Groundwork of the Metaphysics of Morals*, trans. H. J. Paton (New York: Harper, 1964), 90–91; Immanuel Kant, *The Doctrine of Virtue: Part II of the Metaphysics of Morals*, trans. M. J. McGregor (Philadelphia: University of Pennsylvania Press, 1964), 120–21, 452f.; W. D. Ross, *The Right and the Good* (Cambridge: Hacking Publishing Co., 1988), 21, 23; Rawls, *A Theory of Justice*, 114; Dan Brock, "Utilitarianism and Aiding Others," in *The Limits of Utilitarianism*, ed. Harlan B. Miller and William H. Williams (Minneapolis: University of Minneapolis Press, 1982), 231; Alan Gewirth, *Reason and Morality* (Chicago: University of Chicago Press, 1978), 217ff.; Charles Fried, *Right and Wrong* (Cambridge, MA: Harvard University Press, 1978), 128–30; Feinberg, *Harm to Others*, chap. 4. For a discussion of how Kant's and Mill's moral theories support a duty of individual beneficence, see Rory B. Weiner, "Cooperative Beneficence and the Macroallocation of Health Care in the United States" (PhD diss., University of Florida, 1993): chaps. 3 and 4.

Regarding consequentialists, see J. S. Mill, *Utilitarianism* (New York: Prometheus Books, 1987), chap. 5, ¶¶ 15, 25, 37; *On Liberty* (New York: Prometheus Books, 1986), chap. 1, ¶¶ 3 and 12; R. M. Hare, *Moral Thinking* (Oxford: Oxford University Press, 1981); Peter Singer, "Famine, Affluence and Morality," *Philosophy and Public Affairs* 1 (1972): 229–43; Derek Parfit, *Reasons and Persons* (New York: Oxford University Press, 1984), 70–86; Shelly Kagan, *The Limits of Morality* (Oxford: Oxford University Press, 1989); Beauchamp and Childress, *Principles of Biomedical Ethics*, 200ff.; see also William Frankena, "Beneficence/Benevolence," *Social Philosophy and Policy* 4 (1987): 1–20, and Alan Buchanan, "Philosophical Foundations of Beneficence," in *Beneficence and Health Care*, ed. E. Shelp (Dordrecht: Reidel, 1982), 33–62 for discussions and overviews of the concept of beneficence.

21. Singer, "Famine, Affluence and Morality." Some moral philosophers argue that the person in danger has a moral right to our aid and so such cases fall under principles of justice (see Feinberg, *Harm to Others*). Nevertheless, it still makes sense to say that in these cases, a person ought to save a drowning boy whether or not we can establish that he has a right to (is owed) the benefactor's aid. The fact that some moral philosophers insist on aligning legally enforcing easy rescue cases with individual rights may merely reflect the persistent assumption that legal enforcement is not justified unless individual rights are at stake. Patricia Smith defends positive duties by developing a theory of special positive duties that arise from special relationships—such as familial, professional or contractual—so as to categorize these positive duties as duties of justice with correlative rights [*Liberalism and Affirmative Obligations* (Oxford: Oxford University Press, 1998)].

22. Smith, *Liberalism and Affirmative Obligations*, 233, n. 2.

one to rescue another in emergencies, or at least contact the appropriate emergency services, when the risk to the rescuer is minimal.[23] These laws express the moral importance of acts of individual beneficence.

Like the duty of individual beneficence, PCB focuses on "beneficence" rather than "benevolence" to stress, as W. D. Ross explains, "that it is our duty to do certain things, and not [our duty] to do them from a certain motive," or to feel any particular way.[24] In addition, like the duty of individual beneficence, the PCB prescribes that one give active aid to prevent severe harm or premature death rather than merely providing a gift or a favor, which is merely a meritorious nonduty.[25]

The essential difference between PCB and the duty of individual beneficence in that the PCB is applicable under circumstances where successfully preventing severe harm or death from befalling another requires the collaboration of many

23. See, e.g., Vt. Stat., tit. 12 § 519; Minnesota, Stat. §§ 605.05, 609.02; Massachusetts, Gen. Laws chap. 268 § 40; Rhode Island, R. I. Gen. Laws §§ 11-37-3.1, 3.3 and 11-56-1 1984; Wisconsin, Wis. Stat. § 940.34[1],[2]). For some philosophical discussion on these laws and enforcing the duty of rescue generally, see Feinberg, *Harm to Others*, chap. 4; Alison McIntyre, "Guilty Bystanders? On the Legitimacy of Duty to Rescue Statues," *Philosophy and Public Affairs* 23 (1994): 157–91; H. M. Malm, "Liberalism, Bad Samaritan Law, and Legal Paternalism," *Ethics* 106, no. 1 (1995): 4–31; Smith, *Liberalism and Affirmative Obligations*, chap. 2.

In addition to good Samaritan laws, there are twenty-three states that have some form of state constitutional provision for assisting the poor. See, e.g., NC Const. art. 11 § 4 providing that "beneficent provisions for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and Christian state"; NY Const. art 17, § 1 stating that "the aid, care and support of the needy are public concerns and shall be provided by the state." See, generally, William C. Rava who analyzes twenty-three state constitutional provisions for the poor ["State Constitutional Protections for the Poor," *Temple Law Review* 71 (1998): nn. 99, 119, 127, 138].

24. Ross, *The Right and the Good*, 23, emphasis added. See also Frankena who writes "benevolence involves ways of feeling, thinking, and willing. Bene*ficence*, is different; it does not necessarily involve feeling, thought or will. The sun can be beneficent, or a climate or an institution. Something is beneficent if it tends actually to do or produce good and not evil, whether it is benevolent or not. . . . Benevolence is a matter of intention, not of outcome; beneficence is one of outcome, not intention, though it may be intentional" ("Beneficence/Benevolence," 2).

25. I am merely following the analysis of Joel Feinberg in which he distinguishes at least these two senses of "to benefit" another: (1) to advance another's "declining interest back up to or toward his normal baseline," or by preventing it from "falling below that baseline," as when one prevents severe harm or (premature) death from befalling another as when one rescues the child from drowning in the pond; and (2) to advance "another's interest to a point beyond his normal baseline," or by producing a "net gain, profit, advantage etc." as when one gives another spare change for a pay phone or gives another traveling directions (assuming no one's life or limb is in danger) (*Harm to Others*, 139).

people. For example, to prevent successfully the above-described harms associated with people with no health insurance, we need collective or collaborative efforts. The PCB prescribes that each person makes some sacrifice together with others as part of a cooperative effort to prevent severe harm or death.[26] In other words, PCB prescribes a duty of individual beneficence writ large.

The PCB requires additional clarification because a cooperative effort that prevents severe harm or death might be too demanding for individual participants because one can always prevent more harm—giving one more dollar can always prevent harm or a death. In other words, even our sacrifice together with others (i.e., our collective sacrifices) could add up to oppressive demands because any goal to prevent severe harm may require endless giving.[27] Because a PCB might be too demanding, opponents of duties of beneficence argue that at best what the PCB may prescribe is a voluntary moral ideal—the Kantian imperfect duty of charity.

The PCB can overcome this demandingness objection and preserve the obligatoriness of individual beneficence by limiting the demands that it places on people who cooperate in beneficent efforts. The PCB prescribes one of many

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Also, the principle of individual beneficence as used here does not presuppose any special relationship between the benefactor and the beneficiary, such as a familial, professional, or contractual relationship that would create a positive duty to aid. The principle here expresses a general duty of beneficence, namely, what we ought to do to benefit another person *qua* person, and not a special duty of beneficence. In other words, I am not assuming that to defend a positive duty to aid it must be grounded in some special relationship as some have argued it must. See Smith, *Liberalism and Affirmative Obligations.*

26. Derek Parfit nicely articulates this point: "Even if an act harms no one, this act may be wrong because it is one of a *set* of acts that *together* harm other people. *Similarly,* even if some act benefits no one, it can be what someone ought to do, because it is one of a set of acts that together benefit other people" (*Reasons and Persons,* 70, emphasis added). The principle of cooperative beneficence incorporates Parfit's point: even if our (particular) beneficent act does not prevent a severe harm or death, we may still be required to perform it if it is one of a set of acts that *together* would prevent severe harm or death. Cf. Liam Murphy, "The Demands of Beneficence," *Philosophy and Public Affairs* 22, no. 4 (1993): 285.

27. For a discussion of this "slippery slope" problem, see James Fishkin, *The Limits of Obligation* (New York: Yale University Press, 1982). For a discussion of this problem in the context of international famine relief, see Peter Singer, *Practical Ethics,* 2nd ed. (Cambridge: Cambridge University Press, 1991), 218–46. For an objection that Singer's argument imposes too high a standard, see Susan Wolf, "Moral Saints," *Journal of Philosophy* 79 (1982): 419–39. For a defense of an ethic without limits (a pure impartialist ethic), see Kagan, *The Limits of Morality.* For a general discussion of the demandingness of beneficence and surrounding literature, see Murphy, "The Demands of Beneficence."

moral duties that each of us has; and although it deserves a proper place in our set of moral duties, it does not automatically override other duties in the set, as no duty should. In other words, the duty to cooperate in collective beneficent efforts is a prima facie duty that is limited, in part, by the weight of other prima facie moral requirements or options that we have.[28] For example, the duty to cooperate must compete with our contractual or parental and professional duties or with our liberty interests to pursue our legitimate personal projects and relationships.

The principle of cooperative beneficence should not require overriding all other moral duties or liberties because the average person would rarely, if ever, follow such a requirement.[29] A rule or principle that ordinary people cannot follow on a regular basis cannot prescribe obligations; at best it can suggest moral ideals. As explained more fully below, the PCB prescribes duties that people like us are able to follow.

What distinguishes moral rules, which prescribe obligatory acts, from moral ideals, which prescribe heroic or voluntary acts, centers on whether ordinary people like us are genuinely capable of following the rule.[30] One is "genuinely

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28. Samuel Scheffler argues that we should recognize "agent-centered prerogatives," which would limit morality's demands, because they would allow one to give his interests disproportionate weight such that he is always permitted to promote the good but not always required to do so [*The Rejection of Consequentialism* (Oxford: Oxford University Press, 1992), 62ff.].

29. Hare, *Essays on Political Morality*, 237 and J. O. Urmson, "Saints and Heroes," in *Essays in Moral Philosophy*, ed. A. I. Melden (Seattle: Washington University Press, 1958), 198–216. Even Kagan, who defends an ethic without limits, appears to distinguish between a principle of morality as an ideal and what is realistic to expect in practice as obligatory. For example, he writes, "It may be that the full pursuit of the good is a limit which few if any of us can attain, and to which we can only aspire. But *it is a direction* in which we can move, and may try to go *as far as we are able. And this,* I believe, *we are morally required to do*" (*The Limits of Morality*, 403, emphasis added). In other words, spending all of our time promoting the good, although an ideal, is not morally required because few, if any, have the capacity to do that. What people have the capacity to do, and thus what they are required to do, is take a small step together with others toward that ideal. Kagan, however, would probably reject this argument (*The Limits of Morality*, chap. 7), but Michael E. Bateman defends moral options by arguing that although it may be possible for each person to transform his or her personal rankings of what is important to do for the overall good, it is not likely given "the sort of beings" we are ["Kagan on the 'Appeal to Cost,'" *Ethics* 104 (1994): 331]; cf. Thomas Nagel, *Equality and Partiality* (New York: Oxford University Press, 1991).

30. Weiner, "Cooperative Beneficence and the Macroallocation of Health Care in the United States," 135–51 and "Cooperative Beneficence and Professional Obligations," *Professional Ethics: A Multidisciplinary Journal* 3, nos. 3 & 4 (1994): 84–87.

capable of following a rule" when a rule prescribes a duty that one can complete or discharge, when a rule prescribes a duty that is not too demanding, and when a rule is essential for securing shared vital interests, such as being helped when severe harm or premature death is in the offing. The rule that prescribes one to cooperate in large-scale beneficent efforts is obligatory, the following argues, because ordinary people with ordinary capacities can follow it. It does not require endless giving, but rather to do one's part by fulfilling a reasonable, well-defined equitable role toward accomplishing some level of relief.[31] In other words, the principle's three features—that a person's role be reasonable, well-defined, and equitable—makes one's cooperative behavior obligatory by making the act that the principle prescribes dischargeable (it is well-defined) and not too demanding (reasonable and equitable) for people like us.[32]

The following will elaborate on the principle and its three central features. The principle prescribes that each able individual ought to cooperate, with whoever else is cooperating, by fulfilling some reasonable, well-defined equitable role toward preventing severe harm or premature death, given the behavior of people who do not cooperate.[33] By "fulfilling" a cooperative role, I mean contributing positively toward its success, which in most cases simply involves doing one's part. For persons with special skills and knowledge, this may involve initiating the effort. By "reasonable," I mean a role that does not force a person to compromise his (or her) existing (legitimate) roles of equal and greater weight, such as one's (legitimate) parental or professional roles. By "well-defined," I mean a role that one can easily understand and complete. By "equitable," I mean a role whose demands are roughly similar to others with relevantly similar capacities and existing social roles. Thus, persons who voluntarily do more than their reasonable, well-defined, equitable role act heroically; these are persons who accept roles that require more than we can expect from anyone else similarly situated, such as Martin Luther King's role in the civil rights movement.

Limiting one's cooperative role to being reasonable, well-defined, and equitable is what makes fulfilling the role a moral obligation and not merely a praiseworthy

31. In principle, the collective limit (i.e., the limit of the collective moral requirement) is a function of the combined limits of individual cooperative roles, which themselves are a function of ordinary human capacities and competing duties.
32. Urmson, "Saints and Heroes," 212; Peter Singer, *The Expanding Circle: Ethics & Sociobiology* (New York: Farrar, 1981), 157–60; Nagel, *Equality and Partiality*, chap. 10.
33. Donald Regan provides an enormously helpful analysis of the concept of cooperation and the following is influenced by it [*Utilitarianism and Co-operation* (New York: Oxford University Press, 1980), 124ff.]. Regarding the cooperative principle, see also Parfit, *Reasons and Persons*, 30–31, 77ff.; cf. Murphy, "The Demands of Beneficence," 280. Regarding the concept of cooperation see also Robert Axelrod, *The Evolution of Cooperation* (New York: Basic Books, 1984).

ideal or act of charity.[34] To reform the U.S. health care system, for example, would require the cooperation of citizens (when healthy or sick), health care professionals at all levels, the private health care industry (at all levels), the business community, the private health insurance industry, and local, state, and federal governments. Yet each potential cooperator (any ordinary person) may have various beliefs that could undermine her capacity to cooperate. For example, she may believe (1) that her efforts are insignificant, so her omission makes no difference; (2) that she does not need to act because others will—the so-called "bystander effect";[35] (3) that her efforts will be wasted or pointless because others might not cooperate, i.e., she will believe that no chance exists for overall success; (4) that the cooperative goal might force her to sacrifice other duties of equal or greater weight or force her to give up her personal projects and relationships; and (5) that others (noncooperators) will take advantage of her and she will be left with a disproportionate amount of the burden.

Cooperators also face overwhelming strategic difficulties. Cooperation, as Donald Regan reminds us, involves "a potentially infinite hierarchy of reciprocal beliefs." Thus there are an "[infinite number] of ways in which cooperation can break down."[36] Cooperation "is not [merely] a matter of correct behavior," explains Regan, "but certain attitudes and beliefs as well."[37]

The realities that might undermine effective cooperation are serious, and some have underestimated them.[38] If fulfilling one's cooperative role is to be held out as a moral obligation—if the average person is able to follow it—then it must overcome these motivational and strategic difficulties. If it does not, then only the most dedicated people will cooperate. In fact, we typically assign heroic status to people who continue to cooperate against all odds of success or irrespective of the compliance of others. But not everybody is willing to act like that. Because obligatory acts are acts that we can realistically expect almost everybody to perform, our principle of cooperative beneficence must take these difficulties seriously and overcome them.

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34. Reasonable people recognize that cooperation in general is necessary and effective for maintaining our legal, political, and economic institutions. Although each individual's motives for cooperating in these institutions may vary, to prosper they require the cooperation of a sufficient number of people.

35. When there are so many observers to an emergency, psychologists speculate that a bystander is unlikely to help because, in part, her personal responsibility is diffused by thinking that someone else will help or perhaps someone already has. With most bystanders thinking this way, no one helps. See Robert B. Cialdini, *Influence: The New Psychology of Modern Persuasion* (New York: Quill, 1984), 132.

36. Regan, *Utilitarianism and Co-operation*, 129–30.

37. Regan, *Utilitarianism and Co-operation*, 124.

38. Singer, *Practical Ethics*, 232f.; James Rachels, "Killing and Starving to Death," *Philosophy* 54 (1979): 159–71.

The principle of cooperative beneficence overcomes these difficulties in the following way. Regarding the strategic difficulties, Donald Regan points out that the cooperators need only "share a minimum corpus of correct beliefs" about other cooperators. He claims that

> . . . something less than this infinity of beliefs will suffice. As long as each putative co-operator is properly motivated and has some minimum complement of correct beliefs from the lower levels of the hierarchy (say perhaps a correct understanding of the basic structure of the case and an *awareness* [emphases added] that the others are properly motivated and understand the basic structure of the case), and so long as none of the putative co-operators entertain any false beliefs from a higher level of the hierarchy, then we should be willing to say that they are co-operating.[39]

Robert Axelrod, in his study of the evolution and practice of cooperation, also reports that cooperation will emerge and remain stable only if cooperators' have a basic understanding of their roles, of the roles of other cooperators, and if they are sufficiently motivated.[40] Thus, we can reasonably expect ordinary people to fulfill their roles if their roles are simple and understandable and if cooperators are aware of other cooperators who are properly motivated.

Limiting the role that the principle of cooperative beneficence prescribes to one that is reasonable, well-defined, and equitable helps overcome strategic and motivational problems, making one's role easy to follow. For example, by requiring individuals to perform some well-defined role with others who are doing similarly, cooperators may no longer believe that their efforts are insignificant or that they will carry the entire burden. Cooperative efforts to help the environment provide evidence that ordinary people are more likely to do their part when given reasonable, well-defined, equitable roles, and when they have an awareness that others are doing similarly. Amazingly, people today are separating their various metal, plastic, and paper containers and placing them in convenient recycling bins outside their homes or offices. These activities are "amazing" because the project's initiators were able to motivate individuals who not long ago were very doubtful of cooperating. This success, one might argue, results from making each person's role in the project clear and reasonable, and from providing an awareness that others are cooperating. (The high visibility of recycling paraphernalia makes that clear.) Thus, making one's role well-defined, by giving people something to focus on, with clear directions, and providing an awareness that others are acting similarly, a cooperator's motivation to contribute increases, and that leads to cooperative success—for example, a cleaner environment.[41]

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39. Regan, *Utilitarianism and Co-operation,* 130.
40. Axelrod, *The Evolution of Cooperation,* especially chap. 7.
41. Axelrod, *The Evolution of Cooperation,* 118, 121ff.

Prescribing equitable roles also helps overcome motivational difficulties. Generally, cooperators show an interest in comparing their own efforts to those of other cooperators in the context of large-scale cooperative efforts. Significant differences in sacrifices among similarly situated cooperators undermines a cooperator's motivation to continue participating because he believes others are treating him unfairly or others are taking advantage of him.[42] By requiring an equitable role, the principle assures each cooperator that he (she) is being treated fairly; in other words, the principle values his (her) individual dignity by treating him (her) as an equal.[43] Most people, I assume, do not mind making sacrifices if what they sacrifice is similar to what others are sacrificing and if they have a good reason to believe others are not taking advantage of them.

Requiring reasonable roles also helps overcome motivational problems because it assures cooperators that their roles will not be excessive, either from an overambitious project or from others not doing their part. In other words, the principle of cooperative beneficence forbids the noncompliance by others to cause unreasonable demands on those complying because doing so would be counterproductive.[44] We cannot expect ordinary people with ordinary capacities to cooperate if doing so would force them to sacrifice their personal and/or (legitimate) professional roles, their personal projects or relationships, or if doing so would simply wear them out. If I am correct in assuming that morality generally includes prima facie duties associated with such relationships, then the cooperative principle must take them seriously if ordinary people are to follow it. Given these considerations, then, I believe that the principle of cooperative beneficence prescribes a cooperative role as obligatory when the role is reasonable, well-defined, and equitable.

Part 2: Cooperative Beneficence and Health Care Policy

Part 1 of this chapter argued for a principle of cooperative beneficence that prescribes a moral duty of beneficence to cooperate in collective efforts that

42. Peter Singer, *How Are We to Live: Ethics in an Age of Self-Interest* (New York: Promethus, 1995), 24–25; Robert N. Bellah, Richard Madsen, William M. Sullivan, Ann Swidler, and Steven M. Tipton, *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985), 16.

43. But the equitable role does more than this: it limits the cooperator's role to an amount that would be fair under full compliance. Parfit has pointed out, however, that if all cooperators' demands increase *the same* because of the noncompliance of others then we do not necessarily treat any particular cooperator unfairly (Murphy, "The Demands of Beneficence"). However, Dan Brock argues that it is unfair to increase the demands on some because of the indifference of others ["Defending Moral Options," *Philosophy and Phenomenological Research* 51 (1991): 912–13].

44. Murphy, "The Demands of Beneficence."

prevent severe harm and premature death only if one's duty is limited to fulfilling a reasonable, well-defined, equitable role. In Part 2, this chapter explains how policymakers can use the principle of cooperative beneficence to evaluate health care reform policies. It will do this by suggesting that the principle of cooperative beneficence generates three subprinciples for evaluating health care policies. I want to stress, however, that I will not provide any formal proof for how these subprinciples derive from the principle of cooperative beneficence; I am merely suggesting that they do. Moreover, the subprinciples and their use to evaluate health care policies will not provide a definitive answer to what is the best policy. Numerous possible cooperative designs (or patterns of cooperation) exist that could comply with the principle of cooperative beneficence and its subprinciples. The subprinciples provide a framework within which policymakers can identify types of plans that comply more favorably with our duty to cooperate.

Applying the principle of cooperative beneficence requires that we evaluate a cooperative effort for (1) its ability to achieve its beneficent goal, such as preventing severe harm from the lack of or inadequate access to health care, and (2) its ability to respect the limits of its cooperators' roles, namely that they must be reasonable, well-defined, and equitable.[45] Thus, the following sections divide the task of evaluating a cooperative effort into the following three subprinciples. The first centers mostly on the practical aspects of cooperative success, and I will refer to it as a "basic design principle."[46] This subprinciple identifies certain elements of a plan that are important for its success. The second and third subprinciples center mostly on the moral limits of the cooperative effort. The second subprinciple

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45. To some extent (1) and (2) overlap because respecting the reasonableness and fairness of a cooperator's role is crucial to the success of the beneficent effort. In other words, respecting the limits of a cooperator's role not only affects whether he has a duty to cooperate, but whether he might stop cooperating and undermine success. Nevertheless, for ease of exposition, I want to keep separate evaluating a cooperative effort for its ability to achieve its goal, which is mostly a practical evaluation, and evaluating its ability to respect the limits of its participants' roles, which is mostly a moral evaluation.

46. I began seriously thinking about the need to derive subprinciples from the principle of cooperative beneficence after attending a talk by Norman Daniels at the University of Florida in February 1993, where he used his "design principles," which he derived from his theory of justice in health care, to compare different health care reform proposals ("Justice and the Assessment of National Health Care Reform Proposals," Dana-Farber Conference on National Health Care Reform, March 1993). I want to acknowledge my indebtedness to his influence on how to apply theory to practice. For the most recent application of his theory, see Norman Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness for Health Care Reform* (New York: Oxford University Press, 1996), chaps. 4 and 5.

I call a "fair cooperative effort principle," and it will evaluate how the effort distributes the burdens necessary to achieve its goal. I call the third a "reasonable burden principle," and it will evaluate the level of burden imposed on each cooperator. The following will discuss the three subprinciples in turn.

Basic Design Principle

The first subprinciple, which follows from the principle of cooperative beneficence, is the basic design principle. It states: A cooperative beneficent effort should be simple, stable, universal, and it should comply with the fair cooperative effort principle and the reasonable burden principle. Whatever our collective aim (e.g., reducing homelessness, starvation, illiteracy, pollution, or medical poverty), a basic design exists which is most effective for achieving that aim. The basic design principle identifies certain elements that a cooperative beneficent effort (in our case, a health care system) must contain to achieve its goal. If a cooperator's role is obligatory because it is followable, as mentioned above, then cooperators must believe that the cooperative effort has a realistic chance for success. In other words, even if a cooperator's role is reasonable and fair, she must also believe that participating is not simply a waste of time. Thus, the basic design must have, and cooperators must have good reason to believe that it has, a realistic chance for success over the long run. Let me suggest, then, that a successful cooperative beneficent effort generally and a health care reform policy specifically should contain the following design elements for guiding its basic design: simplicity, stability, and universality.

Simplicity

First, our cooperative effort's basic design should be simple. A simple design is more likely to include clear, well-defined roles and be easy to understand. With clear, well-defined roles and an understandable basic design, a cooperator will know what the overall effort expects from her and can compare her role with the roles of others. These comparisons promote public scrutiny of obvious inequities and of noncompliance. Thus, simplicity promotes well-defined roles and an awareness of what the effort expects from each cooperator; importantly, this "cooperative awareness" provides assurance among cooperators that enough others are doing their part, i.e., making similar sacrifices.[47]

47. Recall that in order to overcome difficulties that might undermine a person's capacity to cooperate in large-scale cooperative efforts, cooperators need to share a correct understanding of the effort's basic structure and an awareness that enough others are cooperating (or that a realistic chance exists that they will).

A simple design will also be more responsive to defectors.[48] It allows cooperators to respond more quickly to fraud, abuse, noncompliance, and so on because simplicity facilitates cooperative awareness. Over time, defections can be kept to a minimum because public awareness makes cooperators account for their actions (or inactions). Generally, then, cooperators will know that others will quickly detect and respond to defections. Quick detection and response is essential for effective, stable cooperation over the long run.[49]

An effective cooperative beneficent effort, then, should have a simple design with devices that promote cooperative awareness. A health care reform plan would promote design simplicity and cooperative awareness if it included the following features: (1) administration simplicity, such as standardized insurance forms, billing, coding, and payment mechanisms, and a uniform benefit package; (2) access simplicity, such as a universal insurance card as eligibility for the uniform benefit package, which would be valid at any hospital for any physician and not subject to exclusionary practices for preexisting conditions; and (3) finance simplicity, such as using a single (and simple) progressive health care tax instead of a myriad of different insurance premiums, deductibles, co-payments, and tax incentives and disincentives.[50] These simplicity devices promote cooperative awareness by making the basic design more explicit. Such devices function like the recycling paraphernalia we see in grocery stores, in offices, on sidewalks, etc. They remind us that everyone is working together for a common goal and that each person has a specific role to play that is relatively similar to the role of others. (I will say more about the distribution of roles below.)

For evaluating a health care reform policy for simplicity, a policymaker should ask the following questions:

- Is the basic design simple enough for a typical cooperator to understand how it works?
- Is it easy for a cooperator to understand what the plan expects from her?
- Is it easy for a cooperator to understand what the plan expects from others?
- Does the basic design include, or strongly promote, simplicity in administration, access, and financing?

Simplicity, then, is a virtue for cooperative beneficent efforts generally and a health care system in particular. A health care system should be, according to the principle of cooperative beneficence, as simple as possible, *ceteris paribus*.

48. Axelrod, *The Evolution of Cooperation*, 184ff.
49. Axelrod, *The Evolution of Cooperation*, 54, 121ff., 139ff., 185.
50. See Congressional Budget Office, *Estimates of Health Care Proposals from the 102nd Congress* (Washington, DC: U.S. Government Printing Office, 1993). I should note that with finance simplicity, the simplest design may not be the most preferred. For example, arguably a flat tax is simpler than a progressive tax, but, according to some, it is not fairer.

Stability

In addition to simplicity, to be effective, a cooperative beneficent effort's basic design must promote and maintain a stable pattern of cooperation.[51] The principal device for stability is cooperative motivation. To facilitate cooperative motivation, the basic design must include devices that secure both "motivational stamina" and "motivational assurance." In other words, the cooperative effort must neither wear out cooperators nor make them insecure about the commitment of others, i.e., the assurance that enough others are similarly motivated to cooperate.[52]

The following discusses motivational assurance and motivational stamina, respectively. To secure cooperative motivation, the basic design should assure each cooperator that, regardless of his or her own source of motivation, the effort will continue to motivate enough other people. We can supply this "motivational assurance" if our basic design makes cooperators have a personal stake in its success. This claim does not assume that all cooperators are enlightened egoists, i.e., persons who act only to produce benefits for themselves in the long run. It merely assumes that regardless of one's motives for cooperating—a desire to benefit one's self or a desire to benefit others—one must have some assurance that the effort motivates enough other people.[53] Even a dedicated altruist's motivation would decline if he knew that few others were motivated to help. Thus, to assure each cooperator that enough others will remain motivated, the basic design should include devices that give cooperators a personal stake in the effort's success.

Cooperators will have a stake in a health care system's success if it promotes broad-based participation, i.e., broad-based use of the benefits it aims to provide. For example, not only should everyone contribute to guaranteeing universal

51. Rawls, *A Theory of Justice*, 176–82, chap. 9 and *Political Liberalism* (New York: Columbia University Press, 1993), 316ff. Rawls takes the importance of stable cooperation over time as essential for his conception of justice and his moral theory generally. For example, he tests his theory of justice against relevant moral and social facts in the psychological and evolutionary sciences, not to justify his theory per se, but, he says, "[to] simply [check] whether the conception [of justice] already adopted is a feasible one and *not so unstable that some other choice might be better*" (*A Theory of Justice*, 504, emphasis added). He is not concerned with whether or not it is the most stable, but, he says, "stable enough." See also Brian Barry, *Justice as Impartiality* (New York: Oxford University Press, 1995), 51.

52. Simplicity will play a major role here; a simple design facilitates cooperative awareness and prevents individual roles from getting complex and ambiguous, which would undermine cooperative motivation. But simplicity is not sufficient to sustain cooperative motivation in the long run.

53. Axelrod, *The Evolution of Cooperation*, 7. But cf. Barry, *Justice as Impartiality*, 51, chap. 3.

access to medical care,[54] but the health care system must produce medical benefits that are attractive enough so that nearly everyone would want to use them. Its basic tier, if more than one exists, should be large enough, say over 60 percent of the population, to ensure that it motivates enough people in the long run. With everyone contributing to and most using its basic services, more people will properly monitor the system for effectiveness and quality, and more people will protect the system politically. Thus, with a stake in the effort's success, cooperators have better assurance that others will continue to help make it work.[55]

In addition to motivational assurance, to secure cooperative motivation, hence stability, the basic design must preserve "motivational stamina." Cooperators' roles must not only start as reasonable, but they must remain reasonable over time. A cooperative effort that cannot manage its growth will simply wear out the cooperators, which is counterproductive. For a health care system this means that the basic design must include strategies for effective growth management (or cost containment) over the long run.

Unfortunately, there is very little agreement over what strategies best control a health care system's growth.[56] For example, some aim to cut costs by reducing the demand for health care services. They would do this by requiring or increasing co-payments and deductibles, or by eliminating favorable tax treatment to employer health insurance. Others wish to cut costs by reducing the supply by regulating technological growth, by using global hospital budgets, or by reducing physician supply or physician fees. Some promote a hybrid approach by aiming cost-cutting strategies at both users and providers, by increasing the number of health maintenance organizations, by increasing utilization review and practice guidelines, or by instituting malpractice reform.[57] Moreover, there is disagreement over how to implement cost-cutting strategies: Should we implement these strategies by using free-market "forces," government regulation, or a mixture of both?[58]

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54. I will discuss "universality" and the level of care below.

55. To understand the significance of this point, one need only compare the effectiveness and quality of the Medicare program, which everyone (who works) contributes to and nearly everyone, regardless of class, uses, with Medicaid, which everyone (who pays taxes) contributes to but only the very poor use. Medicaid truly exemplifies the old adage "services to the poor are poor services."

56. Thomas Rice, "Containing Health Care Costs in the United States," *Medical Care Review* 49 (1992): 19–65; Jack D. McCue, ed., *The Medical Cost-Containment Crisis: Fears, Opinions, and Facts* (Ann Arbor: Health Administration Press Perspectives, 1989); Thomas S. Bodenheimer and Kevin Grumbach, *Understanding Health Policy: A Clinical Approach*, 2nd ed. (Norwalk, Connecticut: Appelton & Lange, 1999), chap. 9.

57. Rice, "Containing Health Care Costs in the United States," 25ff.; Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 145ff.

58. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, chap. 9.

Regardless of which method and what means we choose, some of these cost-containment strategies will lead to difficult moral choices, or what some policy analysts describe as "painful" choices.[59] They are painful because to save money, a provider must intentionally limit medical services to some people.[60] Contrast this with "painless" choices, where providers save money by eliminating unnecessary medical treatments and administrative waste, by promoting preventive medicine and healthy lifestyles.

We can reduce the amount of painful strategies if we exhaust all painless strategies first. Painless strategies come in two broad categories.

First, the system could eliminate activities with no clinical benefit, such as eliminating (a) ineffective and inappropriate care and (b) administrative waste.[61] Second, the system could practice medicine differently. For example, it could (a) "[substitute] less costly technologies that are equally effective" and (b) "[increase] the provision of those preventive services that cost less than the illnesses they prevent."[62] In fact, disease prevention and health promotion are probably the most important long-term growth management strategies available.[63] For example, a health care system might cooperate with the educational system (or public information systems generally) to help prevent children (and adults) from developing poor health habits such as using tobacco, using alcohol (excessively), and adopting a sedentary lifestyle.

A health care system should manage its growth painlessly as its first priority. In other words, its basic design should exhaust its painless mechanisms prior to using any painful ones. As cooperators in the system, we would not want to have people denied medical care because the system wasted resources on ineffective care and unproductive activities. In other words, a wasteful system would undermine cooperative motivation because our efforts would waste resources while limiting lifesaving care. Thus, the basic design should include, as a priority, devices that maintain overall system efficiency, that increase research on innovations and medical effectiveness, and that increase prevention and primary care.

Nonetheless, if we must make painful choices, we should do so in a public, democratic manner with full disclosure of reasoning and sufficient input from

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59. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, chap. 8.

60. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 117.

61. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 123–24.

62. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 123.

63. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, chap. 11.

all cooperators.[64] Not to do so would undermine cooperative motivation because cooperators would grow suspicious that their efforts were not producing equitable results for themselves and for others.

Finally, cooperation will become stable and remain stable over time if interactions between cooperators are more durable and frequent.[65] An interaction is more durable if the cooperators know that they will be in contact with each other for extended periods of time. Cooperating becomes more worthwhile when cooperators know that, for example, they will interact for periods of over one year or more. By making an interaction more frequent, cooperators increase the importance of the next interaction. Thus, cooperation emerges more readily in small towns than in big cities because the "frequent [and durable] interactions help promote stable cooperation."[66] In the context of a health reform plan, a policymaker should incorporate into its design features that decentralize administration, delivery, financing, and monitoring. Hospital and clinic ownership, and other health care decision makers, should be local and have long-term ties to the community and frequent interactions with its members.

Thus, when evaluating a health care system for stability, policymakers should ask the following questions:

- Does the basic design require everyone to contribute to, and does it facilitate broad-based use in, the health care benefits it offers everyone?
- Does it have an effective strategy for cost containment, and does this strategy exhaust painless measures prior to adopting painful ones?
- If it uses painful growth management devices, does it use, or does it facilitate the use of, open, democratic decision-making procedures?
- Does the basic design facilitate durable and frequent interactions between participants more than any alternative design?

Universality

Finally, the basic design, to be effective, should aim to prevent severe harm or premature death universally as a prima facie goal. In other words, it should aim to do the most good within the limits of its resources and the duties of its participants. Unless a good reason exists to believe otherwise, we should assume that a person with a medical need wishes to have (or prefers to have) his (her) medical needs met. Thus, an effective health care reform plan must include in its basic design devices that guarantee universal access to a uniform set of comprehensive medical benefits.

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64. See Dan Brock and Norman Daniels, "Ethical Foundations of the Clinton Administration's Proposed New Health Care System," *Journal of the American Medical Association* 271, no. 15 (1994): 1191.
65. Axelrod, *The Evolution of Cooperation*, 129ff.
66. Axelrod, *The Evolution of Cooperation*, 130.

Because a person's duty to cooperate is a function of reasonableness, our collective effort's scope (and its content) will depend on an assessment of its effects on individual cooperators. For example, if it were to turn out that supplying some level of health care to everyone who needs it demanded too much from individual cooperators, we would have to reevaluate both the scope and content of the benefit. Ideally, we want to get the level of demand high enough to produce a universal level of uniform comprehensive benefits, but not so high as to undermine cooperative success. Nonetheless, we should proceed with the assumption that our collective beneficent effort should apply universally until we have good reason to act otherwise.

A health care reform policy, then, should contain devices that facilitate universal access to a comprehensive set of uniform medical benefits. For example, health insurance, whether public or private, should be affordable, nonexclusionary, community rated, and transportable. In other words, receiving medical benefits should not be contingent on one's ability to pay, job status, prior medical history, or, for that matter, where one lives.[67] Moreover, by "universal access to medical benefits," I do not mean merely a universal guarantee to receiving emergency care in a hospital, which federal law already requires.[68] I mean a

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67. Brock and Daniels, "Ethical Foundations of the Clinton Administration's Proposed New Health Care System," 1189. One limitation on focusing on guaranteeing universal insurance as a means for universal access is that insurance is necessary but not sufficient for many people to actually access medical services. There are numerous nonfinancial reasons for why a person, even if insured, may not get adequate care, such as an insufficient supply of relevant personnel and facilities (say in a rural area), transportation, information due to language and cultural barriers, or personal motivation due to incorrect beliefs, attitudes, and/or misinformation about hospitals, doctors, or medical science in general. See Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 35–38; John Billings, "Access to Health Care Services," in *Health Care Delivery in the United States*, ed. Anthony Kovner and Steven Jonas (New York: Springer Publishing Co., 1999), 412–24. I am assuming that the universality element requires a plan to go beyond, when necessary, providing insurance and include elements that help overcome some of the abovementioned nonfinancial barriers as well.

68. This universal legal right to emergency medical care is required by the Emergency Medical Treatment and Active Labor Act (EMTALA), codified at 42 U.S.C. §1395dd *et seq.* EMTALA requires any hospital with an emergency room, and in receipt of Medicare funds, to evaluate and stabilize any person arriving at the hospital emergency room regardless of that person's insurance status or whether he can afford the care. See Karen H. Rothenberg, "Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care," *Houston Law Review* 26 (1989), 21–76; Andrew J. McClurg, "Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping," *Wake Forest Law Review* 24, no. 2 (1989), 182. For an overview of the EMTALA and a discussion of its limits, see Julia Ai, "Note: Does EMTALA Apply to Inpatients Located Anywhere in a Hospital," *Rutgers Law Journal* 32 (2001): 549–81.

broad range of comprehensive benefits that the majority of the public would accept. If the benefits were not acceptable to most people, then the cooperative effort would lose the kind of broad-based participation necessary to secure cooperative motivation, as discussed above.

Finally, the element of universality, which the basic design ought to include, must not only aim to benefit everyone in principle; it must also have a realistic chance to do so in practice. In other words, it is not enough for a health care reform plan merely to aim at providing universal coverage of a uniform set of comprehensive benefits as an ideal. We must analyze this aim to determine empirically if, within the context of its other basic design elements, it has a realistic chance of success. The Congressional Budget Office (CBO), for example, provided estimates on four health care reform bills presented to the 102nd Congress in 1992 when the health care reform debate was in full swing. These four plans were the following: (1) H.R. 1300, a single-payer health insurance plan, modeled after the Canadian system; (2) H.R. 5502, a plan that would expand Medicaid and Medicare benefits; (3) H.R. 5919, a plan that would provide tax incentives for purchasing private health insurance for the self-employed, regulate employer-based health insurance, promote the electronic transmission of health data and reform medical malpractice; and (4) H.R. 5936, a plan that would promote managed competition and subsidize private insurance for low-income people (CBO 1993).[69] According to its estimates, the single-payer plan, if implemented in 1993, would have covered everyone by the year 2000. However, the H.R. 5919 plan, which resembled the American Medical Association's (AMA) plan, would have left 38 million without health insurance by the year 2000. Yet the authors of the AMA plan referred to it as a means "to ensure universal coverage with a standard set of health care benefits for all Americans."[70] Thus, a policy should not merely claim to provide universal coverage, it must have a realistic chance to do so when implemented.[71]

69. For a more comprehensive analysis of these types of proposals and their effects on cooperators, see Office of Technology Assessment, *An Inconsistent Picture: A Compilation of Analyses of Economic Impacts of Competing Approaches to Health Care Reform by Experts and Stakeholders*, OTA-H-540 (Washington, DC: U.S. Government Printing Office, June 1993).

70. American Medical Association, *Providing Health Coverage for All Americans* (Chicago: American Medical Association, January 1994).

71. A number or state-sponsored studies comparing single-payer plans against rival multitiered plans have also concluded that a single-payer plan would cover more people and save more money. See MassCare, *Universal Single Payer Health Care: A Fiscally Responsible Approach* (1998), available at www.masscare.org/summary.htm at 1; Lewin Group, Inc., *Massachusetts Comparative Projected Health Expenditure Model* (1998), available at www.masscare.org/lewin.pdf; Lewin Group, Inc., *Analysis of the Costs and Impact of Universal Health Care Models for the State of Maryland: The Single-Payer and Multi-Payer Models*, available at www.healthcareforall/lewin.pdf; Solutions for

One important reason for empirically testing the plan for a realistic chance of universality is that the cooperator's motivation would be undermined if they learned that they were working in an effort whose goal was unrealistic empirically or not the most realistic. Why, cooperators would ask, are we not working in a plan that has the most realistic chance for achieving our beneficent goal, *ceteris paribus*?

Another reason for testing for universality is the role universality plays in promoting stability and fairness. Without universal access, the system will continue to shift the costs of the uninsured to paying patients through higher co-payments, deductibles, premiums, and hospital prices.[72] Importantly, the burden of paying for the uninsured by cost shifting is not equitable, but tends to be shifted disproportionately onto private paying individuals and small employers because large employers can typically negotiate lower prices and avoid any cost shift. Because cost shifting is an inefficient, hidden tax, which drives up health care costs for some, it is bad for the stability of a plan.

Thus, when evaluating a health care reform plan for universality a policymaker should ask:

- Does the plan provide, in principle, universal access to a set of continuous, uniform comprehensive medical benefits that most people would accept if offered?
- Does the plan, when tested by the best empirical studies, have a realistic chance when implemented to provide these benefits to everyone?

Assuming a plan does have a realistic chance to meet its goal, a policymaker must next analyze the moral limits of its demands of cooperators, which brings us to the next two subprinciples.

Fair Cooperative Effort Principle

The second subprinciple, which follows from the principle of cooperative beneficence, is the fair cooperative effort principle. This principle tests whether individuals are sharing equitable roles in the cooperative effort. It states: Our cooperative effort should distribute equitably the burdens or sacrifices necessary and effective for its success.

Progress, Inc., and Access and Affordability Monitoring Project, *Universal Comprehensive Coverage: Modeling the Cost of Health Care Reform in Massachusetts* (1998), available at www.masscare.org/solutions.pdf; Lewin Group, *Analysis of the Costs and Impact of Universal Health Coverage Under a Single Payer Model for the State of Vermont*, available at www.dsw.state.vt.us/districts/ovha/ovha22.htm

72. See Congressional Budget Office, *Responses to Uncompensated Care and Public Controls on Spending: Do Hospitals "Cost Shift"?* (Washington, DC: U.S. Government Printing Office, 1993).

Recall that a cooperator's role is followable, in part, if she believes that the cooperative effort treats her fairly.[73] I cannot here defend a principle of distributive justice, but I will use a principle that most moral philosophers share, namely, that when distributing benefits and burdens, we should give equal weight to the equal interests of all those affected by our actions.[74] A cooperative role is equitable, then, if the burdens of complying are similar to others' burdens, relative to each person's other legitimate social roles and personal capacities. Minimally, then, a cooperator would have to know that her sacrifices are similar to similarly situated others. Because the cooperative effort is simple and promotes publicity of cooperative roles, cooperators could properly compare their roles.

But we cannot analyze everyone's individual role separately. That would require difficult interpersonal comparisons and a level of practical complexity that we wish to avoid. We could, however, identify the impact on the roles of the most commonly cited groups that health care reform policies involve. By analyzing groups' sacrifices, we can determine roughly the kinds of sacrifices individuals make as members of these groups. For cooperating in a health care system, for example, these groups would include (but not be limited to) (a) the potential users of health care services, including the uninsured, (b) health care personnel (e.g., physicians, nurses, dentists, physician assistants, etc.), (c) the private health care industry (e.g., for-profit and not-for-profit hospitals, nursing homes, outpatient specialty clinics, the pharmaceutical industry, medical suppliers, and other private medical organizations), (d) federal, state, and local governments,

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73. "Fairness" in this context is about how to distribute equitably the burdens or sacrifices necessary toward cooperative success. We should not confuse this "distributional" sense of fairness with an "entitlement" sense of fairness in the context of the debate over whether receiving health care is a right. The debate between the rights approach and the charity approach is over whether fairness guarantees an individual a moral right to health care and a corresponding social obligation to enact appropriate legislation. But that debate over whether the concept of fairness generates a right to health care is distinct from, and does not itself answer, how society should distribute the burden necessary for paying for a social obligation to guarantee universal health care, if one exists (see Daniels, Light, and Caplan, *Benchmarks of Fairness for Health Care Reform*, 33, 44ff.). In other words, there is a sense of fairness used in debates over what rights or entitlements we should have and a sense of fairness used in debates over how we should distribute the burdens necessary to secure those rights, whatever they are. So, for example, we can disagree over what rights we have, but agree that whatever rights we have we should distribute the burdens necessary to secure them by implementing a progressive tax system (cf. Nozick, *Anarchy, State, and Utopia*, 267). Because the cooperative beneficence approach uses the principle of beneficence, not justice (or fairness), to ground our social duty to cooperate in guaranteeing health care, it uses fairness to mean evaluating how the effort should distribute the burdens or sacrifices necessary to fulfill that social duty.

74. See R. M. Hare, *Moral Thinking* and "Rules of War and Moral Reasoning," *Philosophy and Public Affairs* 1 (1972): 166–81; Rawls, *A Theory of Justice*; Singer, *Practical Ethics*.

including public health care facilities, (e) employers (small, medium, and large), and (f) the private health insurance industry (both for-profit and not-for-profit). I understand that some overlap is inevitable, and the list is incomplete and too general; but it should suffice for purposes here.

It will still be difficult to compare burdens between groups. Thus, the fair cooperative effort principle evaluates the policy by identifying the most obvious cases of inequitable burdens, namely, if the effort categorically, and unjustifiably, excuses one group from cooperating, or if it singles out one or more groups for obviously excessive cooperation compared to others. In particular, any reform policy would have to address the regressive financing of health care associated with our current system.[75] For example, people with incomes of at least $100,000 spend 5 percent of their income on health care each year (including premiums, out-of-pocket costs, and wage reduction from employer-paid premiums), whereas people with an income under $10,000 spend 23 percent of their income for health care.[76] I take that to be an obviously excessive difference. To avoid this problem, and to produce a more equitable payment system, a reform policy should either adopt a progressive health care tax, restructure insurance to provide for community rating with a sliding scale for pricing premiums, or provide tax advantages for targeted groups.

For evaluating a health care reform plan for fairness in distributing its burdens, the policymakers should ask:

- Does the health plan single out a group (or groups) for excessive cooperation compared to others? For example, the financing of health insurance should be progressive.
- Does it categorically, and unjustifiably, excuse one group from cooperating?

Reasonable Burden Principle

The third and final subprinciple is the reasonable burden principle. This principle tests the size (or extent) of a cooperator's burden, given his (or her) current capacities and other equally important social, professional, and personal obligations.

75. Bodenheimer and Grumbach, *Understanding Health Policy: A Clinical Approach*, 19; Institute of Medicine, *Employment and Health Benefits: A Connection at Risk*, ed. Marilyn J. Field and Harold T. Shapiro (Washington, DC: National Academy Press, 1993): 111; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 333.

76. Shearer, "The Health Care Divide: Unfair Financial Burdens," 13. The regressive financing of health care is even built into the favorable tax treatment that the higher income person receives. An employee's contribution to his health insurance premium is paid by pretax dollars thereby providing a tax savings equivalent to the employee's tax bracket. Thus the wealthier person receives a larger tax break.

It states: Our cooperative effort should not require an individual cooperator to compromise his or her other legitimate duties of equal or greater weight. Again, for simplicity, we cannot analyze every person's role. However, we can analyze the reasonableness of a group's role. A group's cooperative role is unreasonable if it forces its members to compromise their related professional and personal duties which group membership requires.

This subprinciple is probably the most difficult to apply because it requires not only that we clearly understand how the cooperative effort will affect a group's members' other legitimate duties, but also that we know which groups and which duties are legitimate. Suppose, for example, that to cooperate in a health care system some private for-profit hospitals had to return less profit to their shareholders. Is their cooperative duty unreasonable because it forces the hospital to compromise its duty to its investors? The answer will depend on the legitimacy of the hospital's duty to its investors. Another important consideration is whether that duty to the shareholders may override the duty to cooperate to help prevent harm to others.

As another example, suppose the duty to cooperate requires a physician (or some other health care professional) to sacrifice her right to professional autonomy or her fiduciary duty to her patients. In the former case, her role may dictate whom to treat and how much, what specialty to practice in, what types of treatments to prescribe, or where to practice. In the latter case, her role may require her to choose less expensive treatments that might not be in her patient's best interest. Would any of these restrictions make her role unreasonable? Again, the answer depends on the nature and weight of her "right" to professional autonomy and her fiduciary duty to determine under what conditions, if any, her cooperative duty may override them. Elsewhere I have argued, for example, that a health care professional's duty to cooperate in a health care plan may be unreasonable if the role undermines her fiduciary duty, but not if it merely undermines some of her professional autonomy.[77]

As a final example, consider how the cooperative duty may force local, state, or federal governments to sacrifice other goals of equal or greater weight, such as funding for public primary and secondary education, for police and fire protection, or for the national defense. This question reminds us that the cooperative goal (of guaranteeing universal access to health care) is limited, in part, by other important social goals that we have and that we must prioritize these goals through democratic procedures when we cannot satisfy them all at the levels we wish.[78] The

77. See Weiner, "Cooperative Beneficence and Professional Obligations," 96ff.

78. Admittedly, this statement regarding the use of democratic procedures for determining spending priorities is a bit naive given the current problems with our campaign financing system that ostensibly preserves the status quo. But that is a problem for another time.

reasonable burden principle, in other words, reminds us that while working together to help others, we should preserve not only our personal, individual projects but our other legitimate collective ones as well.

Thus, when evaluating health care reform plans for reasonableness, policymakers must ask the following questions:

- Does the policy force a group's members to compromise their (legitimate) professional or personal duties of equal or greater weight? If so, is such a compromise justified?
- Does the policy force society to compromise other social goals of equal or greater weight? If so, have we used a democratic procedure to determine the priorities of these social goals?

Summary and Conclusion

I have offered a cooperative beneficence approach to health care reform as an alternative to current approaches that fundamentally disagree over the status of individual moral rights to health care. The cooperative beneficence approach takes seriously our individual duty to rescue others writ large. Central to this approach is a defense of a principle of cooperative beneficence that makes some cooperative behavior obligatory, namely, a reasonable, well-defined, equitable role in a cooperative effort to guarantee universal health insurance in the United States. Finally, I suggested, and outlined, how this principle generates three subprinciples to provide a framework within which we can ethically evaluate different types of health care reform policies.

To conclude I will list the questions that the cooperative beneficence approach recommends we ask when analyzing health care reform policies.

On the Basic Design

Simplicity

- Is the basic design simple enough for a typical cooperator to understand how it works?
- Is it easy for a cooperator to understand what the plan expects from her?
- Is it easy for a cooperator to understand what the plan expects from others?
- Does the basic design include, or strongly promote, simplicity in administration, access, and financing?

Stability

- Does the basic design require everyone to contribute to, and does it facilitate broad-based use in, the health care benefits it offers everyone?

- Does it have an effective strategy for cost-containment, and does this strategy exhaust painless measures prior to adopting painful ones?
- If it uses painful growth management devices, does it use, or does it facilitate the use of, open, democratic decision-making procedures?
- Does the basic design facilitate durable and frequent interactions between participants more than any alternative design?

Universality

- Does the plan provide, in principle, universal access to a set of continuous, uniform comprehensive medical benefits that most people would accept if offered?
- Does the plan, when tested by the best empirical studies, have a realistic chance when implemented to provide these benefits to everyone?

On Fair Burdens

- Does the health plan single out a group (or groups) for excessive cooperation compared to others? For example, the financing of health insurance should be progressive.
- Does it categorically, and unjustifiably, excuse one group from cooperating?

On Reasonable Burdens

- Does the policy force a group's members to compromise their (legitimate) professional or personal duties of equal or greater weight, and if so, is such a compromise justified?
- Does the policy force society to compromise other social goals of equal or greater weight, and if so, have we used a democratic procedure to determine the priorities of these social goals?

The devil is always in the details, but it is my hope that by applying competent policy studies to this framework we can produce a number of ethically defensible plans that the United States should eventually adopt.