Chapter 1

Health Care Systems and Ethics

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Abstract: This paper gives a brief and basic introduction to some of the concepts and vocabulary used in the debates about health-care systems. It differentiates between socialism and communism and points out that the two are hardly identical and that democracy and capitalism are not necessarily related. The difference between single- and multiple-tiered health care systems and arguments for and against each are briefly discussed. The attempt to deal with our ethical problems in health-care and to create a just health-care system may by itself positively affect what is now perceived to be a basically unjust society.

1. INTRODUCTION

Physicians are confronted with an ever-increasing number of ethical problems. Some of these problems are old problems that have been complicated by the ever-increasing technical ability of medicine; others are new problems brought about by entirely novel and unanticipated technologies;

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still others are ethical problems which have been brought about by economic factors and a changing health care system.

The problems of ethics at the bedside practice of medicine in the United States today are what I have previously referred to as "rich man's" ethics. That is, they are the problems which concern those of us with ready access to medical care.[1] Questions of terminating treatment, of futility or of in vitro fertilization are problems of little concern to those forty-two to forty-five million of us who cannot have access to preventive or early curative treatment. Our attention in health care ethics has been predominantly on those bedside problems that affect the insured. Although ethicists have occasionally paid lip service to equitable access for all, they have refused to take an organized, let alone an effective, stand. Neither has organized medicine invested a great deal of energy in pursuing an agenda they profess to embrace. It is, I would claim, most difficult if not indeed impossible to practice ethically within an unethical system just as it is difficult to create a just system within a basically unjust society.

Even when there is equitable access, the nature of the system shapes the ethical problems that physicians confront and limits the responses they can have. Thus a system with free choice of physicians or a system in which patients are seen by different physicians inside or outside the hospital will affect the relationship that physicians, patients and other health care professionals have with one another. Moreover, such a system will, therefore and inevitably, shape how and what we come to recognize as ethical problems. I am not arguing for one or another system—I am merely stating that to understand and truly appreciate the problems and the options one must understand the system. When systems stand in the way of ethical practice, physicians, I shall argue, have two obligations:

1. To do the best they can within the system (which, at times, may even include "gaming the system" as perhaps the lesser of several evils)
2. To play an active part in changing the system itself

For the sake of this discussion, I shall assume but not argue that a decent community that can afford it, is obligated to supply at least basic health care for all within its borders.[2] Such an assumption is grounded in an understanding of what defines a well functioning and decent community—one which tries all it can not to disparage its members.[3] A libertarian model may provide structure for a loose association of people united by obligations of non-interference with one another and an adherence to freely entered contract but such a model will fail to yield the solidarity communities require if they are to flourish and evolve. When individuals recognize that their individual goals can be pursued with a good chance of success for all only

within the embrace of a community, and when society is aware that its success depends upon fostering individual skills and talents, communities will have a solidarity based on their mutual and intertwined common goals and ends. A community that unnecessarily leaves persons uneducated, bereft of the basic necessities of life or without equitable access to health care plays a role in disparaging some members at the expense of others. Communities in which individuals feel a strong bond with one another are communities that will prosper, evolve and endure—such communities will accept the obligation to meet basic needs as a condition of successfully association.[4]

The most erudite discussions of the finer details of justice or the professions of despair by the medical community at the number of uninsured are pointless without political action. This is not a new observation: Aristotle long ago saw politics and ethics as firmly entwined. Questions of ethics are questions directed at courses of action—action which when it comes to systems can only be modified within a political context. It is my thesis that those persons associated or concerned with the ethical practice of medicine have an obligation to take an active role in creating a system in which ethical practice can take place. Such an obligation transcends that of the ordinary citizen. It is one which (and with particular force) ethicists who are supposedly the most concerned about ethical practice should eagerly embrace. Doing one's job as well as one can—or teaching the finer points of ethical theory—is pointless if the constraints of the system force one to practice in a way which one readily recognizes as being ethically problematic.

The health care system in the United States is the most expensive, the most inequitable and the most bureaucratized in the world. As good as the care of critically ill patients still is in the United States, even that is no longer the best there is. We in the United States today have become very skilled at remedying crises we could have easily prevented. Often we remedy an acute crisis only to send patients out into the very same situations that produced the crisis in the first place. Not only is this ethically problematic but it is, in the long run, economically unwise.

Most people recognize that the various solutions proposed for remedying the problems of our health care system have not only *not* turned out to be solutions but have, in fact, made the problem worse. Managed care (especially for-profit managed care) which was to be the American answer to what is improperly called "socialized medicine" has resulted in even more people being uninsured and without proper access. Managed care, as I shall show, has made the ethical practice of medicine most difficult, has distorted the patient-physician relationship and has added a new layer of ethical problems without solving the old. Most of us would agree that an equitable health care system in the United States is sorely needed.

2. BASIC LANGUAGE AND CONCEPTS

A system is something that has some sort of internal coherence and controlling elements. The cardiovascular system and the educational system are examples. In the health care system as it exists in the United States today the only internal coherence and the only controlling element is a theory of the free market—and not even that is entirely carried into practice.

Before we can speak of building a health care system, certain basic concepts, terms and language must be agreed upon. Many terms are loosely used and need to be defined. What follows is an attempt to define some of these terms.

2.1 Economic and Political Distinctions

The term "socialized," since it is bandied about rather freely, must be understood. Socialism, first of all, is a term often equated with communism. This is untrue and inaccurate. Communism denies the right to private property; socialism recognizes the right to private property but insists that the fruits of labor ought, by right, go to those who work. Thus, worker ownership of United Airlines or the Saturn Car Company is, in a sense, a form of socialism. Furthermore, socialism importantly holds that certain goods and institutions essential to the community should be owned and controlled by it (and this is where the term "socialized medicine" comes in). Persons here in the United States are persistently taught that democracy necessarily entails capitalism and that capitalism furthers democracy. Nothing could be further from the truth. First of all capitalism is an economic system and socialism a political system—and while economic and political systems should preferably fit together, they are not synonymous. Both capitalism and socialism can exist in a monarchy, a dictatorship or a political democracy. The philosophical basis of capitalism is the freestanding, largely asocial individual, whereas the philosophical basis of socialism as well as of democracy is community. Social democracy is a democracy that emphasizes democratic process and accepts social responsibility; democratic socialism is a system in which the means of production are predominantly in the hands of those who have a part in creating the product and in which decisions are made in a democratic fashion. In democratic socialism, private capital exists but is strictly regulated and the community controls many things basic to communal life (things like health care, education and public utilities).

Most national health care systems are not "socialized"—that is, they are not operated by the state. A socialized system is one in which the state from general taxation creates, maintains and operates a health care system. Many if not most systems in the industrialized world that provide at least basic

health care to all citizens do not meet such a definition. They are operated by and through various usually government supervised insurance schemes; but they are not, in the true meaning of the word, socialized.

If we are to allow the market to control the distribution of a commodity, we must first ask if the philosophy of the market is appropriate to the particular commodity. The basic philosophy of the market presupposes that consumers have sufficient:

1. Resources to participate in the market
2. Understanding of what constitutes a "good" product for them to choose
3. Leisure to "shop around" and compare quality and price
4. Protections against fatal injury, should they make a "wrong" choice

In health care none of this applies.[5] In general, when it comes to health care, consumers do not have funds sufficient to engage in a free market. They do not and cannot understand what a good product would be. They have little time when ill to "shop around and compare;" and, should they make a wrong choice, they might well be fatally affected. Beyond this, the philosophy of the market requires that consumers and purchasers are one and the same entity: they can weigh their personal idea of price and quality and, within the limits of their financial possibility, come up with a decision reflecting their evaluation. In the United States today the consumer (the patient) and the purchaser (almost invariably the patient's employer) are interested in quite different things—the patient in quality and accessibility, the purchaser in cost.

2.2 Single and Multiple, Tiered and Payer Distinctions

If one is thinking of creating a health care system one first of all must decide whether such a system should be single- or multiple-tiered and who should pay. Although the two terms are often used as though they were synonymous, a single payer system is not synonymous with a single-tiered system. In a single payer system there is one agency (be it government or private) which pays out "benefits." This payer could conceivably be a large insurance company selling different policies to different persons: i.e., one payer who pays differently for different persons.

In a single-tiered system all get the same of a given commodity and no one can buy more; in a multiple-tiered system a basic minimum is provided and more can be bought by those willing or able to buy more. All getting the same could mean that all insured by a given company (let us say all members of Kaiser-Permanente) get the same services or it could mean that all

members of a community under the umbrella of a communal plan receive the same services. In the way I shall use the term I am referring to all members of the community. In most communities and as a general rule, fire and police protection are single-tiered, while education is multiple-tiered. In terms of health care, all "getting the same" refers to those things which affect outcome: physicians, nurses, waiting time, procedures, drugs, etc. A single-tiered system, the way the term is used here, might well be one in which the affluent could purchase a private room, nice curtains on the windows and a bottle of wine with dinner. But they (the affluent) could not buy different physicians, a shorter waiting time or a hospital bed that is better staffed than another. Multiple-tiered systems provide a basic minimum to all and leave additional services up to the individual's ability and desire to buy them. Canada and the Scandinavian systems are essentially single-tiered systems whereas the British system is multiple-tiered. A single-tiered as well as a multiple-tiered system can be socialized or not. It is conceivable that the state could manage and finance a system in which one class of employee would receive different benefits from another and it is equally conceivable that a system operated through insurance companies might be essentially single-tiered.

3. A BRIEF COMPARISON OF SYSTEMS AND THEIR ETHICAL IMPLICATIONS

Various countries have adopted a variety of health care systems. In all of these countries there is one common denominator—they all provide at least basic health care coverage to virtually all residing within their borders. The United States, as has been said, is unique in *not* doing this.

The Scandinavian countries differ among themselves but have two important features in common: they are exclusively publicly funded and they use primary care physicians as gatekeepers. Germany, Austria and to some extent Switzerland are funded via mandatory employer/employee contributions, have a strictly regulated (but becoming increasingly less strictly regulated) insurance system and provide insurance for those who would be otherwise uninsured. The United Kingdom has a multiple-tiered, nationalized system with the national health care sector publicly funded. Canada's system is single-tiered and nationalized with public funds distributed among the provinces. France has a mixed system.[6]

Different systems spawn different ethical problems. A system in which physicians care for their patients both inside and outside the hospital (as is generally the rule in the United States) has somewhat different or at least differently shaped ethical problems than does a system in which ambulatory

and in-hospital care are strictly separated. A capitated system offers different incentives than does one that is fee-for-service. Physicians who must deal with private insurance companies face different ethical problems than do physicians who are paid directly by the government.

In most systems a common denominator remains: physicians are primarily obligated to the good of their individual patients. That physicians are primarily obligated to the individual patient is a medical tradition as old as medicine itself. Furthermore, it is a tradition of medicine, which is and has, in a variety of cultures, been a constant societal expectation. Of course, expectations by themselves do not create obligations. But when expectations are consistently met over a long period of time, they become a justified expectation and eventually an obligation is created. In the United States and under our current system of Managed Care, this ancient tradition has frayed; the expectation that physicians are, above all, committed to their particular patients' good come what may, is often not met. Trust is attenuated and suspicion of the medical profession, unfortunately often not unjustified, escalates. Physicians today are often forced to choose between their patients' good, loyalty to their organization and personal self-interest. Increasingly physicians regard themselves more as good employees of their organization than they do as advocates for and of their patients.

The language we use conditions the way we think and often determines the way we feel and act. In the last few decades there has been a gradual shift in language, which both reflects and has driven these other changes in physician-patient relationships. Physicians have become providers; patients have become first clients, then consumers and now, even worse, customers. Often they are, in insurance jargon, simply spoken of as "lives." This shift in language (one still fairly unique to the United States) is, in my view, by no means accidental or trivial—it is a shift at the very least encouraged by those who stand to gain by the disruption of an ancient relationship. It is one that health care professionals buy into at their peril.

4. APPROACHES TO PROBLEMS

Whether we build a single- or a multiple-tiered system is in part dependent upon how we see ourselves related as individuals to one another and to our community. If we envision ourselves as united merely or mainly by obligations of mutual non-harm but by few if any obligations of mutual help, we will build a far different social system than if we see ourselves united not only by the obligation not to harm but equally by the obligation to help one another. There are two possible approaches: one is termed the "poor law" philosophy. A poor law approach is one in which a certain segment of the

population is entitled to certain benefits if and only if they meet definite criteria—food stamps below a certain level of income might be one example. The other approach is what has been termed the "welfare" approach. In such an approach persons are entitled to certain basic goods and services not because they meet certain criteria, but by virtue of being members of the community—police and fire protection would be an example.[7] Most societies adopt a mixture of both philosophies–which predominates is a function of how we see ourselves related to one another and to our community. Societies that are more committed to accepting obligations of mutual assistance rather than merely obligations of mutual non-harm are more apt to construct single- rather than multiple-tiered systems.

There are sound arguments for both kinds of systems. Those committed to a multiple-tiered system providing at least a basic minimum to all, argue that persons ought to be free to support whatever values are most important to them. Persons who prefer to have a luxury car or an elaborate vacation trip should be free to make such a choice at the expense of more sophisticated health care. Further, people committed to a multiple-tiered system will argue that it seems unfair that persons who have worked hard and saved money should subsidize those who have either been lazy or profligate. A multiple-tiered system would give basic health care to all but reserve more sophisticated and more expensive care for those willing (out of pocket or through insurance) to buy such care. An argument about not caring for diseases that are the product of personal risk-taking is often appended to such an approach: persons who chose to live a healthy life style should not be asked to bail out those who smoked, drank or went bunjie-jumping.

Those who prefer a single-tiered system will argue on two levels: first of all, they will argue that a true community is properly committed to support the weak and frail. In such an argument support of everyone within the limits of a community's capacity is part of the definition of a true community. Communities that support their weak and frail (something we potentially all are) will, it is argued, show more solidarity, have a better chance to endure and, ultimately, offer their members a greater possibility for optimizing their values and pursuing their interests.

Second, those who prefer a single-tiered system will argue by countering the arguments that are made for a multiple-tiered system. The argument that all persons should be free to support their own values is true only within the context of a community that allows certain values to be expressed. We generally do not value our necessities until we are deprived of them: few of us give much thought to food or drink until we are hungry and thirsty—and if we failed to take enough money along to buy food and drink we shall go hungry and thirsty. Similarly, persons do not value their health until it is threatened. Unless they have "taken along enough money'' it is quite possi-

ble that they will find themselves without access to medical care when it is most needed. Since few of us would wish to live in a community which allowed persons to die simply because they lacked foresight, were lazy or lived above their means (and fewer still would wish to see their families treated in this way), we would be likely to end up either paying for such care as a community or collecting private money. And, indeed, this is what frequently happens today. Uninsured persons are taken into charity hospitals or supported out of the public coffer when they become critically ill. Often private collections are taken up for those who are uninsured (and, therefore, not acceptable to most transplant programs). Here a weeping, well-dressed and soft-spoken grandmother, psychologically, "has it all over" someone sloppily dressed and using coarse language. Yet, upon critical reflection, such a state of events should accord with few persons' sense of fairness.

More importantly: people who fail to buy additional insurance are unlikely to be those who have been lazy or who have preferred to buy luxury items. People who fail to buy additional insurance are frequently not choosing between expensive automobiles and additional insurance but between additional insurance or food (or perhaps schooling) for their children. They have most often been neither lazy nor profligate: they have simply been hard working, poor and unlucky. Arguing that those who jeopardized their own health should not burden the community with the expense of treating the result of their behavior is not an argument against a single-tiered system. It is entirely possible to tax many of these activities and to use the tax revenue to support the additional health care. Whether or not this is fair is another question—but it most certainly can be done.[8]

Resources are limited. What is spent for one thing cannot be spent for another. Economists refer to this phenomenon in terms of "opportunity costs"—spending on one thing precludes the opportunity of spending the same money on another. Health care—important as it is—is neither the only nor the most important of several social goods.

Imagine the following experiment: Persons are asked to choose two from among three social goods. The one not chosen will be something that they would have to obtain by whatever private means they could; the ones chosen would be things guaranteed for life. The choices are: (1) having all biological needs met—the person will never go hungry, without shelter and so forth; (2) having all educational needs fully met; and (3) having complete and free access to medical care. The choice must be made behind a Rawlsian veil of ignorance. That is, the choosers will not know their age, sex, social standing, wealth or state of health.[9] Most prudent choosers would undoubtedly choose to have those things necessary to sustain life vouchsafed to them—after all, if one is not alive, nothing else means very much. Furthermore, most of us would choose full educational opportunity, for without it the content of our

lives would be impoverished. With our biological necessities guaranteed and our educational needs met we would probably be able to gain access to medical care should we become ill. I do not argue that health care is unimportant or that a decent society should not in justice supply medical care to all—indeed, I feel that a community able to supply all three is *obligated to do so.* I do argue that important social goods must balance one another—as in a symphony one instrument cannot be allowed to drown out all others, so in a community one social good cannot be allowed to swamp all others.

Since resources are limited and demand is great, a system of equitable distribution is essential. To deny this fact is to delude oneself. Two steps are inevitable–the first is rationalization: that is, to expend our resources only for those things that are of accepted value, to stop waste and to eliminate duplication. Depending how these things are defined and done, few would argue against such measures. The problem, of course, is that what is and what is not valuable or wasteful is hardly self-evident. The second step is rationing, something that we have done for a long time and in all systems but have never really admitted to doing in any of them. In the United States we ration by ability to pay—those who (by insurance, out of pocket or through charitable funds) are able to pay receive services; others do not. With managed care some rationing—though not called by that name—also occurs by interposing a great deal of administrative work between request and fulfillment. This has been called the hassle factor and, although not ever called a rationing measure, surely works as such. It sharply reduces request for. services—the greater the hassle, the more the chance that people will forgo what they had wanted. In other systems other ways of rationing (generally referred to by other names) takes place. I do not oppose rationing—I fear that it is inevitable. I *do* oppose not dealing with people in a straightforward and honest manner—if rationing is needed, call it that and defend it.

When physicians deal with their patient's problems, they are dealing with identified lives—that is, with persons they directly know or can identify as real persons. When we deal with people we recognize as persons and especially when we deal with such people in a setting of illness or misfortune our natural empathy is aroused. If, however, we are to help such people we need to engage more than our emotions—our emotions alone could lead us to do very destructive or omit very important actions. We need to temper our emotions with reason—ending up with what I have called "rational compassion." When rationing resources or building a health care system we deal with people we do not know and of whom we have no direct knowledge. Such unidentified or statistical lives engage our reason. But reason alone is cold and distant when it comes to dealing with human problems. In building health care systems or rationing resources we need to be mindful that such lives are neither merely statistical nor unidentified but merely not identified

by ourselves. By virtue of being lives and by virtue of all human lives occurring in a social nexus, such lives are very much real and very much identified by others. It behooves us to try and visualize decisions we make in human terms—that is, to allow our compassion to help us understand what the lives of those for whom decisions are made are like. We need to season our reason with compassion—a step I have called "compassionate rationality."[10]

Tempering compassion with reason or seasoning reason with compassion necessitates the use of curiosity and imagination—human capacities that in our civilization tend to be downgraded. When dealing with identified lives curiosity prompts us to ask how certain courses of action would affect the person we are dealing with and imagination would allow us to sketch an answer; reason and compassion (but not compassion alone) would then allow us to make a choice. In dealing with statistical lives curiosity would impel us to ask what being in their shoes might be like and imagination would help us to achieve at least some understanding of their plight. Compassion together with reason but not reason alone would then allow us to come to a decision.[11]

Our concern with how to create a health care system or how to reshape one that exists is perhaps not the first concern we should have. Invariably when we are confronted with a problem in ethics we ask, "what shall we do." This is true no less in building a system or creating a policy than it is in facing problems at the bedside. This question, however, is not the first question we need to ask. The first question, I think, is not what shall we do but who is entitled to decide what should be done and then how the voices of those who should be involved in deciding should be heard. We have, I think, for all too long crafted an ethic *for* others—*for* the weak, *for* the sick, *for* the poor; it is time, I think, to craft an ethic *with* instead of *for* people. The creation of an ethic for others is a remnant of autocracy and monarchy that in a democratic society has outlived its usefulness. Clearly, if we truly believe in democracy, all those potentially or actually affected by a policy ought to share in shaping it.

Creating a health care system is a most difficult task. It is one in which physicians, nurses, economists, sociologists, ethicists, administrators and many others must contribute their expertise and work together towards a common solution. There is no doubt that none of us has sufficient expertise to come up with more than a small part of an answer. Nevertheless, the broad outlines of a policy are things in which the electorate at large should have a powerful voice. Issues such as whether a single- or multiple-tiered system would serve us best or what should and what should not be considered as necessary health care services are issues which concern the man or woman on the street who is ultimately affected. It seems self-evident that he or she should have an opportunity to have his or her voice heard.

Finally, one cannot create a just system in the context of an unjust society. Having all of those who are potentially or actually affected participate in crafting a solution entails a truly democratic system and not merely a *pro forma* political democracy in which everyone has a right to vote and in which counting of votes is at least not overtly fraudulent. A political democratic process—which ultimately seems to be the only acceptable way of creating public policy—necessitates that the preconditions of democracy are met. John Dewey long ago stated that at least three preconditions must be in place before political democracy could be expected to function. First is personal democracy—a willingness by all to respectfully and thoughtfully listen to other opinions, to exchange viewpoints and engage in dialogue. Second is economic (he called it industrial) democracy—a state of affairs in which grinding poverty was eliminated and basic needs were met. Third is educational democracy — in which illiteracy were eliminated and all had complete and free access to developing their talents and pursuing their interests.[12] Absent these three preconditions, political democracy is apt to become the plaything of powerful pressure groups and, indeed, that is what has happened.

In the United States today, public dialogue about issues that affect the lives of the electorate is regrettably sparse. We tend to live in our enclaves and communicate with our social and educational peers. In part this is due to the lack of the second precondition Dewey mentions: the economic and hence the social situation in the United States is producing a steady growth in extreme poverty as well as in extreme wealth. Furthermore, primary and secondary education, because of the way in which schools are funded tends, to be bad precisely where it should be excellent and access to college and University is more and more restricted to those with higher incomes. This creates a situation in which true political democracy cannot flourish. Indeed, it is one in which a viable political democracy predictably will die.

It is difficult to create a health care system in the context of such a situation. Poverty and lack of education are both directly linked to disease—the lower the income and the lower the level of education the higher the incidence of almost every disease studied. Therefore, we have a task before us: while emphasizing the importance of craftsmanship of any health care system, we must be aware of the social context in which such crafting takes place. If done right one can hope to not only craft a flexible, changeable and equitable health care system but in the process of doing so benefit the entire social system. Taking care that the process is interactive and democratic and not simply a "top-down" strategy can set an example for other social policies to follow.

We who teach health care ethics have an obligation to lead the way. Teaching health care ethics is a social task. Important as the problems at the

bedside and the options available to us in dealing with them are, they are inevitably shaped and constrained by the system in which they take place. Again, for too long we who teach health care ethics have been chiefly concerned with what I have called "rich-man's" ethics—the ethical problems those of us well off and able to have ready access to the health care system have had the luxury of being able to worry about. At best we have paid a few moments of lip service to the millions whose problem is not when to stop treatment or whether toget in vitro fertilization but where to get a meal, shelter and care for their hypertension. Worrying about the ownership of a dead man's sperm—an activity that consumed hours of time for persons of considerable talent in a health care ethics discussion group to which I belong—is as "safe" as it is useless. It is an interesting parlor game and one that will not get one into difficulties with the establishment. Keeping oneself safe, sitting in one's ivory tower and studiously ignoring what is going on in the real world is precisely what academics did in Nazi Germany. With that they not only were neutral to any solution, they very much became part of the problem. One would hope that we in today's world and in nations which pretend to be democracies can do better than that.

ENDNOTES AND REFERENCES

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3. In an overlooked but highly significant book Margolit argues that the decent society is the society which shames or embarrasses people as little as possible. See: A. Margolit, *The Decent Society,* trans. by Naomi Goldstein (Cambridge, MA: Harvard University Press), 1996.
4. EH Loewy, *Freedom and Community: The Ethics of Interdependence* (Albany, NY: State University of New York Press), 1995.
5. EH Loewy, "Of Markets, Technology, Patients and Profits, *Health Care Analysis* 1994; 2(2): 101-110.
6. This brief comparison is abstracted from a recent edition of *Health Care Analysis* in which various systems, their structure and consequent ethical problems are discussed. See: Special Issue of *Health Care Analysis* (ed. by EH Loewy), 1999; 7(4): 309-411.
7. B. Barry, "The Welfare State *v.* Relief of Poverty," *Ethics* 1990; 199: 503-529.
8. For a discussion of this issue, see EH Loewy, "What would a Socialist Health Care System look like? A Sketch," *Health Care Analysis* 1997; 5: 195-204 and EH Loewy, "Justice and Health Care Systems: What would an Ideal Health Care System look like?' *Health Care Analysis,* 1998; 6: 185-192.

9. The "veil of ignorance" introduced by J. Rawls can, despite its drawbacks (which take us too far afield to be discussed here), serve as a heuristic device in making important social choices. (See, J. Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press), 1971. Imagine yourself behind a Rawlsian veil of ignorance which would not have you know who you are, how old, well or unwell you might be, what race, or what gender or income group you belong to. You are told only that you will have to choose among three different social goods, only two of which would be guaranteed to you—the third would be up to luck and your own devices. These three would be a) all biological necessities would be guaranteed; b) a full education to develop your interests and talents would be yours for the asking; and c) health care would be fully supplied in case of illness. It is likely that most prudent choosers would choose to forego guaranteed health care in favour of the other two.
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