VIEWING HEALTH CARE AS A COMMON GOOD:
LOOKING BEYOND POLITICAL LIBERALISM

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INTRODUCTION

“The signs are unmistakable: Washington is rediscovering the health care crisis. It did not, after all, go away with the failure of the Clinton Administration’s attempt at universal coverage in 1994.”1 In the new, incremental politics of health care, managed care (for the insured) is demonized and patients’ rights are protected, while concern about the uninsured remains marginal. Quality of care is now the issue: Consumers want “choice” restored in the medical marketplace, and physicians decry their perceived loss of professional autonomy.2 The managed care

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2. See, e.g., Geoffrey Cowley & Bill Turque, Critical Condition, NEWSWEEK, Nov. 8, 1999, at 58 (“HMOs can be hell. From frustration with HMOs to worries about cost, health care is at the top of the agenda. The political war over patients’ rights and the human side of managed care.”); Russell Watson, HMOs Go Under the Knife, NEWSWEEK, Nov. 8, 1999, at 63 (same). See also, e.g., Suzanne Gordon & Timothy McCall, Healing in a Hurry: Hospitals in the Managed-Care Age, NATION, Mar. 1, 1999, at 11 (acknowledging that cutting hospital stays reduces governmental and corporate costs—at
revolution, inspired by the private sector to contain costs, has stalled—\textsuperscript{3}\textsuperscript{—}\textsuperscript{the upward trend in medical spending is reasserting itself—yet America’s liberal political system seems incapable of comprehensive health care reform.

Why? At root, it is the limits of liberalism itself. To the extent that liberalism is wanting when deliberating about health policy, other ways of thinking about health care must be found. This Article traces the shape of one such alternative—the \textit{political common good}—and argues that the Oregon Health Plan—an innovative and controversial effort to provide Medicaid coverage to a greater number of Oregon residents—while imperfect, highlights the potential of political common good thinking in overcoming many of liberalism’s limits.

The Article begins by discussing the limits of liberalism within the health care context. Part I introduces the question against the backdrop of President Clinton’s failed health care plan and offers the political common good as a fresh way of thinking about health care. Part II explores two distinctive features of anti-perfectionist liberalism—loyalty to the individual and emphasis on neutrality. In doing so, it explains why a liberal paradigm is incapable of providing a coherent theoretical framework for promoting health care reform. Part III explores three different conceptions of the common good. First, it examines the common good as presented in recent Catholic social teaching. Next, it summarizes John Rawls’ conception of political liberalism, with particular emphasis on public reason and the common good. Finally, it defines a third conception—the political common good—and argues in favor of adopting this as a more robust theoretical foundation for political discourse on health care reform. Part IV uses the Oregon Health Plan, enacted in 1989 and implemented in 1994, to point out the potential of understanding health care as a political common good. The Article concludes by speculating on what a rescue of common good-talk would add to deliberations over health care policy.

\footnote{least in the short term—yet questioning whether the costs to society are reduced); Joseph P. Shapiro, \textit{Giving Doctors the Final Word}, U.S. NEWS & WORLD REP., Nov. 22, 1999, at 20 (reporting that the country’s second-biggest managed care company was returning medical decisionmaking to doctors from bureaucrats).}

\footnote{3. \textit{See, e.g., U.S. Health Care Costs Rose Faster in 1998}, N.Y. TIMES, Jan. 11, 2000, at F14 (“Total health care spending rose 5.6 percent in 1998, compared with 4.7 percent in 1997. The increase was the biggest since an 8.7 percent jump in 1993.”).}
I. CLINTON’S HEALTH CARE PLAN AND THE LIMITS OF LIBERALISM

Every American must have the security of comprehensive health benefits that can never be taken away. That is what the Health Security Act is all about. . . . In short, all the things that are wrong with our health care system threaten everything that’s right. To preserve what’s right and fix what’s wrong, we must get the system under control—and put people first.4

Promising cradle-to-grave security for all, regardless of health or employment status, and intending at the same time to curb skyrocketing health care costs, President Clinton’s grand strategy for overhauling American health care—his 1993 Health Security Act5—was simply too complex and politically vulnerable, as both academics and journalists tell us,6 to make it through Congress. And yet another try at comprehensive health care reform misfired.


5. S. 1757, H.R. 3600, 103d Cong. (1993). Incorporating selective regulatory and market concepts of managed competition—a prominent health care reform strategy developed by market-oriented health economists—Clinton’s plan envisioned a government-guided system of private health plans and insurance companies that would compete to enroll large regional purchasing cooperatives, or “health alliances,” of workers and other groups. However, worried that competition to win contracts with employers would not drive down health spending quickly enough, the President deserted managed competition on this crucial point and proposed that the federal government—with a new National Health Board regulating the national budget for health care spending—impose caps on the growth in health premiums. Compare The President’s Health Security Plan: The Draft Report (Sept. 7, 1993), in THE PRESIDENT’S HEALTH SECURITY PLAN, supra note 4, at 44-51, 60-70, 81-90, 102-10, with Alain C. Enthoven, The History and Principles of Managed Competition, HEALTH AFF., Supp. 1993, at 24.

6. Clinton’s plan failed for many reasons. See, e.g., CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 122 (2d ed. 1998) (contending that Clinton’s young administration failed “to appreciate the limits of its political mandate and its indulgence of insiders who preferred a heavier involvement of government than Congress and the nation were prepared to endorse”); CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 75-80 (1995) (arguing that “[t]he Clinton program, in trying to bridge the gulf between true egalitarianism and a system based on market choices, was true to the principles of neither and suffered the shortcomings of both”); HAYNES JOHNSON & DAVID S. BRODER, THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT (1996) (attributing outcome to political forces and miscalculations); JOSEPH A. SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 30 (1998) (attributing failure to “politics as usual, the health care and insurance industries’ $100 million campaign against the reform, the fear the cost would increase our already staggering national debt, the plan was too complex, Americans’ wariness of government programs . . . ”). See also THEIDA SKOCPOL, BOOMERANG: CLINTON’S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996); Nativism, Hollow Corporations, and Managed Competition: Why the Health Care
That account of complexity and politics is fashionable. This Article tells a different story. It contends that Clinton’s plan overlooked certain fundamental defects in our health care system—namely, its almost reverential regard for liberal individualism and its failure to consider health care as a public or common good. While Clinton fashions himself a new kind of Democrat, his proposed reforms reflected a hackneyed version of liberalism by treating with uncompromising respect the health care choices of autonomous individuals and doing little to encourage debate over competing visions of what might constitute good health care. At its root, Clinton’s failed plan underscores what is blocking comprehensive health care reform: It is the limits of liberalism itself.

These limits are also illustrated in the nation’s response to the demise of Clinton’s plan. In its wake, private actors—especially large corporations that provide health coverage to their workers—embraced market competition as the way to manage growing problems with health care spending and quality. Having evolved on its own because of economic pressures, managed care hurriedly became the de facto national health policy, and now dominates the medical marketplace. Not surprisingly, as


7. Six basic principles defined Clinton’s plan: security, simplicity, savings, quality, choice, and responsibility. See Clinton Letter, supra note 4. See also PRESIDENT’S REPORT, supra note 4. Notably absent is any discussion of community-centered values or alternatives to health care viewed as a commodity—a private good purchasable in the medical marketplace.


10. Membership in health maintenance organizations (HMOs) increased nationally from 36.5 million in 1990 to 67.5 million in 1996, or to approximately one in four Americans, with an additional 97.8 million enrolled in less tightly organized Preferred Provider Organizations (PPOs). See American Ass’n of Health Plans, Managed Care Facts 1-2 (visited June 3, 1999) <http://www.aahp.org/menus/index1.cfm>. See also Steven Findlay, Eighty-five Percent of American Workers Using HMOs, USA TODAY, Jan. 20, 1998, at A3 (reporting on 1997 study of 3,900 employers which “found that 85% of workers at firms with 10 or more employees are now enrolled in managed health plans, up from 77% in 1996 and 52% in 1993”).
managed care has spread, so have complaints from patients and physicians about the loss of choice and prerogatives. An anti-managed care backlash has already prompted many states to enact laws expanding patient rights, and both parties in Congress to propose patient-friendly legislation.

Partisans counter that the transition to managed care did meet its foremost goal of decelerating growth in health spending over the past five years. That much is true. Yet the sharp turn toward cost containment has


12. In 1998, Congress considered three main pieces of legislation, including a Democratic leadership bill endorsed by the White House, intended to codify a “Patients’ Bill of Rights.” All three measures extended to patients their choice of providers, access to medical specialists and emergency services, and provided them with the right to appeal decisions made by their health insurer. See, e.g., Lizette Alvarez, Clinton and G.O.P Press Rival Plans on Health Care, N.Y. TIMES, July 17, 1998, at A15; Amy Goldstein & Helen Dewar, Partisan Split on Patients’ Rights Widens, WASH. POST, July 16, 1998, at A1.

Despite parliamentary maneuvers to bring to the Senate floor a Republican bill passed earlier by the House, the year-long effort to subject the managed care industry and other health insurers to new federal regulations died in the closing days of the 105th Congress. See, e.g., Amy Goldstein & Helen Dewar, Senate Kills ‘Patients’ Rights’ Bill, WASH. POST, Oct. 10, 1998, at A1.

In 1999, the rallying cry of “patients’ rights” was again heard in the new 106th Congress. See, e.g., Amy Goldstein, ‘Patients’ Rights’ Is Revived as a Congressional Debating Point, WASH. POST, Mar. 18, 1999, at A6; Alison Mitchell, House G.O.P. Pushes Bills to Increase Patients’ Rights but Keep Curbs on Suing H.M.O.’s, N.Y. TIMES, June 10, 1999, at A26. See also Healthcare Reform, HEALTH L. DIG. (American Health Law Ass’n), June 1999, at 35 (noting that at least ten comprehensive federal managed care reform bills were filed in the 106th Congress).

In October 1999, the House passed a bill on managed care, strongly supported by President Clinton, “to give patients a wide range of new rights, including the right to sue health insurance plans that cause injury by denying care or providing substandard treatment.” Robert Pear, House Passes Bill to Expand Rights on Medical Care, N.Y. TIMES, Oct. 8, 1999, at A1 (describing H.R. 2990, 106th Cong. (1999)). A Senate measure, passed in July, provides “patients with a more limited set of rights . . . [and] would not expand the right to sue H.M.O’s.” Id. (describing S. 1344, 106th Cong. (1999)).


Of course, the rush to managed care is not the only story here. Low general and medical-specific inflation and excess health system capacity also contributed to slowing spending increases. See id. at 35, 37. More dramatically, big-business health care purchasers pressured insurers and managed care organizations to keep premium increases below underlying costs, and required workers to pay ever larger shares of those premiums. Other recent cost-containment efforts by big business have included dropping eligibility for dependents and eliminating coverage for some employees. See Martin, supra note 8, at 560-74 (1997).
left more Americans uninsured, and with health insurance premiums predicted to rise again, enduring health care reform may require more than managed care alone can deliver.

Still, the ever-increasing role of managed care illustrates how private market forces are transforming the American health care system in fundamental ways, and further highlights how much of the current discourse on reform is market-oriented. No better case of this can be found than the 1997 Medicare legislation which, over the next five years, will transform Medicare from a government insurance program into one in which the federal government increasingly buys beneficiaries private coverage from participating health plans.


Following five years of near-stability, health spending is expected to rise as a share of gross domestic product (GDP) beginning in 1998, climbing from 13.6 percent in 1996 to an estimated 16.6 percent by 2007 . . . . National health spending will likely [double over the next decade, reaching] 2.1 trillion by 2007.

Id. Most recent data confirms these predictions; in 1998, national health care spending experienced its largest increase since 1993. See supra note 3.


17. See, e.g., AREEN ET AL., supra note 9, at 732:

At its core, the debate [over health care reform] revolves around the complex issue of how to obtain maximum efficiency in the market (e.g., cost-effectiveness, quality, and fair distribution of services). The key question, then, is how to assure the conditions under which the market can best achieve greater access, fairer distribution, higher quality, and lower cost in health care services. Whether the market alone can accomplish these objectives or whether the government must intervene, and to what extent, lies at the heart of health care reform in the United States.

Id. The Balanced Budget Act of 1997 § 4001, 42 U.S.C.A. §§ 1395 w-21 to w-27 (West Supp. 1998), created a new Medicare Part C entitled “Medicare+Choice Program.” Part C greatly expands the options available to Medicare beneficiaries, spanning virtually the entire health insurance spectrum from fee-for-service plans to medical savings accounts, see id. at § 1395 w-21(a)(2), and “enable[s] the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.” H.R. Rep. No. 105-217, at 585 (1997).
effect, “ratifies market-oriented approaches as the new national health policy for dealing with health care costs.”

This enthusiasm from Washington politicians for market competition and patient rights is predictable. Ours is truly a liberal nation, equally resistant to government solutions for societal problems and in love with individual rights. Leaving health care to the market is a natural outcome of state neutrality—the liberal ideal that government should be neutral among competing conceptions of the good life. In considering how best to reorganize America’s ailing health care system, national political leaders not surprisingly adopt cautious technological solutions that monkey with the market paradigm, while skirting the more difficult cultural issues such as defining health and disease or setting limits on “choices, progress, and profit” in health care. And when challenged by voters’ displeasure with managed care, their response is equally liberal—a remedy anchored in individual rights.

Our nation’s abiding confidence in neutrality and rights is understandable, though misplaced. What Daniel Callahan calls the “reigning vision” of American health care is unabashedly liberal, for it includes “a broad, limitless definition of health; a highly subjective notion of individual need, one captivated by the diversity of personal goals and desires; and a strong view of human rights, in particular the right of individuals to have access to adequate healthcare.” Add to this vision “several deeply ingrained values that have come to characterize our

20. See RONALD DWORKIN, A MATTER OF PRINCIPLE 191 (1985) (“[Liberalism] supposes [as its constitutive political morality] that political decisions must be, so far as possible, independent of any particular conception of the good life, or of what gives value to life.’’). For Dworkin’s mature view on liberal neutrality, see infra notes 110-30 and accompanying text.
22. Daniel Callahan, Rationing Medical Progress: The Way to Affordable Health Care, 322 NEW ENG. J. MED. 1810, 1811 (1990). One of Callahan’s most important contributions to the ongoing debate on health care reform is to label the American health care crisis as moral and cultural, not just economic. See generally, e.g., DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS (1990) [hereinafter CALLAHAN, WHAT KIND OF LIFE]; DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987).
23. See CALLAHAN, WHAT KIND OF LIFE, supra note 22, at 34.
24. Id.
system” and one can easily chart the difficult course of meaningful health care reform in the United States.

First, we prize autonomy and freedom of choice and want everyone to have them: patients, physicians and other health care workers, and hospital and health administrators. In the name of freedom we indulge our hostility to governmental control and planning, thus setting ourselves apart from every other developed country. Second, we cherish the idea of limitless medical progress, which has come to mean that every disease should be cured, every disability rehabilitated, every health need met, and every evidence of mortality, especially aging, vigorously challenged. Moreover, we embrace the good living that can be made in the effort to combat mortality. Doing good and doing well have found their perfect meeting place in American health care. Finally, we long for quality in medicine and health care, which in practice we define as the presence of high-class amenities (no gross queuing or open wards for us) and a level of technology that is constantly improving and welcoming innovations. High quality medicine is understood, in effect, as a kind of medicine that is better today than yesterday and will be even better tomorrow.

That vision and those values expose the paramount status American culture accords to the “value complex of individualism,” with its emphasis on autonomy, self-determination, and individual rights. And, as Callahan tells us, this cultural gestalt easily extends to health care.

As this Article tries to show, true reform will require looking beyond individual choices made by bargain-hunters in the medical marketplace and beginning to think in the “‘first person plural.’” Fundamentally different than much of contemporary liberalism, “first person plural” thinking (in the area of health) rejects liberal neutrality, fosters debate among competing conceptions of the good life and, after public deliberation, adopts a particular conception (or congruous conceptions) which, in turn, guides the design of health care policy.

25. Callahan, Rationing Medical Progress, supra note 22, at 1811.
26. Id.
28. This expression is from Amy Gutmann & Dennis Thompson, Democracy and Disagreement 148 (1996) (describing one deliberative conception of accountability in the practice of political representation within the authors’ argument for deliberative democracy). The meaning of the expression as used here is mine.
29. For prototypes of this alternative, more communitarian, thinking within the health care context, see Ezekiel J. Emanuel, The Ends of Human Life: Medical Ethics in a Liberal Polity (1991) (arguing for a liberal communitarian vision of health care); Callahan, What Kind of Life, supra note 22 (arguing that political society must not hesitate to talk about human ends and the human good in setting general health care priorities).
alternative “constitutive political morality” that defies liberalism as the de facto public philosophy in America; it exposes the failure of liberal political philosophy to provide an effective theory of justice for health care.31

What is at the heart of this failure, and why is substantive health care reform so elusive for America’s liberal polity? As we shall see, liberalism itself, with its true core of autonomy,32 is the problem. A look at the basic values of liberalism, particularly the intertwined notions of pluralism and freedom, reveals an obstacle for achieving genuine reform. That obstacle is the nation’s “emphasis on the individual”33 and its fondness for liberal theories holding “that requirements of justice must reflect the free agreement of rational individuals concerned to further their own ends.”34 While there is much to be said for America’s predominant weltanschauung in other political spheres,35 liberal individualism fares less well in the particular world of health policy because, in part, it views health care as a private good to be safeguarded rather than a public good to be shared in common. At the same time, this conviction alone orders much of current 30. This expression is from DWORKIN, supra note 20, at 192. Dworkin defines a “constitutive position” as “a political position valued for its own sake: a political position such that any failure fully to secure that position, or any decline in the degree to which it is secured, is pro tanto a loss in the value of the overall political arrangement.” Id. at 408 n.1.
31. Cf. NORMAN DANIELS, JUST HEALTH CARE 44 n.2 (1985):
[Rawls’] principles [of justice] do impose some substantive constraints on the fleshed-out principles of justice, even if the details of [weighing] the index of [primary goods] are not known: the worst off, however determined by an appropriate index, must be maximally well off. But this advances little toward a substantive theory for health care. All we know is that our fair share of social goods will be weighted according to some appropriate consideration of our health care needs, given social conditions, etc. If this is all that emerges from contract theory then we have not moved very far toward knowing what our entitlements to health are likely to be, which was the point of turning to the theory in the first place.
Id.
32. See JOHN KEKES, AGAINST LIBERALISM 15 (1997). For more on Kekes’ view of liberalism, see infra notes 51-53, 55-56 and accompanying text.
34. Jecker & Jonsen, supra note 33, at 208 (citing JOHN RAWLS, A THEORY OF JUSTICE (1971)); ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA (1974)).
35. This worldview combines the genius of the American self-image—individualism, self-reliance, progress, and prosperity—with the theoretical categories of liberal social philosophy—the self-interested, acquisitive self; the self-regulating market; the instrumental conception of social relationships; and the notion that politics is bargaining among interests. See generally BEHLAH ET AL., supra note 33.
policy debate and typically forecloses serious discussion of alternatives. Indeed, the question remains whether any shift in health care thinking might enrich the political landscape. This Article takes on the challenge of endorsing an alternative paradigm for deliberating about health policy, one that focuses on community-centered values and identifies health care as a common good that benefits the whole society.37

To point health policy discourse and design in a new direction by making the case for the common good first requires looking to, and then beyond, the political liberalism of John Rawls.38 Particularly intriguing is Rawls’ reluctance to put aside the idea of the common good.39 When any liberal approach to political philosophy, much less Rawls’, grants standing to the common good and moves in a more communitarian direction, this turn should not go unnoticed.40 Here, the task is not simply to exhume, but rather to reclaim the wisdom of the common good tradition, to translate


38. It is a commonplace observation that Rawls’ A Theory of Justice (1971) defined the agenda for much of political theory in the 1970s and 1980s, and his subsequent “turn to the political” in Political Liberalism (1993) remains controversial in the late 1990s. For Rawls’ comments on a political conception of justice as fairness, see infra notes 225-37 and accompanying text.

39. In a well-ordered society regulated by Rawls’ political conception of justice, the common good may qualify as a permissible form of public reason. See infra notes 242-52 and accompanying text.

40. Traditional common good thinking—with roots in classical and medieval (Roman Catholic) political theory—did not withstand the philosophical challenges of the Enlightenment. In particular, the British empiricist tradition beginning with Hobbes, and the comprehensive liberal visions of Kant and John Stuart Mill, eventually led secular political philosophies to abandon common good thinking. For more on this philosophical history, see Kevin P. Quinn, S.J., Sandel’s Communitarianism and Public Deliberations Over Health Care Policy, 85 GEO. L.J. 2161, 2171-75 (1997). In Rawls’ own words, “[t]here is, or need be, no war between religion and democracy . . . . [P]olitical liberalism is sharply different from and rejects Enlightenment Liberalism, which historically attacked orthodox Christianity.” John Rawls, The Idea of Public Reason Revisited, 65 U. CHI. L. REV. 765, 804 (1997).
these insights in light of political liberalism, and finally to apply them to health policy discourse and design.

Of course, much in traditional common good thought is undemocratic. There is no denying that deliberation about the common good was often tied to various strategies of exclusion, and the subordination of private interests to a unitary public good inevitably carried risks of coercion, tyranny, and “even mysticism.” In traditional societies, moreover, people sought to shape the common good in the image of their comprehensive moral and religious ideals. These are common arguments against the common good. Must we simply accept them with regret? Not if we can deliver the “politics of the common good” from its exclusive and coercive tendencies, allowing it to foster legitimate “first person plural” thinking in a democratic society.

What, then, is distinctive about the common good? To be sure, “[t]he notion of the common good has...a vagueness that cries out for specification and clarification.” A tempting first answer might be this: “Unlike approaches that begin (and often end) with an emphasis upon individualism, the common good is fundamentally social and institutional in its focus.” Catholic social teaching, in particular, invokes the common

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43. This expression is from Michael J. Sandel, *Democracy’s Discontent: America in Search of a Public Philosophy* 25 (1996). I use it, following Rawls, to mean a political rather than comprehensive understanding of the common good. See infra notes 225-37 and accompanying text.
45. B. Andrew Lustig, *The Common Good in a Secular Society: The Relevance of a Roman Catholic Notion to the Healthcare Allocation Debate*, 18 J. MED. & PHIL. 569, 574 (1993). See also JOHN XXIII, *MATER ET MAGISTRA* (1961), reprinted in *CATHOLIC SOCIAL THOUGHT*, supra note 42, at 84, 94 (“[The common good] embraces the sum total of those conditions of social living, whereby men are enabled more fully and more readily to achieve their own perfection.”); JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 155 (1980) (defining common good as “a set of conditions which enables the members of a community to attain for themselves reasonable objectives, or to realize reasonably for themselves the value(s), for the sake of which they have reason to collaborate with each other
good “to temper and to correct the inequities often associated with secular individualism.” That corrective function finds expression in the case offered here for adopting a more community-centered vision of health care.

To take up the common good, however, does not require defending comprehensive doctrines long associated with it. Rather, this Article argues for a “political view” of the common good or, as Rawls puts it, “the common good . . . expressed in terms of political values.” Rawls’ view of the common good avoids an appeal to any comprehensive doctrine and in its place seeks the support of an overlapping consensus based on publicly accessible reasons. I adopt a similar approach here. The Article seeks to explain why it is appropriate—nay, necessary—in the health care context for citizens to deliberate over a political kind of common good, or as complete a conception of a common good as is possible within a morally pluralistic society. To be clear, the political common good is “political” in the Rawlsian sense, and “common” in the Catholic sense with its organic vision of society. In this way, we can look beyond political liberalism and view American health care as a common good.

(positively and/or negatively) in a community”); DAVID HOLLENBACH, CLAIMS IN CONFLICT: RETRIEVING AND RENEWING THE CATHOLIC HUMAN RIGHTS TRADITION 64 (1979) (defining common good as the “set of social conditions which facilitate the realization of personal goods by individuals”); John Langan, Common Good, in THE WESTMINSTER DICTIONARY OF CHRISTIAN ETHICS 102 (James F. Childress & John Macquarrie eds., 1986) (noting that the common good “insists on the conditions and institutions which are necessary for human cooperation and the achievement of shared objectives as decisive normative elements in the social situation, elements which individualism is both unable to account for in theory and likely to neglect in practice”).

46. Lustig, supra note 45, at 574.
47. As used in this Article, the phrases “‘political view’ of the common good,” “political kind of common good,” and “political common good” are synonymous.
49. The theoretical framework that I propose in this Article is not meant to be appropriate in all contexts and circumstances. Cf. Robert P. George, Public Reason and Political Conflict: Abortion and Homosexuality, 106 YALE L.J. 2475, 2495, 2499 (1997) (arguing that “political liberalism” cannot provide a rational alternative to the conflict of comprehensive views, at least when it comes to morally charged issues such as abortion and homosexuality).
50. See GUTMANN & THOMPSON, supra note 28, at 92 (defending an ideal of deliberative democracy that “does not aim at the kind of common good that many communitarians seek [i.e., comprehensive conceptions of the good]”).
II. HEALTH CARE REFORM AND THE LIMITS OF LIBERALISM

Liberalism, with its true core of autonomy\textsuperscript{51} and attendant values of pluralism\textsuperscript{52} and freedom,\textsuperscript{53} has become the de facto public philosophy of our time. It is a theory, or more precisely a family of theories, about political morality that presupposes that “only individuals count, that all individuals count equally, and that all individuals count as agents.”\textsuperscript{54} These fundamental commitments and values, by themselves, prove incapable of providing a coherent political framework that engages the normative issues necessary to the debate over health care reform. This Part explains why liberalism is ultimately unequal to the task: The liberal view is too limited because more is at stake than individual needs and state-neutrality over competing visions of what good health care might be.

A. LIBERAL INDIVIDUALISM

While it is necessary to understand liberalism as a spectrum that ranges from libertarianism\textsuperscript{55} to egalitarianism,\textsuperscript{56} much of contemporary

\textsuperscript{51} See KEKES, supra note 32, at 15 (“Although pluralism, freedom, rights, equality, and distributive justice are the basic values of liberalism, it must be explained why liberals attach such great importance to them . . . . [Autonomy] is the true core of liberalism, the inner citadel for whose protection all the liberal battles are waged . . . .”).

\textsuperscript{52} See id. at 6 (“[G]overnment should be neutral about the conceptions of a good life its citizens pursue . . . . Pluralism is thus the liberal value that defines the right political attitude toward the good.”).

\textsuperscript{53} See id. at 7 (“If pluralism is the recognition that there are many different values and conceptions of a good life, then freedom is the political space in which individuals can choose among them.”).

\textsuperscript{54} DAVID JOHNSTON, THE IDEA OF A LIBERAL THEORY: A CRITIQUE AND RECONSTRUCTION 24 (1994).

\textsuperscript{55} Libertarian liberalism presumes that:

[T]he most basic liberal value is freedom, conceived as the absence of external interference with individual activities . . . . The role of government is to do what is necessary to guarantee the most extensive private sphere within which individuals are left free to make of their lives what they please.

. . . . This is the liberalism of Mill, Berlin, Friedrich Hayek, and Robert Nozick, among others.

\textsuperscript{56} In contrast:

[Egalitarian liberalism requires] both freedom and welfare rights. It requires that individuals should be guaranteed certain basic goods that are needed for living according to any conception of a good life. The role of government, therefore, is to protect not merely freedom rights but also welfare rights. Since the resources required for equal welfare rights are unequally distributed, part of the role of government is to redistribute resources so as to assure that everyone has an equal opportunity to pursue one among the available plurality of conceptions of a good life.

. . . . This is the liberalism, for instance, of Bruce Ackerman, Ronald Dworkin, David Gauthier, Alan Gewirth, Thomas Nagel, and Rawls, to name some of the its best-known representatives.
liberalism can be seen as a reaction against utilitarianism. The works of Rawls,57 Dworkin,58 and Nozick59 are, in one way or another, dominated by the aim of developing a political theory to replace utilitarianism. Rights-talk figures prominently in this development; its special function is to represent the individual interest against the general good or claims of others, to put limits on the pursuit of the general welfare or collective interest.60 As Ronald Dworkin puts it, “[t]he concept of rights . . . has its most natural use when a political society is divided, and appeals to cooperation or a common goal are pointless.”61

Though responsive to the commonplace criticism that “[u]tilitarianism does not take seriously the distinction between persons,”62 our current infatuation with rights-talk “disserves public deliberation not only through affirmatively promoting an image of the rights-bearer as a radically autonomous individual, but through its corresponding neglect of the social dimensions of human personhood.”63 This does not imply that liberal theory is necessarily deficient in its fullest sense, but rather in the seemingly narrow, individualistic sense that has been predominantly implemented in practice. In the long run, a defensible theory of the nature

KEKES, supra note 28, at 13 (citations omitted).

57. See JOHN RAWLS, A THEORY OF JUSTICE 3 (1971) (“My guiding aim is to work out a theory of justice that is a viable alternative to [classical utilitarianism and intuitionist conceptions of justice] which have long dominated our philosophical tradition.”).

58. See RONALD DWORKIN, TAKING RIGHTS SERIOUSLY vii (1977) (in defending “a liberal theory of law,” Dworkin is sharply critical of “the ruling theory of law” and its two parts: legal positivism and utilitarianism).

59. See ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 26-53 (1974). Nozick’s attempt to derive the legitimacy of a minimal state from strongly individualistic premises is decidedly anti-utilitarian.

60. Dworkin’s rights thesis, with its metaphor of individual rights as trumps, is paradigmatic. See DWORKIN, TAKING RIGHTS SERIOUSLY, supra note 58, at xi (“Individual rights are political trumps held by individuals. Individuals have rights when, for some reason, a collective goal is not a sufficient justification for denying them what they wish, as individuals, to have or to do, or not a sufficient justification for imposing some loss or injury upon them.”). On liberal individualism as a rights-based theory, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 69-77 (4th ed. 1994).

61. DWORKIN, TAKING RIGHTS SERIOUSLY, supra note 58, at 184.

62. RAWLS, A THEORY OF JUSTICE, supra note 57, at 27. See Amartya Sen & Bernard Williams, Introduction to UTILITARIANISM AND BEYOND 4 (Amartya Sen & Bernard Williams eds., 1982) (“Essentially, utilitarianism sees persons as locations of their respective utilities—as the sites at which such activities as desiring and having pleasure and pain take place. Once note has been taken of the person’s utility, utilitarianism has no further direct interest in any information about him.”).

63. MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE 109 (1991). Glendon argues that “[u]r current American rights talk . . . is set apart from rights discourse in other liberal democracies by its starkness and simplicity, its prodigality in bestowing the rights label, its legalistic character, its exaggerated absoluteness, its hyperindividualism, its insularity, and its silence with respect to personal, civic, and collective responsibilities.” Id. at x.
and value of individual autonomy will fall between radical individualism and extreme collectivism.\textsuperscript{64} It must explain the obligations to create and maintain social and political institutions that support the exercise and flourishing of autonomy.\textsuperscript{65} As matters now stand, however, contemporary American culture has elevated the concept of liberty (and respect for autonomy) to a level that seems to undermine the concept of community to the detriment of both society at large and many of its citizens.

James Madison wrote in \textit{The Federalist No. 45} that “the public good, the real welfare of the great body of the people, is the supreme object to be pursued.”\textsuperscript{66} Unfortunately, we have allowed unchecked individualism to prevent us from living up to Madison’s expectations.

In \textit{Habits of the Heart},\textsuperscript{67} Robert Bellah and his associates conclude that over the past century, among major contending American traditions of moral discourse, modern individualism\textsuperscript{68} has captured the American mind by overshadowing (though not extinguishing) other prominent cultural strands such as biblical religion and civic republicanism.\textsuperscript{69} To be sure, the

\begin{itemize}
\item \textsuperscript{64} See \textit{Beauchamp \& Childress}, \textit{supra} note 60, at 124-25:
\smallskip
Some critics of the current emphasis on autonomy in ethical theory view it as focused too narrowly on independence from others, while underestimating the importance of intimate and dependent relationships. Religious traditions are sometimes suspicious of appeals to autonomy that render the individual independent of a transcendent power, and several philosophical traditions question the model of an independent self, especially when presented as a rational will that is inattentive to communal life, reciprocity, and the development of persons over time. . . . These criticisms typically apply to stark, individualistic conceptions of autonomy that more balanced theories avoid.
\smallskip
\textit{Id.}
\item \textsuperscript{65} See \textit{id.} at 125 (“Communal life and human relationships provide the matrix for the development of the self, and no defensible theory of autonomy denies this fact.”).
\item \textsuperscript{66} \textit{The Federalist No. 45}, at 134 (James Madison) (Roy P. Fairfield ed., 2d ed. 1981).
\item \textsuperscript{67} \textit{Bellah ET AL., Habits of the Heart, supra} note 33 (aspiring to restore the idea of social science as public philosophy through a sociological exploration of contemporary American culture and character in the spirit of Tocqueville’s \textit{Democracy in America}).
\item \textsuperscript{68} Bellah et al. define individualism as follows:
\smallskip
\textit{Individualism}. A word used in numerous, sometimes contradictory, senses. We use it mainly in two: (1) a belief in the inherent dignity and, indeed, sacredness of the human person. In this sense, individualism is part of all four of the American traditions we have described in this book—biblical, republican, utilitarian individualist, and expressive individualist; (2) a belief that the individual has a primary reality whereas society is a second-order, derived or artificial construct, a view we call \textit{ontological individualism}. This view is shared by utilitarian and expressive individualists. It is opposed to the view that society is as real as individuals, a view we call \textit{social realism}, which is common to the biblical and republican traditions.
\smallskip
\textit{Id.} at 334. See \textit{id.} at 32-35, 142-52.
\item \textsuperscript{69} According to Bellah et al.: [The republic tradition] presupposes that citizens of a republic are motivated by civic virtue as well as self-interest. It views public participation as a form of moral education and sees its purposes as the attainment of justice and the public good . . . . In much of American history, the republican tradition has been closely linked to the biblical tradition.
\smallskip
\textit{Id.} at 335 (emphasis omitted).
\end{itemize}
language of individualism governs most contemporary discussion of the public order: “The rules of the competitive market, not the practices of the town meeting or the fellowship of the church, are the real arbiters of living." Yet the authors share Alexis de Tocqueville’s concern that this individualism, untempered by our biblical and republican traditions, might eventually destroy the conditions necessary for freedom by dividing and isolating Americans.

Bellah’s study, however, uncovered solid evidence that public life still survives, “built upon the second languages and practices of commitment that shape character.” Among these second languages, those of civic republicanism and biblical religion especially “form those habits of the heart that are the matrix of a moral ecology, the connecting tissue of a body politic.” For this reason, many Americans—nostalgic about the idealized nineteenth-century “small town”—hope for a republican revival, while others want to recapture the “utopian touch” of our Puritan ancestors: “We must delight in each other, make others’ conditions our own, rejoice together, mourn together, labor and suffer together, always having before our eyes our community as members of the same body.” They realize that though individualism historically has promoted human dignity and provided the impetus to the struggle for popular self-government, it must

70. Id. at 251.
71. In the 1830s, Tocqueville coined the word individualism and described this aspect of the American character derisively, as a “mature and calm feeling, which disposes each member of the community to sever himself from the mass of his fellows, and to draw apart with his family and his friends” thereby leaving “society at large to itself.” ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 173 (Andrew Hacker ed., Washington Square Press 1964) (1863). He cautioned that individualism first “saps the virtues of public life,” leading individuals to imagine that “[t]hey owe nothing to any man,” and to acquire the habit of “always considering themselves as standing alone . . . and to imagine that their whole destiny is in their own hands.” Id. at 173-75. It then “attacks and destroys all other [virtues], and is at length absorbed in downright selfishness.” Id. at 173.
72. See BELLAH ET AL., supra note 33, at vii.
73. Id. at 251.
74. Id.
75. Id.
77. See BELLAH ET AL., supra note 33, at 29.
78. John Winthrop, A Model of Christian Charity (sermon), in PURITAN POLITICAL IDEAS 1558, 1575, 1592 (Edmund S. Morgan ed., 1965), quoted in BELLAH ET AL., supra note 33, at 28. Winthrop (1588-1649) was a Puritan and elected first governor of the Massachusetts Bay Colony. Freedom for Puritans was not liberty to do whatever they wanted, but rather moral freedom—liberty to do what is good, just, and honest as part of an ethical community. See id. at 28-29.
now be balanced by a renewal of commitment and community if we are not to self-destruct.

Echoing similar concerns in the language of political theory is the communitarian critique of liberalism.\textsuperscript{79} Among the several themes on which the liberal-communitarian debate has focused,\textsuperscript{80} two are of particular interest here: asocial individualism and neutrality.\textsuperscript{81} While communitarians

\textsuperscript{79} In the 1980s, Michael Sandel identified himself and others (e.g., Alasdair MacIntyre, Peter Berger, Charles Taylor, Michael Walzer, and Michael Oakeshott) as “communitarian critics of rights-based liberalism.” Michael J. Sandel, \textit{Introduction} to \textit{LIBERALISM AND ITS CRITICS} 1, 5-6, 10-11 (Michael J. Sandel ed., 1984) [hereinafter Sandel, \textit{Introduction}]. However, the word “communitarian” is largely attributed to these authors by commentators (sympathizers and critics alike) and is not unambiguous. For instance, the very status of Walzer as a communitarian is occasionally questioned. See, e.g., Patrick Neal & David Parks, \textit{Liberalism and the Communitarian Critique: A Guide for the Perplexed}, 23 \textit{C AN. J. P OL. S CI.} 419, 419 & n.1 (1990). By the 1990s, with Rawls’ ongoing self-critique and reinterpretation of \textit{A Theory of Justice}, Sandel’s principle target has become “minimalist liberalism.” SanDel, DEMOCRACY’S DISCONTENT, supra note 43, at 18. For a brief overview of Sandel’s critique of liberalism and liberal responses, see Quina, supra note 40, at 2165-70. The literature on the debate between communitarians and liberals is extensive. See, e.g., \textit{COMMUNITARIANISM AND INDIVIDUALISM} (Shlomo Avineri & Avner de-Shalit eds., 1992); \textit{STEPHEN MULHALL & ADAM SWIFT, LIBERALS AND COMMUNITARIANS} (2d ed. 1996); \textit{UNIVERSALISM VS. COMMUNITARIANISM} (David Rasmussen ed., 1990); Symposium, \textit{Rawlsian Theory of Justice: Recent Developments}, 99 \textit{ETHICS} 695 (1989).

\textsuperscript{80} Mulhall and Swift identify five themes in the communitarian critique of liberalism: the conception of the person, asocial individualism, universalism, subjectivism or objectivism, and anti-perfectionism and neutrality. See \textit{MULHALL & SWIFT, supra} note 79, at 9-33. In comparison, Avineri and de-Shalit maintain that communitarianism offers both a methodological and normative challenge to individualist political theories. See \textit{Shlomo Avineri & Avner de-Shalit, Introduction to COMMUNITARIANISM AND INDIVIDUALISM}, supra note 79, at 1-11. On method, “the premises of individualism such as the rational individual who chooses freely are wrong or false, and . . . the only way to understand human behaviour is to refer to individuals in their social, cultural, and historical contexts.” Id. at 2. As to normative discourse, “in order to justify the special obligations that [communitarians] hold to members of our communities . . . one must attach some intrinsic (i.e. non-instrumental) value to community itself and to our relations with other members of the community.” Id. at 6. Buchanan summarizes the fundamental communitarian criticisms of liberalism in five points:

\begin{itemize}
  \item[i)] Liberalism devalues, neglects, and/or undermines community, and community is a fundamental and irreplaceable ingredient in the good life for human beings.
  \item[ii)] Liberalism undervalues political life—viewing political association as a merely instrumental good, it is blind to the fundamental importance of full participation in political community for the good life for human beings.
  \item[iii)] Liberalism fails to provide, or is incompatible with, an adequate account of the importance of certain types of obligations and commitments—those that are not chosen or explicitly undertaken through contracting or promising—such as familial obligations and obligations to support one’s community or country.
  \item[iv)] Liberalism presupposes a defective conception of the self, failing to recognize that the self is “embedded” in and partly constituted by communal commitments and values which are not objects of choice.
  \item[v)] Liberalism wrongly exalts justice as being “the first virtue of social institutions,” failing to see that, at best, justice is a remedial virtue, needed only in circumstances in which the higher virtue of community has broken down.
\end{itemize}


\textsuperscript{81} For discussion on liberal neutrality, see infra Part II.B.
challenge the fundamental premises and trace the limits of contemporary liberalism with different types of criticism, ranging from the socialist left to the conservative right, all oppose the “thinness” of liberal community. In large part, they claim that liberal individualism makes it impossible to achieve a genuine community capable of offering its members a just distribution of goods and a morally meaningful life.

Community is a notoriously ambiguous concept. The definition that Bellah et al, provide is useful for our purposes: “A community is a group of people who are socially interdependent, who participate together in discussion and decision making, and who share certain practices . . . that both define the community and are nurtured by it.” These practices are defined as

shared activities that are not undertaken as means to an end but are ethically good in themselves (thus close to praxis in Aristotle’s sense).

A genuine community—whether a marriage, a university, or a whole society—is constituted by such practices. Genuine practices are almost always practices of commitment, since they involve activities that are ethically good.

Community in this strong sense is what most communitarians champion. Membership in a given community, political or nonpolitical, is understood by communitarians to be a “constitutive attachment, a vital aspect of their well-being and identity rather than an attribute or end which they merely happen to possess.” In short, they regard the community as a
need\textsuperscript{89} and so criticize liberalism for its impoverished understanding of community: Social behavior is more than simply a process of rational cooperation in which people seek to find mutual benefit.\textsuperscript{90} It has some intrinsic (that is, noninstrumental) value in itself.

To be sure, there are objections to communitarianism as a political theory,\textsuperscript{91} and yet liberals of all kinds (with the exception of libertarians)\textsuperscript{92} have taken standard communitarian criticisms to heart. In recent responses there seems to be a consensus recommending “a melding of liberal and communitarian principles”\textsuperscript{93} with liberal thought renewed according to the communitarian critique.\textsuperscript{94} One prominent example is Dworkin’s self-appointed task to define \textit{liberal} community and to explain its relevance to moral ordering.\textsuperscript{95} He rejects the communitarian claim that people need the material and intellectual resources (for example, economic and security benefits, culture and language) that a \textit{morally homogeneous} community

\textsuperscript{89} See \textsc{Communitarianism and Individualism}, supra note 79, at 7 (citing \textsc{Walzer}, supra note 83, at 65-84 (on membership and need)).

\textsuperscript{90} See \textsc{generally David Gauthier}, \textsc{Morals by Agreement} (1986) (arguing that moral principles are principles of rational choice made on an agreed basis of cooperation, rather than according to what would give the individual the greatest expectation of value).

\textsuperscript{91} Foremost among these objections is the charge that, although much of their criticism presents a credible challenge to liberalism, communitarians lack a constructive and well-defined political alternative (in theory or practice) to today’s liberalism. \textit{See}, \textsc{e.g.}, Buchanan, supra note 80, at 853 (“It is fair to say that the eloquence and rhetorical power of communitarian writers frequently exceed their ability to expound their theses clearly and to make the logical structure of their arguments manifest.”); Gutmann, \textit{supra} note 82, at 319 (“The communitarian critics want us to live in Salem, but not to believe in witches.”). \textit{But see Amitai Etzioni}, \textsc{The Spirit of Community: The Reinvention of American Society} 4 (1993) (presenting the communitarian “agenda” in four points: “a moratorium on the minting of most, if not all, new rights; reestablishing the link between rights and responsibilities; recognizing that some responsibilities do not entail rights; and, most carefully, adjusting some rights to changed circumstances”).

\textsuperscript{92} Nozick, for instance, argues that rights should not be pushed aside for the sake of any idea of a common good. \textit{See} \textsc{Nozick}, \textit{supra} note 59, at 149-64.

\textsuperscript{93} Philip Selznick, \textsc{Dworkin’s Unfinished Task}, 77 \textsc{Cal. L. Rev.} 505, 508 (1989).

\textsuperscript{94} \textit{See}, \textsc{e.g.}, Buchanan, \textit{supra} note 80, at 882: A political philosophy that successfully assimilates the best communitarian thinking will almost certainly contain a more subtle and qualified conception of individual rights than is often associated with liberalism, but it is safe to say, I believe, that it will still include a firm commitment to the idea of individual rights. The development of such a theory would represent a fruitful convergence of what is best in liberalism and communitarianism, not a victory of the one over the other.

\textit{Id.}

\textsuperscript{95} \textit{See} Ronald Dworkin, \textsc{Liberal Community}, 77 \textsc{Cal. L. Rev.} 479 (1989) (arguing that liberalism provides the best interpretation of a new concept of community; i.e., integration suggests that people should align their own interests with those of their political communities).
provides, but concedes that “[c]itizens identify with their political community when they recognize that the community has a communal life, and that the success or failure of their own lives is ethically dependent on the success or failure of that communal life.” On this view, “[p]olitical community has [limited but powerful] ethical primacy over . . . individual lives.”

Other liberals do not go so far, but most agree with Dworkin that liberalism espouses some kind of state neutrality. That is an equally important source of communitarian unease.

B. LIBERAL NEUTRALITY

A distinctive feature of anti-perfectionist liberalism is its emphasis on neutrality—the view that public institutions, laws, and policies should not promote any particular conception of the good life, or that in the politics of a liberal society the right should be given priority over the

96. See id. at 487-90.
97. Id. at 499. Dworkin argues that “[t]he integrated liberal will not separate his private and public lives . . . He will count his own life as diminished—a less good life than he might have had—if he lives in an unjust community, no matter how hard he has tried to make it just.” Id. at 501. See also Ronald Dworkin, Foundations of Liberal Equality [hereinafter Dworkin, Foundations], in E QUAL FREEDOM: SELECTED TANNER LECTURES ON HUMAN VALUES 190, 239 (Stephen Darwall ed., 1995) [hereinafter EQUAL FREEDOM]: [O]n some occasions[.]. . . [w]e sense that the most fundamental ethical unit is collective not individual, that the question of whether my life is going well is subordinate to the question whether, for some group of which I am a member, our life is going well.

. . .

I have in mind, as raising a puzzle for ethics, a different and more radical way of connecting my ethical life to my community. This supposes that a community has an ethical life of its own and that the critical success of any individual’s life depends to some degree on the critical success of the life of his community. . . .

Id.

98. Dworkin, supra note 95, at 304.
99. Not all liberals share the view that governments should be neutral between differing conceptions of the good. Contemporary liberals who find this theory of government restraint unsatisfactory include Joseph Raz and William Galston. See WILLIAM GALSTON, LIBERAL PURPOSES (1991); JOSEPH RAZ, THE MORALITY OF FREEDOM (1986). A detailed discussion of their version of liberalism (i.e., perfectionism) exceeds the scope of this Article.
100. Neutrality can be defined and justified in quite different ways. Dworkin’s former view on neutrality is well-known and still widely quoted: [L]iberalism supposes [as its constitutive political morality] that political decisions must be, so far as it is possible, independent of any particular conception of the good life, or of what gives value to life. Since the citizens of a society differ in their conceptions, the government does not treat them as equals if it prefers one conception to another, either because the officials believe that one is intrinsically superior, or because one is held by the more numerous or more powerful group.

DWORKIN, supra note 20, at 191. For Dworkin’s mature argument on state neutrality, see infra text accompanying notes 110-30.
good. The liberal state seeks neutrality not with respect to questions of the right or of justice, but with respect to judgments about what makes a life good or valuable. For many liberals, this requires a moral bracketing in matters of public reasoning—namely, dividing an individual’s conception of the good from one’s public life, especially from the political discourse that seeks to define individual rights and formulate public policy.

Here liberalism faces a second communitarian difficulty; critics attack its separation of personal values from political ideals. The principle target is Rawlsian political liberalism. In justifying the priority of the political, Rawls must insist that “the ideas of the good in the political conception have to be appropriately political and distinct from those in more extensive [comprehensive] views.” For political liberalism, then, citizens should disregard values emanating from incompatible philosophical, religious, and moral doctrines when engaging in public reasoning about “constitutional essentials and questions of basic justice” because the doctrines are not by definition part of the overlapping consensus of political values.

In response, communitarians such as Sandel inquire: “Why, in deliberating about justice, should we set aside the moral judgments that inform the rest of our lives?” “Why must we ‘bracket’ . . . our moral and religious convictions, our conceptions of the good life? Why should we not base the principles of justice that govern the basic structure of society on our best understanding of the highest human ends?” The political liberal

101. See John Rawls, Political Liberalism 173-211 (paperback ed. 1996) (1993) [hereinafter Rawls, Political Liberalism]; John Rawls, The Priority of Right and Ideas of the Good, 17 Phil. & Pub. Aff. 251 (1988). Kekes describes the priority of right as follows: [It] may be further elaborated as the view that the business of government is to formulate and maintain the rules that enable its citizens to make what they wish of their lives. Conformity to these rules is what is right, whereas the good is what guides citizens in trying to live according to their conceptions of what their lives ought to be. The liberal view is that political morality should be concerned with the right and that it should be left to individuals to decide about the good.

Kekes, supra note 32, at 6.

102. This is the ambition of Rawls’ Political Liberalism—to make the case for a political conception of justice as fairness. “Political liberalism, then, aims for a political conception of justice as a freestanding view. It offers no specific metaphysical or epistemological doctrine beyond what is implied by the political conception itself.” Rawls, Political Liberalism, supra note 101, at 10. For more on Rawls’ political liberalism, see infra notes 225-37 and accompanying text.

103. Rawls, Political Liberalism, supra note 101, at xxi.

104. Id. at 214. See also id. at 227-30 (specifying “constitutional essentials”).

105. See id. at 144. “[I]n a constitutional democracy the public conception of justice should be, so far as possible, presented as independent of comprehensive religious, philosophical, and moral doctrines.” Id. (emphasis added). See also id. at 9-11, 144-45.


107. Id. at 1772-73.
might reply, as Rawls does, that “an overlapping consensus of reasonable doctrines . . . is not a mere modus vivendi but is moral in both its object and its content.”108 But suppose Rawls is right, and the idea of an overlapping consensus does not imply moral indifference or skepticism.109 His position is still a direct rejection of communitarian demands for a morally acceptable political society built around a shared comprehensive conception of the good.

In his more recent articles,110 Dworkin parts company with Rawls in defending anti-perfectionist liberalism by purely political means. He considers the communitarian criticism of liberal neutrality “formidable,”111 and Rawls’ defense of liberalism “ingenious,”112 yet ultimately unsatisfactory due to its disconnection of ethics and politics (which Dworkin labels a “strategy of discontinuity”).113 For Dworkin, political liberalism’s flaw is transparent:

Liberalism apparently asks us to ignore instincts and attitudes on political occasions that are central to the rest of our lives . . . . It asks us to put our most profound and powerful convictions, about religious faith and moral virtue and how to live, to sleep. Liberalism therefore seems a politics of ethical and moral schizophrenia; it seems to ask us to become, in and for politics, people we cannot recognize as ourselves, special political creatures wholly different from ordinary people who decide for themselves, in their ordinary lives, what to be and what to praise and whom they love.114

As an alternative defense of liberalism, Dworkin proposes to root liberal politics in personal ethics: “to show how liberalism as a political

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108. Rawls, Political Liberalism, supra note 101, at 126. See id. at 147 (“[A]n overlapping consensus is quite different from a modus vivendi . . . [in] two aspects: first, the object of consensus, the political conception of justice, is itself a moral conception. And second, it is affirmed on moral grounds.”). Thus the overlapping consensus is more than a compromise among conflicting views: “in the overlapping consensus . . . the acceptance of the political conception is not a compromise between those holding different views, but rests on the totality of reasons specified within the comprehensive doctrine affirmed by each citizen.” Id. at 170-71.
109. See id. at 150-54.
112. Id. at 204.
113. Id. at 203-07.
114. Id. at 202.
philosophy connects with another part of our intellectual world, our ideas about what a good life is.”115 Employing a “strategy of continuity” (in which the political perspective is continuous with the personal), his aim is to construct a liberal ethics116—“instincts and convictions about the character and ends of human life that seem particularly congenial to liberal political principles.”117 For Dworkin, there is no denying that “ethics shapes justice, how our sense of what morality requires draws on our sense of what a good life is.”118

So the challenge within liberalism lies in forging a link between individual ethics and community politics, in recognizing that liberals ought to connect their own conceptions of the good and the ethical with a political conception of equality and justice. In the end, Dworkin’s version of liberalism in politics aims to vindicate the claim that “liberal values of freedom and equality are themselves part of what gives value to life.”119

In constructing his argument, Dworkin first appeals to what he calls the “challenge” model of critical ethical value.120 Here he adopts Aristotle’s thesis that, as Dworkin puts it, “a good life has the inherent value of a skillful performance . . . . [I]t holds that events and achievements and experiences can have ethical value even when they have no impact beyond the life in which they occur.”121 Dworkin then insists “on the priority of ethical integrity in any judgments we make about how good someone’s life is.”122

Together, the challenge model of ethics and the priority of ethical integrity “fuse[] value and choice.”123 In other words, “[t]he challenge model is a continuity strategy for justifying political liberty . . . . Accepting

115. Id. at 190.
116. Id. at 207-08.
117. Id. at 207.
118. Id. at 214.
120. See Dworkin, Foundations, supra note 97, at 241, 244-45.
121. Id. at 244 (emphasis added). In adopting the challenge model of ethics, Dworkin rejects an alternative model, “the model of impact, [which] holds that the value of a good life consists in its product, that is, in its consequences for the rest of the world.” Id. at 240. For Dworkin, “[m]any of the ethical goals people regard as very important are not matters of consequence at all.” Id. at 243.
122. Id. at 267. Dworkin contends that: Ethical integrity is the condition someone achieves who is able to live out of the conviction that his life, in its central features, is an appropriate one for him, that no other life he might live would be a plainly better response to the parameters of his ethical situation rightly judged . . . . Giving priority to ethical integrity makes a merger of conviction and life a parameter of ethical success, and it stipulates that a life that never achieves that kind of integrity cannot be critically better for someone to lead than a life that does.

123. Id. at 272.
an *ethical* liberal premise about the value of a life thus leads to political liberal doctrines about liberty.”

Prominent among these doctrines, of course, is neutrality.

From ethics to politics, Dworkin’s more recent version of state neutrality emerges from a liberal ethical framework that emphasizes the challenge model. The need to maintain this neutrality does not arise, as Rawls’ discontinuity strategy suggests, as an axiom “at the start of the story it tells,” but instead, according to Dworkin, as a theorem “in the course of . . . the argument.” This is derivable from more basic propositions of liberal ethics. “The continuity strategy hopes to show how liberalism develops naturally from ethics so that ethics merges into politics, the personal into the political perspective.” On Dworkin’s view, citizens conceived of as “ethical liberals” (that is, wedded to the challenge model of ethical value) and deliberating about what principles should govern their community’s political life would “have good reason to become political liberals, and in particular to adopt the conception of liberalism [he] call[s] liberal equality.” They would, for example, choose a political structure that stresses neutrality and tolerance as continuous rather than discontinuous with their own comprehensive ethical convictions.

Dworkin’s willingness to accept the relevance of the good in the definition of the right, to introduce into political discourse notions regarding the value of a good life, makes him unique among anti-

124. Darwall, *supra* note 119, at 10. Darwall develops this insight further:

If a person can have a good life only if she lives out what, in her own conviction, would be an appropriate response to challenges she faces, then a political order will further the condition for good lives only if it furthers the conditions for ethical integrity. The state will thus lack paternalistic justification for restricting individual liberty, since, if a good life requires ethical integrity, paternalism is likely to be self-defeating.

*Id.*


126. *Id.*

127. *Id.* at 276.

128. Dworkin conducts a thought experiment with deliberators that are very different from the parties in Rawls’ original position. Dworkin’s deliberators know everything actual people know about their own interests, convictions, and situation. *See id.* at 276-77.

129. *Id.* at 277.

130. Liberal equality’s idea of tolerance “insists that government must be neutral in ethics in the following sense. It must not forbid or reward any private activity on the ground that one set of substantive ethical values, one set of opinions about the best way to lead a life, is superior or inferior to others.” *Id.* at 228. *See also id.* at 297-305 (discussing tolerance). Dworkin also claims that his deliberators would choose equality of resources, not of welfare or outcome. *See id.* at 223. Equality of resources insists that the “ideal distribution is achieved only when the resources different people control are equal in the *opportunity costs* of those resources, that is, the value they would have in the hands of other people.” *Id.* at 223. *See also id.* at 223-25, 280-97 (discussing equality of resources).
perfectionist liberals. Yet state neutrality remains a foundation of Dworkin’s liberalism, albeit neutrality in different philosophical dress.

C. HEALTH CARE POLICY IN A LIBERAL POLITY

Why is substantive health care reform so elusive for America’s liberal culture? Our cultural gestalt—distinguished by liberal individualism and neutrality—plainly extends to health care. This Section explains how these two liberal values can only hamper genuine reform.

Individualism. There can be little doubt that individualism reigns over American health care.\footnote{See, e.g., Charles J. Dougherty, Ethical Values at Stake in Health Care Reform, 268 JAMA 2409 (1992): Physicians want to retain or restore autonomy of practice. Hospitals want market choices but protection from market discipline. Suppliers of medical devices and pharmaceuticals want the widest range of proprietary control in the development and marketing of products and drugs. Insurers want release from cost shifting and mandated benefits and freedom to exclude high risk individuals. Patients and consumers of health insurance want the greatest range of coverage at the lowest cost and access to the highest quality of medical care—without gatekeepers, waiting lists, or rationing of care. American taxpayers do not want to sacrifice the freedom represented by their disposable incomes, and many are reluctant to abandon unhealthy habits. In short, . . . American health care is dominated by an individualism that asserts self- or group interest over the common good . . . .}

Equally obvious, liberal individualists de-emphasize, or sometimes neglect, “[t]he skein of relationships of which the individual is a part, the sociomoral importance of the interdependence of persons, and of reciprocity, solidarity, and community between them.”\footnote{Id. at 2411. See generally CHARLES J. DOUGHERTY, BACK TO REFORM: VALUES, MARKETS AND THE HEALTH CARE SYSTEM (1996) (arguing that exclusive reliance on marketplace reforms to improve health care is inconsistent with values that are central to securing genuine health care reform; these values include human dignity, protection of the least well-off, and the common good).}

As a result, socially oriented values, virtues, and issues are relegated to secondary status. This vision is too limited, because a great deal more than individual needs and advantage is at stake. More than simply a private commodity exchanged for profit, health care is also a social good dedicated to the improvement of an entire community’s health and well-being.\footnote{See generally CHARLES J. DOUGHERTY, BACK TO REFORM: VALUES, MARKETS AND THE HEALTH CARE SYSTEM (1996) (arguing that exclusive reliance on marketplace reforms to improve health care is inconsistent with values that are central to securing genuine health care reform; these values include human dignity, protection of the least well-off, and the common good).}

For these reasons, we need to see more in health care reform than just a zero sum game:

\begin{itemize}
  \item \footnote{In saying that health care is a social good (here and later in this Article), I am not concerned about public health. “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.” INSTITUTE OF MED., THE FUTURE OF PUBLIC HEALTH 19 (1988) (emphasis added). Its focus is not the individual patient, but the community at large. Instead, my focus remains on the individual, despite suggesting that the individual’s interests in health care are also communal. Also, I use the term social good in a different sense than do some philosophers. See, e.g., WALZER, supra note 83, at 7 n.1 (“All the goods with which distributive justice is concerned are social goods.”).}
\end{itemize}
Too often, individuals and groups are led to focus exclusively on safeguarding their own private good. Inevitably, when the benefits they expect from healthcare reform are offset by sacrifices they are required to make, reform appears to be a zero sum game. By contrast, if people were encouraged to consider reform’s objectives as something that would benefit the entire society, then reform would be seen as offering additional, societal benefits.  

Liberals also invoke the notion of a right to health care as a basis for allocating health care resources. This idea of an individual’s claim to health care—that is, obsessive concern about the health care that is due to each individual—is problematic on three counts. First, America’s preoccupation with rights talk, particularly with its adversarial character and exaggerated absoluteness, impoverishes our debate over health care reform. Second, because people fundamentally differ over the meaning and legitimacy of a ‘right to health care,’” many commentators now question its usefulness as a basis for allocation decisions.  

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135. For a general discussion on current rights talk in political conversation, see GLENDON, supra note 63. Daniels discusses rights in the health care context: Faced with significant inequalities in the distribution of health-care services, many start by invoking the notion of individual rights and assert that a violation of basic rights is involved. They believe that a just redesign of health-care institutions can be effected by appealing to such notions. In doing so, some mean to claim justiciable welfare rights. Such claims may implicitly assume that health care is more like certain other social goods, say certain liberties, to which we assert right claims, than it is like other goods . . . to which we do not . . . . However, others who assert a right to health care have in mind no particular theoretical account of its foundations—grounds or justification—or its limits. The assertion of a right may simply be the natural or only way that comes to mind to argue for just reform and to insist that the health-care system eliminate the particular inequalities found objectionable. DANIELS, supra note 31, at 4-5.  

As reported by Kilner, the 1983 President’s Commission explicitly rejected the rights language of an earlier presidential panel. See id. at 1071. See also DANIELS, supra note 31, at 54 (“Great care is taken by the [1983] Commission to avoid talking about rights to health care. . . . The Commission instead talks about a social obligation to provide adequate care without undue burdens, but it is careful to say that such a view involves no commitment to health-care rights.”).  

In 1952, the President’s Commission on the Health Needs of the Nation concluded that “access to the means for the attainment and preservation of health is a basic human right.” Instead of speaking in terms of “rights,” however, the current Commission believes its conclusions are better expressed in terms of “ethical obligations.” PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAV. RES., I SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 4 (1983) (citations omitted). So the 1983 Commission affirmed the community’s ethical obligations to provide “access for all to an adequate level of care without the imposition of excessive burdens.” Id. at 1.
based theories are, by most accounts, eviscerated moral philosophy.137 Again, the ongoing challenge to health care reform is to go communal: de-emphasize the notion of an individual’s claim to health care, lower the volume on rights talk, and champion a more explicit social understanding of health care.

Neutrality. The neutrality constraint of liberalism urges governments not to adopt any particular conception of the good.138 That curb prevents liberalism from sustaining a just scheme to prioritize and distribute health care because liberals have no criterion for assessing what medical services need to be provided for all citizens. Any criterion would impose value-laden judgments of worth, and that is contrary to liberal neutrality.139

The limits of liberalism are again exposed. It is impossible to allocate health care resources, either among competing societal needs or within medicine to particular patients or categories of treatment, without appealing to some notion of the good, or to what gives value to life.140 Only by moving beyond liberal neutrality between different conceptions of the

137. See, e.g., BEAUCHAMP & CHILDRESS, supra note 60, at 76 (“One problem with basing ethics in rights is that rights are only a piece of a more general account that stakes out what makes a claim valid.”); DANIELS, supra note 31:

[The appeal to a right to health care is not an appropriate starting point for an inquiry into just health care. Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation. Rather, we are justified in claiming a right to health care only if it can be harvested from an acceptable, general theory of distributive justice, or, more particularly, from a theory of justice for health care. Such a theory would tell us which kinds of right claims are legitimately viewed as rights. It would also help us specify the scope and limits of justified right claims.

Id. at 5. But cf., e.g., DWORKIN, TAKING RIGHTS SERIOUSLY, supra note 58, at 169-77 (arguing that political morality is rights-based). See generally Jeremy Waldron, Introduction to THEORIES OF RIGHTS 1, 1 (Jeremy Waldron ed., 1984) (“The idea that political morality and social choice are to be based wholly or partly on some account of the rights of the human individual is a familiar theme in Western politics. . . . But this idea has never gone unchallenged.”).

138. See supra notes 99-100 and accompanying text.

139. Ezekiel Emanuel makes this argument. See EMANUEL, supra note 29. Emanuel explains his view of liberal neutrality as follows:

Liberalism espouses the ideal of neutrality, namely that public institutions, laws, and policies should not promote any particular view of what is worthy or good. But, absent judgments about what is worthy or good, we cannot decide whether a medical intervention promotes a patient’s well-being or is deemed harmful. . . . It is not just that different people will have different views on what is worthy or good and that in practice achieving consensus on these judgments will be difficult; it is that by prohibiting the polity from espousing particular views of the good life, liberal political philosophy excludes, even in theory, a shared framework for resolving such medical ethical questions.


140. See EMANUEL, supra note 29, at 97-154.
good, then, is it possible to do the detailed balancing that a theory of justice in health care requires.\textsuperscript{141}

So, in short, meaningful reform of health care demands moving beyond political liberalism.

III. HEALTH CARE REFORM AND THE COMMON GOOD

Asking too much of liberalism, the 1993 Health Security Act crashed on takeoff. It is not sufficient, then, for policymakers to tarry solely within the political framework prescribed by traditional liberalism. As Part I attempted to show, it is impossible to engage in a fruitful discussion of health care reform without engaging the normative questions; it is impossible to grapple with the complexities of the issue by simply asking for state-neutrality or obsessing over individual rights. So there is a need to make new types of arguments, or even to resurrect and reform older ones. To argue, as I do in this Part, for an alternative paradigm that focuses on community-centered values and identifies health care as a social good is not new.\textsuperscript{142} Rather, my argument is an ancient one dressed in contemporary clothing. And it is deceptively simple: True reform will require looking beyond individual choices made by bargain-hunters in the medical marketplace and promoting “first person plural”\textsuperscript{143} thinking. That preferred way of thinking, as I explain in Section C, rejects liberal neutrality, fosters debate among competing political conceptions of the good life and, after public deliberation, adopts a particular conception (or congruous conceptions) which, in turn, guides the design of health care policy.

The argument has several pieces. First, an understanding of the common good, particularly as reformulated in recent Catholic social teaching, helps us to understand “first person plural” thinking. The task in Section A, however, is not simply to exhume, but rather to reclaim the wisdom of the common good and, more importantly, to translate those insights in light of political liberalism. Rawls invites that translation because, post-\textit{Political Liberalism}, his developing understanding of political liberalism recognizes that “Catholic views of the common good... when they are expressed in terms of political values” are “forms

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{141} See \textit{id.} at 139 (“Only by rejecting liberal principles can a legislator actually determine which scheme of health care services is just.”).
\item \textsuperscript{142} For others who have argued for a more community-oriented paradigm, see supra note 37.
\item \textsuperscript{143} See \textit{supra} note 28.
\end{itemize}
\end{footnotesize}
of permissible public reason.”¹⁴⁴ For that reason, Section B briefly summarizes Rawls’ conception of public reason, paying particularly close attention to his most recent adoption of the “wide view of public political culture.”¹⁴⁵ Finally, in Section C, connecting elements of Catholic common good thinking with Rawls’ understanding of public reason, I attempt to make the case for public deliberation and naming of political common goods for health care.

A. A CATHOLIC NOTION OF THE COMMON GOOD

Roman Catholic social teaching has aroused public interest in recent years with the increased involvement of U.S. Catholic bishops in matters of civic morality,¹⁴⁶ with the growth of liberation theology in Latin America,¹⁴⁷ and with the ongoing political and economic statements of Pope John Paul II.¹⁴⁸ A vital ingredient of that social teaching is the idea of

¹⁴⁴ Rawls, supra note 40, at 775.
¹⁴⁵ Id. at 768, 783-87.
¹⁴⁷ Latin American liberation theology emphasizes the motif of liberation from economic and cultural oppression and interprets the sources of Christianity in terms of that motif. See, e.g., GUSTAVO GUTIERREZ, A THEOLOGY OF LIBERATION 307 (Caridad Inda & John Eagleson eds. & trans., Orbis Books 1973) (1971). According to Gutierrez:
The theology of liberation attempts to reflect on the experience and meaning of the faith based on the commitment to abolish injustice and to build a new society; this theology must be verified by the practice of that commitment, by active, effective participation in the struggle which the exploited social classes have undertaken against their oppressors.

¹⁴⁸ See generally JOSÉ MIGUEZ BONINO, REVOLUTIONARY THEOLOGY COMES OF AGE (1975) (liberation theology surveyed and evaluated by a Latin American participant-critic).

For the mandate from Latin American bishops that the Catholic Church evangelize for the poor, for liberation, and for an end to unjust social structures, see PUEBLA AND BEYOND (John Eagleson & Philip Scharper eds., John Drury trans., 1979) (complete texts from 1979 Puebla Conference of Latin American Bishops, plus commentaries); SECOND GENERAL CONFERENCE OF LATIN AMERICAN BISHOPS, THE CHURCH IN THE PRESENT-DAY TRANSFORMATION OF LATIN AMERICA IN THE LIGHT OF THE COUNCIL (1970) (collecting position papers and conclusions from the 1968 Medellín Conference).

the common good, revived\textsuperscript{149} and recast in light of contemporary moral and political discourse. In recent Catholic discussions

the common good provides a conceptual organizing category for mediating the excesses of individualism or communitarianism. It serves as a way of construing the relationship of the individual to a society so that the limits and possibilities of both individual and communal well-being are preserved, and in which the appropriate responsibilities and obligations that exist among individuals are clarified and articulated. It shares with liberalism the impulse to affirm and extend the idea of individual freedom to its appropriate limits. With communitarianism it shares the conviction that only in the context of community can the fullest possibilities of the individual be realized.\textsuperscript{150}

Among Catholic scholars, David Hollenbach is a leading proponent of this common good renaissance.\textsuperscript{151} Hollenbach’s views suggest that evolving Catholic conceptions of the common good may in fact be complementary to Rawls’ maturing idea of public reason post-Political Liberalism.

Hollenbach connects talk of the common good with the language of rights in order to make the classical idea of the common good relevant in a modern liberal democracy. He finds ample support for this connection in

\textsuperscript{149} From Vatican II’s closing in 1965 to the mid-1980s, official Catholic social teaching virtually ignored the concept of the common good. Cf. Curran, \textit{supra} note 42, at 113-17; Oliver F. Williams, \textit{To Enhance the Common Good: An Introduction}, in \textit{THE COMMON GOOD AND U.S. CAPITALISM} 1, \textit{supra} note 42, at 1 (“The term ‘common good’... has not had one entry in the Catholic Periodical and Literature Index in almost twenty years [mid-1960s to mid-1980s].”).

\textsuperscript{150} James A. Donahue, \textit{Introduction} to \textit{RELIGION, ETHICS, & THE COMMON GOOD} ix, \textit{supra} note 42, at ix, x.

recent Catholic social teaching. *Pacem in Terris*, Pope John XXIII’s second social encyclical, distinguished the common good in terms of human rights: “It is agreed that *in our time* the common good is chiefly guaranteed when personal rights and duties are maintained.” For Hollenbach, this new emphasis on rights within the common-good tradition is pivotal:

> Emphasis here is on the way individual persons benefit from the enhancement of the common good. The distinctively modern notion of rights is invoked to specify the most fundamental demands of the common good . . . . The duty to promote the common good, therefore, entails the duty to protect the human rights of all.

> . . . Community and solidarity are to be highly valued, but so are freedom and the dignity of each person.

It is important to note that, in formulating the state of the question regarding the common good today, the good of each person is still bound up with the good of the community, yet the tension between individual

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153. *Id.* No. 60, at 141 (emphasis added). For a more recent papal statement on the common good, see JOHN PAUL II, *SOLlicitudo REI SOCIALis* [ON SOCIAL CONCERN] (1987), reprinted in *CATHOLIC SOCIAL THOUGHT*, supra note 42, at 395.

154. In his first social encyclical, *Mater et Magistra*, Pope John XXIII had defined the common good in more traditional language as embracing “the sum total of those conditions of social living, whereby men are enabled more fully and more readily to achieve their own perfection.” JOHN XXIII, *MATER ET MAGISTRA* [CHRISTIANITY AND SOCIAL PROGRESS] No. 65 (1961), reprinted in *CATHOLIC SOCIAL THOUGHT*, supra note 42, at 84, 94.

155. Hollenbach, *Common Good*, supra note 151, at 193. See also JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 218 (1980) (“On the one hand, we should not say that human rights, or their exercise, are subject to the common good; for the maintenance of human rights is a fundamental component of the common good. On the other hand, we can appropriately say that most human rights are subject to or limited by each other and by other aspects of the common good . . . .”); DREW CHRISTIANSEN, S.J., *The Common Good and the Politics of Self-Interest: A Catholic Contribution to the Practice of Citizenship*, in BEYOND INDIVIDUALISM: TOWARD A RETRIEVAL OF MORAL DISCOURSE IN AMERICA 54, 54-63 (Donald L. Gelpi, S.J. ed., 1989) (arguing that John XXIII’s formulation “offers a more comprehensive, accurate, and definitive understanding of the common good than the customary appeal to ‘conditions of social living’” and reveals a surprisingly “more complex, egalitarian public philosophy”).
interests and the public good is not skirted. (A traditional understanding would grant undisputed priority to society’s welfare over individual self-interest.) In other words, John XXIII’s revision is more subtle. The common good, even for traditionalists, was never simply “a summation of the goods of individual citizens” but was a “set of social conditions which facilitate the realization of personal good by individuals.”\(^{156}\) While simple utilitarian calculation (suggested by the formula “the greatest good for the greatest number”) never specified the common good, and emphasis on the participation of all in the common good was stressed, the focus of that traditional language remained structural and organizational.\(^{157}\) By introducing rights-talk into the definition, John XXIII recast the notion of the common good in assigning “greater value to individual life and development,”\(^{158}\) and so redressed the structural bias present in traditional formulations. Thus in an important way John XXIII’s reformulation takes seriously the distinction between persons.\(^{159}\)

Hollenbach takes this distinction even further. Any case for the common good today, Hollenbach argues, must “free[] that tradition of its sometimes repressive tendencies.”\(^{160}\) His contribution to this project is to reformulate the current state of the question in three points by reexamining the Christian tradition.\(^{161}\) First, from St. Augustine’s *The City of God*, Hollenbach identifies “principles that support the legitimacy, indeed the necessity, of institutional pluralism.”\(^{162}\) Second, from St. Thomas Aquinas (as interpreted by Jacques Maritain), he recaptures the analogical concept of the common good present in Thomistic sources. Third, from this reconstructed “pluralistic-analogical” understanding of the common good, Hollenbach generates a communitarian interpretation of liberal rights.

The doctrine of the two cities is Augustine’s most distinctive contribution to the problem of civil society. His famous formulation states:

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157. In traditional formulations, the common good was *common* in two different senses: “collectively, to mean the sum total of all the parts, or distributively, to mean what all share in whether they be taken singly or all together . . . . The common good, then, may belong either to the group and its members *en masse*, or directly and personally to each individual comprised.” THOMAS GILBY, BETWEEN COMMUNITY AND SOCIETY 89-90 (1953).
158. Christiansen, *supra* note 155, at 83.
159. In this way, the mature Johannine formulation of the common good distances itself from utilitarianism. Cf. RAWLS, *supra* note 57, at 22-33, 183-92 (arguing that classical utilitarianism fails to take seriously the “plurality and distinctness” of individuals).
161. See *id.* at 79-93.
162. *Id.* at 93.
“We see then that the two cities were created by two kinds of love: the earthly city was created by self-love reaching the point of contempt for God, the Heavenly City by the love of God carried as far as contempt of self.” Augustine’s theological dilemma was a perennial one, that of a spiritual church in a secular world. His practical problem was more immediate: refute the charge that the expansion of Christianity precipitated the collapse of Rome. For these reasons, The City of God fundamentally asks: “’Who is this God you talk of, and how is it proved that he is the only one to whom the Romans owed obedience and that they should have worshipped no god besides him?” And Augustine responds by offering both a comprehensive picture of divine history and a biblical-philosophic apology for the Christian faith.

This answer includes a “stringently theological understanding of the common good.” Augustine argues:

It follows that justice is found where God, the one supreme God, rules an obedient City according to his grace, forbidding sacrifice to any being save himself alone; and where in consequence the soul rules the body in all men who belong to this City and obey God, and the reason faithfully rules the vices in a lawful system of subordination; so that just as the individual righteous man lives on the basis of faith which is active in love, so the association, or people, of righteous men lives on the same basis of faith, active in love, the love which a man loves God as God ought to be loved, and loves his neighbour as himself. But where this justice does not exist, there is certainly no ‘association of men united by a common sense of right and by a community of interest’. Therefore there is no commonwealth; for where there is no ‘people’, there is no ‘weal of the people’.

As Hollenbach warns, “[s]uch a high theological definition of the full good of human society is precisely the sort of thing that liberals such as Dworkin and Rawls dread might be imposed upon everyone—believer and unbeliever alike—even by force of arms, should the social balance of power permit this.” This will not happen, according to Hollenbach, because the promotion of any common good in a liberal, democratic society must, by definition, recognize the existence of, and the need for, moral and

164. Id. pt. II, bk. XIX, ch. 22, at 884.
political pluralism.\textsuperscript{168} It is an appealing innovation (to any reform-minded common good thinker\textsuperscript{169}), but one might ask where Hollenbach finds support for this pluralistic turn.

Notwithstanding its theologizing (Augustine’s vision of the full human good does ultimately require membership in the heavenly city), \textit{The City of God} includes numerous formal political insights. Among these Hollenbach underscores the necessity of a pluralistic form of politics as particularly relevant. For Augustine, the heavenly and earthly cities embody the eternal categories of salvation and damnation and are not equated with any particular communities, such as the Christian Church or the Roman Empire. These cities instead are inextricably intertwined in all human communities throughout history. Because this conceptual blend maintains a legitimate interest in the (limited) good achievable in political societies within history, Hollenbach is able to refocus the genius of Augustine’s theological vision and to argue for a pluralistic understanding of the common good. He argues that the truth of Augustinianism is that “[n]o sphere [of historical existence] can rightly occupy the position of be-all-and-end-all in our lives without throwing the rest out of proper proportion—neither vocation, nor family, nor voluntary association, nor private projects, nor politics.”\textsuperscript{170} For this reason, the “pursuit of the common good demands full respect for the many different forms of interrelationship and community in which human beings achieve their good in history. Thus the temporal common good—the common good that is achievable in history—is a pluralistic ensemble of goods.”\textsuperscript{171}

With this language of pluralism, Hollenbach abandons the traditional monolithic notion of the common good and repositions a contemporary alternative closer to classical liberalism. Though not espousing a noncognitivist position on the nature of values or a liberal position of neutrality among competing schemes of the full human good,\textsuperscript{172} this revised understanding is obviously sympathetic to liberal concerns about

\textsuperscript{168} See \textit{id.} at 81-85.
\textsuperscript{169} A “reform-minded” common good thinker, like Hollenbach, holds out for a third alternative that moves beyond the debate between communitarians and their liberal critics. \textit{Cf.} JEFFREY STOUT, \textsc{Ethics After Babel: The Languages of Morals and Their Discontents} 236 (1988) (“[a]tomistic individualism and totalitarian solidarity do not exhaust our options”).
\textsuperscript{170} Hollenbach, \textit{Common Good Revisited}, supra note 151, at 84 (quoting STOUT, supra note 169, at 235).
\textsuperscript{171} \textit{Id.} at 85.
\textsuperscript{172} On the nature of liberal neutrality, see supra notes 99-101 and accompanying text.
pluralism and freedom in pursuing any common good\textsuperscript{173} without denying the continued moral burden of the concept good. Liberalism, therefore, subtly redefines the common good, while the common good tradition simultaneously challenges classical liberalism.

This dialogue is only enhanced by a renewed emphasis on the analogical nature of the common good. Hollenbach recaptures the importance of analogy by rereading Aquinas as interpreted by Jacques Maritain in the 1940s. Maritain’s discussion of analogy in \textit{The Person and the Common Good}\textsuperscript{174} is predictably theological, for analogical language was expressly developed within Christian theology to describe human knowledge of God.\textsuperscript{175} “The central theological root of Maritain’s discussion of the relation between the person and the common good,” according to Hollenbach, “is that ‘the idea of the person is an analogical idea which is realized fully and absolutely only in its supreme analogue, 173. See Hollenbach, \textit{Liberalism, Communitarianism, and the Pastoral Letter}, supra note 151, at 24.

174. \textsc{Jacques Maritain}, \textit{The Person and the Common Good} (John J. Fitzgerald trans., Univ. of Notre Dame Press 1966) (1947/1946). Hollenbach labels Maritain’s position “personalist communitarian,” for it affirms that “personality tends by nature to communion.” Hollenbach, \textit{The Common Good Revisited}, supra note 151, at 85 (quoting \textsc{Maritain}, supra, at 47). In other words, “the dignity of persons can be realized only in community, and genuine community can exist only where the dignity of persons is secured. Personhood and community are mutually implicating realities.” \textit{Id.}, at 86.

For another perspective along these lines by a non-Catholic commentator, see \textsc{William Lee Miller}, \textit{The First Liberty: Religion and the American Republic} 288 (1986):

“The common good,” the central term—the \textit{res publica}—is a theme running down through the Catholic ages. Catholicism, like Judaism in a different way, may bring to this excessively individualistic American Protestant culture that sense of life being bound up with life, of “solidarity,” . . . the awareness, as part of the fundamental religious insights and commitment, of the intertwining of human beings in community. All of that—a personalistic communitarianism, let us call it, may be distinguished both from the collectivisms of our much-denounced world adversaries and from the all too individualistic libertarianism created by the forces—very much including our sort of Protestantism—that have combined to build a prevalent form of American culture.

\textit{Id.}

175. See Frederick Ferré, \textit{Analogy in Theology}, in \textsc{1 The Encyclopedia of Philosophy} 94 (Paul Edwards ed., 1972) (1967). Ferré describes the dilemma and proffered solution by Christian theologians as follows:

Christian theology . . . finds itself committed, from [its Scripture and from Hellenistic philosophy], to apparently incompatible axioms. On the one hand God, to be the God of the Bible or of the philosophers, must be so utterly different from all finite created beings that no statement with God as referent can mean what it would mean if it had any other referent. . . . On the other hand, however, genuine knowledge of God—of some kind—must be insisted upon if God has somehow been revealed to men. . . .

Thus we may properly consider the “middle way” of analogy as a second-order attempt to escape from a first-order collision between basic theological premises. The statements incorporating man’s knowledge of God, we are told, are not wholly unequivocal, nor are they entirely equivocal. Instead, it is claimed, such statements are \textit{analogical}.

\textit{Id.} (emphasis added).
Thus, “to properly understand human society, we must see it as located on ‘an analogical scale’ between the perfect society of persons that is the [Christian belief of God as] Trinity and that which is not a society in the proper sense at all, but only in a metaphorical sense, i.e. animal society.”

As Hollenbach sees it, Maritain’s theologizing “opens up a number of useful perspectives on the ethical and political meaning of the common good.” Central among these is a strong antitotalitarian bias premised on the reality of human transcendence and the failure of any earthly common good to embody the full human good. In short, Maritain’s understanding of the analogical nature of the common good demands the rejection of any theory that makes the good of the polis the highest good or that grants absolute sovereignty to the state. Human beings are destined to a good that is beyond both civil society and the state. Both civil society and the state have an obligation to respect this transcendence of the human person by respecting human rights. Thus respect for freedom and dignity demands support for the many forms of relationship in which personhood is realized: friendships, families, voluntary associations, civil society, politics, and relationship with God as well. Each of these relationships realizes a part of the terrestrial common good. Each is analogous to the ultimate common good: the union of human beings with God and with each other in God.

Liberals have long maintained that “the common good is not in fact a good, but rather many goods that are not necessarily in harmony with each other.” This is a false dilemma. Rereading the classic sources of common-good doctrine, Hollenbach is able to claim “a theological warrant for many liberal values and institutions,” including the reality of common goods in a political community. With this move, he effectively (if not completely) appropriates a central liberal concern as a principle in a reconstituted doctrine of the common good.

177. Id.
178. Id. at 87.
179. See id.
As previously seen, the language of individual rights dominates much of liberal public discourse. I revisit that issue here to ask of Hollenbach whether liberal rights talk is at all compatible with common good language. He answers yes, while proposing a moderate communitarian variant on liberal rights.

Following John Stuart Mill, Hollenbach identifies liberal rights “with certain negative freedoms that are protected against coercion or interference by others. Rights seen this way are immunities, defenses against the intrusions that other persons or the government might try to make into the individual’s zone of freedom.” In On Liberty Mill questioned “the nature and limits of the power which can be legitimately exercised by society over the individual.” His analysis of civil or social liberty is classic:

The object of this essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties or the moral coercion of public opinion. That principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant . . . . The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

This “very simple principle” is further clarified by two maxims offered in the essay’s final chapter:

1. First, that the individual is not accountable to society for his actions in so far as these concern interests of no person but himself. . . . Secondly, that for such actions as are prejudicial to the interests of others, the individual is accountable and may be subjected either to social or to legal punishment if society is of the opinion that the one or the other is requisite for its protection.

183. See supra notes 57-65 and accompanying text.
184. Hollenbach, The Common Good Revisited, supra note 151, at 89.
186. Id. at 13.
187. Id. at 114.
Mill’s discussion of political liberty is often uncritically “praised as a classic statement of the case for individual liberty from governmental control.” The individual in On Liberty is unquestionably sovereign over one’s self and Mill does advocate complete liberty for “self-regarding” conduct. In this regard, Mill epitomizes the liberal tradition which grounds individual rights in the primacy of liberty (a Hohfeldian privilege or immunity) or identifies rights as claims (Hohfeldian claim-rights) to political liberty. It is this aspect of Mill which Hollenbach predictably chooses to caricature in his “classical liberal account” of rights. This is unfortunate since Mill’s complete theory does not absolutize the value of liberty but promotes “the greatest possible amount of individual liberty from collective authority—compatible with living in a society.”

Although Mill characteristically assumes the ultimate value of individuality and regards “utility as the ultimate appeal on all ethical questions,” his second maxim which basically justifies most any societal restraint on “other-regarding” conduct inimical to social progress insinuates certain nascent communitarian concerns. As Currin Shields recognizes, “[i]ndividual freedom is justified, according to Mill, by a contribution to

188. Currin V. Shields, Introduction to Mill, supra note 185, at vii, xix.
189. See Wesley Newcomb Hohfeld, Some Fundamental Legal Conceptions as Applied in Judicial Reasoning, 23 Yale L.J. 16 (1913). Jeremy Waldron provides a useful summary of Hohfeld’s account:

(1) ‘[P has a right to X]’ may mean ‘P has no duty (to a particular person Q or to people in general) not to do X’. This relation is sometimes spoken of as a bare liberty, though Hohfeld used the term ‘privilege’ (presumably to indicate that the idea is often used to convey P’s special position in relation to an otherwise generally applicable duty, e.g. ‘A policeman has the right to be out after curfew’). . . .

(2) Talk of P’s right to do X may be meant to indicate that Q (or everyone) has a duty to let P do X. The existence of such a duty gives P some sort of claim against Q, and this second relation is often referred to as a claim-right. Of course, ‘to let P do X’ is a loose phrase, and a claim-right may involve anything from a purely negative duty not to impede P’s action to a positive requirement to do what one can to make it possible for P to do X. The class of claim-rights therefore includes rights to active assistance as well as rights to negative freedom. . . .

(3) The third sense of ‘right’ which Hohfeld distinguished involves the ability or power of an individual to alter existing legal arrangements. . . . These rights are concerned not so much with the immediate acts that I perform . . . as with the effect of those actions. . . . Powers themselves are not correlative to duties but to liabilities: if I have a legal power, someone (or everyone) is liable to have his legal position changed by an exercise of my will. . . .

(4) Oddly, we sometimes use the term ‘right’ to describe not only a power but also the correlate of the lack of a power—an immunity from legal change. If P has an immunity with regard to X, then Q (or maybe everyone) lacks the power to alter his legal position in regard to X. Constitutionally guaranteed privileges and claim-rights often also involve an immunity: not only do I have no duty not to do X or not only do others have a duty to let me do X, but also no one—not even the legislature—has a power to alter that situation. . . .

Waldron, supra note 137, at 6-7.
190. Hollenbach, The Common Good Revisited, supra note 151, at 89.
191. Shields, supra note 188, at xxi (emphasis added).
the general interest. Liberty is a valuable means to the more highly valued end of progress, in which every member of society has an interest."\textsuperscript{193} While this “general interest” undeniably articulates an individualist and utilitarian conception of the public good, Mill’s vaunted liberalism appears slightly closer to the common good tradition than at first glance.

Though Hollenbach’s effort to reconcile liberal and communitarian viewpoints is not as decisive given his failure to underscore Mill’s second maxim, his reinterpretation of the liberal account of individual rights is far more robust than Mill’s incomplete and negative notion of rights as immunities. In his revised conception of rights, Hollenbach augments this negative notion with a positive one which he labels an “empowerment” (which conceivably corresponds to a Hohfeldian power).\textsuperscript{194} Rights are “also empowerments that enable those who exercise them to be active participants in the life of the various communities to which they belong.”\textsuperscript{195} This addition obviously tempers the excessive emphasis on individualism (that is, individuals as the paramount reality) present in the classical understanding of rights. However, this revision does not deny the continued importance of rights viewed as negative immunities.\textsuperscript{196} In this regard, Hollenbach and other revisionists heed the relevant admonition of Jeremy Waldron:

Questions about rights generally arise when it is proposed that the interests of one or more individuals should be traded off for the sake of others’ or in the name of some allegedly more important moral or political ideal. If we make such a proposal, it seems plausible to insist that we ought at least to produce reasons for our action which are in principle capable of being accepted by the people whose interests are at stake. But this requirement seems to imply that we must leave intact at least those interests that are central to each person’s capacity to recognize and understand moral reason and moral argument (again, his freedom of thought and expression and maybe certain basic interests in material well-being).\textsuperscript{197}

To buttress his argument for a more expansive notion of individual rights, Hollenbach favorably quotes Alan Gewirth\textsuperscript{198} who he insists

\begin{itemize}
  \item \textsuperscript{193} Shields, \textit{supra} note 188, at xxii.
  \item \textsuperscript{194} For a description of a Hohfeldian power, see \textit{supra} note 189.
  \item \textsuperscript{195} Hollenbach, \textit{The Common Good Revisited}, \textit{supra} note 151, at 90.
  \item \textsuperscript{196} See \textit{id.} at 89.
  \item \textsuperscript{197} Waldron, \textit{supra} note 137, at 19-20.
  \item \textsuperscript{198} ALAN GEWIRTH, \textit{HUMAN RIGHTS: ESSAYS ON JUSTIFICATION AND APPLICATIONS} 3 (1982), quoted in Hollenbach, \textit{The Common Good Revisited}, \textit{supra} note 151, at 90: Human rights are of supreme importance, and are central to all other moral considerations, because they are rights to the necessary conditions of human action, i.e. those conditions that
\end{itemize}
“presses beneath the frequently drawn distinction between positive and negative rights to a more fundamental quality of all rights: they protect the possibility of human agency.” 199 This protection of human agency for Gewirth demands the guarantee of the necessary conditions of freedom (civil-political rights) and well-being (socio-economic rights). 200 What is lacking in Gewirth’s proposal, however, is an adequately strong social understanding of human agency. Thus, Hollenbach criticizes Gewirth for his “continuing adherence to the classic Kantian notion of agency as autonomy” and revises Gewirth’s theory in a communitarian direction by asserting that “human agency is made possible and sustained only through communal relationships.” 201 Human rights, for Hollenbach, “are the rights of persons in community.” 202 More pointedly, “human rights cannot be understood apart from social interdependence nor can social well-being be understood apart from personal rights.” 203 In sum, Hollenbach’s communitarian reconceptualization of liberal rights “represents a careful balancing act between the personal and the communitarian.” 204

This balancing act continues. Along with other commentators, Hollenbach’s bid to formulate the state of the question regarding the common good today—a common good which is pluriform, analogical, and appreciative of individual rights in community—has not gone unnoticed, even among liberal theorists such as John Rawls.

B. RAWLS’ POLITICAL LIBERALISM AND THE COMMON GOOD

To make a case for common good thinking in health policy discourse first requires a look at Rawls’ evolving conception of liberalism, paying

\* Id.


203. Id. at 61. The U.S. Catholic bishops define human rights as “the prerequisites for a dignified life in community . . . . In Catholic social thought, therefore, respect for human rights and a strong sense of both personal and community responsibility are linked, not opposed.” CATHOLIC BISHOPS, ECONOMIC JUSTICE FOR ALL, supra note 146, No. 79, at 597. See id. generally Nos. 79-84, at 597-99 (suggesting human rights as “the minimum conditions for life in community”).

particular attention to his second book, Political Liberalism,205 and the continuing communitarian response.206

Rawls’ conception of “justice as fairness” set forth in A Theory of Justice207 (“Theory”) is by now well-known. According to Rawls, the fundamental principles of justice, which are the foundations of a well-ordered society,208 are those that free and rational persons who are concerned to advance their own interests would accept in an initial position of equality.209 These rational and mutually disinterested agents, who are in a wholly hypothetical (as opposed to an actual or historical) “original position,” decide on the foundations of a just society behind a “veil of ignorance.”210 That is, “no one knows his place in society, his class position or social status, nor does any one know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like.”211 Persons in the initial situation are even oblivious to their “conceptions of the good.”212

Rawls argues that under such conditions, the parties negotiating in the original position would agree on two principles of justice. “[T]he first requires equality in the assignment of basic rights and duties, while the second holds that social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society.”213 These principles, along with two

205. See Rawls, Political Liberalism, supra note 101.
206. On the recent liberal-communitarian exchange of views, see supra notes 79-80. Any reform-minded common good thinker would find much in common with both philosophical and popular communitarians.
207. For Rawls on justice as fairness, see Rawls, supra note 57, at 11-17, 54-117.
208. See id. at 4-5.
209. See id. at 11.
210. Id. at 12.
211. Id.
212. Id. Of course, persons in the original position must have at least a “thin” conception of the good; otherwise, they are incapable of rational choice.
213. Id. at 14-15. The final statement of these principles in A Theory of Justice reads:

First Principle
Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.

Second Principle
Social and economic inequalities are to be arranged so that they are both:
(a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and
(b) attached to offices and positions open to all under conditions of fair equality of opportunity.

Id. at 302.
priority rules, constituting the core of a liberalism based on justice as fairness.

Much of the communitarian agenda, of course, derives from Rawls’ theory of justice as fairness and, in particular, his characterization of the original position. For Michael Sandel, long a critic of Rawlsian liberalism, “[t]he priority of individual rights, the ideal of neutrality, and the conception of persons as freely choosing, unencumbered selves, taken together form the public philosophy of [contemporary liberalism].” In a well-ordered society of justice as fairness, formulated in the way favored by Sandel, “the right is prior to the good” or, more prosaically, “a just society . . . must govern by principles that do not presuppose any particular conception of the good.” Sandel’s critique of Rawls traces the limits of liberalism to a conception of the self that underlies it, and argues for a

214. Rawls describes the priority rules as follows:
First Priority Rule (The Priority of Liberty)
The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty. There are two cases:
(a) a less extensive liberty must strengthen the total system of liberty shared by all;
(b) a less than equal liberty must be acceptable to those with lesser liberty.
Second Priority Rule (The Priority of Justice over Efficiency and Welfare)
The second principle of justice is lexically prior to the principle of efficiency and to that of maximizing the sum of advantages; and fair opportunity is prior to the difference principle. There are two cases:
(a) an inequality of opportunity must enhance the opportunities of those with the lesser opportunity;
(b) an excessive rate of saving must on balance mitigate the burden of those bearing this hardship.

Id. at 302-03.
215. See MULHALL & SWIFT, supra note 79, at 1-3, 9.

For Sandel, the notion that “the right is prior to the good” encapsulates Rawls’ core thesis:
[S]ociety, being composed of a plurality of persons, each with his own aims, interests, and conceptions of the good, is best arranged when it is governed by principles that do not themselves presuppose any particular conception of the good; what justifies these regulative principles above all is not that they maximize the social welfare or otherwise promote the good, but rather that they conform to the concept of right, a moral category given prior to the good and independent of it.

Sandel, supra note 88, at 1.
219. Sandel, Procedural Republic, supra note 216, at 82. According to Sandel, “[t]he priority of the right means first, that individual rights cannot be sacrificed for the sake of the general good . . . , and second, that the principles of justice that specify these rights cannot be premised on any particular vision of the good life.” Id.
deeper understanding of community than liberalism allows.\textsuperscript{220} He finds the parties to the original position—and ourselves, insofar as we are thinking of justice as Rawls would—to be “unencumbered” selves “understood as prior to and independent of purposes and ends,”\textsuperscript{221} and so incapable of social or communal attachments of any sort. In short, the liberal view of self ignores membership in any constitutive community and consequently “fails to redeem its own liberating promise”\textsuperscript{222} because Rawlsian liberalism “forgets the possibility that when politics goes well, we can know a good in common that we cannot know alone.”\textsuperscript{223}

Arguments like Sandel’s have had an impact.\textsuperscript{224} In \textit{Theory}, Rawls argued that “[a]n essential feature of a well-ordered society associated with justice as fairness is that all its citizens endorse this conception on the basis of . . . a comprehensive philosophical doctrine.”\textsuperscript{225} In \textit{Political Liberalism}, he now concedes that this account of justice is “unrealistic,”\textsuperscript{226} has a “serious problem,”\textsuperscript{227} and “must be recast.”\textsuperscript{228} “A modern democratic society is characterized not simply by a pluralism of comprehensive religious, philosophical, and moral doctrines but by a pluralism of incompatible yet reasonable comprehensive doctrines.”\textsuperscript{229} Recognizing this as a permanent condition of democracy, Rawls therefore asks: “How is

\begin{itemize}
\item \textsuperscript{220} See Sandel, supra note 88, at 1-65.
\item \textsuperscript{222} Sandel, supra note 88, at 179.
\item \textsuperscript{223} Id. at 183.
\item \textsuperscript{224} Rawls’ self-protective response to communitarian criticisms is as follows: The changes in the later essays are sometimes said to be replies to criticisms raised by communitarians and others. I don’t believe there is a basis for saying this. Of course, whether I am correct in this belief depends on whether the changes can be satisfactorily explained by an analytic view of how they fit into the revised account of stability. It is certainly not settled by my say so.
\item \textsuperscript{225} RAWLS, \textit{POLITICAL LIBERALISM}, supra note 101, at xix n.6. See generally Mulhall & Swift, supra note 79, at 192: [I]t is plausible to argue that some of [the communitarian] criticisms rested either upon misreadings or upon an imperfect grasp of certain elements of \textit{A Theory of Justice}; and Rawls’ 1980 Dewey Lectures—published before the main texts associated with the communitarian critique—provide further material for such an argument.
\item \textsuperscript{226} Id. For representative liberal responses to Sandel’s challenge, see Norman Daniels, \textit{Preface to Reading Rawls} xiii, xviii (Norman Daniels ed., 1989) (arguing that Rawls’ ideal of the person is not intended as a complete moral idea of the person, but rather a restricted one, appropriate because of its fit with the social ideal of a well-ordered society); Sibyl A. Schwarzenbach, \textit{Rawls, Hegel, and Communitarianism}, 19 Pol. Theory 539, 554 (1991) (“In the original position, Rawls is not giving us an account of the ‘self’ or ‘subject’ at all but is . . . presenting us with the minimal conditions for modern, political personhood or citizenship.”).
\item \textsuperscript{227} Id. at xvii-xviii.
\item \textsuperscript{228} Id. at xvi-xvii.
\item \textsuperscript{229} Id. at xvii.
\end{itemize}
it possible that there may exist over time a stable and just society of free and equal citizens profoundly divided by reasonable though incompatible religious, philosophical, and moral doctrines?" Rawls’ answer requires him to transform "the doctrine of justice as fairness as presented in Theory into a political conception of justice that applies to the basic structure of society." Recasting justice as fairness in political terms compels Rawls to reformulate his conception of the person, and to introduce “the ideas of a reasonable overlapping consensus and of public reason” —two ideas not found in Theory and fundamental to Political Liberalism. As a result, from “the idea of the person as having moral personality with the full capacity of moral agency,” Rawls now conceives of the person qua citizen only in so far as that person is a “political person of a modern democracy” and not for any other aspect of the person’s life. And as citizens looking to secure stability and social unity in a pluralist society, what is needed is a workable, political conception of justice which will command an overlapping consensus of opinion. To Rawls’ way of thinking, citizens in the overlapping consensus must employ “public reason,” conducting “their fundamental discussions within the framework of what each regards as a political conception of justice based on values that the others can reasonably be expected to endorse.” Hence, the species of liberalism Rawls now defends is purely political, and so no longer depends on controversial philosophical or metaphysical claims of a comprehensive liberalism.

230. Id. at xx.
231. Id. at xliii. See also id. at xxxvii-xxxviii n.2 (“[Rawls uses] the term doctrine for comprehensive views of all kinds and the term conception for a political conception and its component parts, such as the conception of the person as citizen.”).
232. Id. at xlvi (citations omitted).
233. Id. at xlv.
234. Id.
235. See id. at 44. Rawls elaborates: “Three conditions seem to be sufficient for society to be a fair and stable system of cooperation between free and equal citizens who are deeply divided by the reasonable comprehensive doctrines they affirm. First, the basic structure of society is regulated a political conception of justice; second, this political conception is the focus of an overlapping consensus of reasonable comprehensive doctrines; and third, public discussion, when constitutional essentials and questions of basic justice are at stake, is conducted in terms of the political conception of justice.

236. Id. at 226. For similar iterations of Rawls’ conception of public reason, see id. at i; Rawls, supra note 40, at 773.
237. Sandel, for one, labels Rawls’ turn to the political “minimalist” liberalism. See SANDEL, supra note 43, at 17-19, 354 n.28.
Rawls’ turn to the political is predictably controversial, given “the fact of reasonable pluralism.” To its critics, the ideas (and ideals) of an overlapping consensus and public reason are particularly vulnerable. Comprehensive liberals will generally bemoan Rawls’ methodological retreat from claims involving theories of values or wide-ranging conceptions of the good; while communitarians and others will accuse him of dividing or “bracketing” an individual’s vision of the good from her public life. For purposes of this Article, however, more intriguing is Rawls’ reluctance to put aside the idea of the common good: “Political liberalism . . . does not try to fix public reason once and for all in the form of one favored political conception of justice” and even admits “Catholic views of the common good and solidarity when they are expressed in terms of political values.” Rawls’ liberalism, in the end, invites deliberation over the common good as one form of permissible public reason in a well-ordered constitutional democratic society.

Finding a place in political liberalism for Catholic views of the common good results from a fortunate turn in Rawls’ most recent writings. As noted previously, Rawls’ political liberalism attempts to deal with the descriptive reality of reasonable pluralism by emphasizing a political

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238. RAWLS, POLITICAL LIBERALISM, supra note 101, at xix.

239. For a concise summary of these criticisms (with exhaustive references), see Leslie Griffin, Good Catholics Should Be Rawlsian Liberals, 5 S. Cal. Interdisc. L.J. 297, 298-325 (1997). As Griffin points out, Rawls himself identifies four objections to the overlapping consensus: “Critics will argue that it is really a modus vivendi; that the concept implies indifference or skepticism about the truth; that . . . a workable political conception must be comprehensive; and that it will not be stable if it exists.” Id. at 305 (citations omitted). Criticisms of public reason include “the general charges of exclusion of and discrimination against religion” and the more troubling “accusations of bracketing . . . the individual’s comprehensive doctrine from her public life.” Id. at 314-15.

240. Dworkin, for one, describes his view as a version of comprehensive liberalism. See Dworkin, Foundations, supra note 97. Dworkin’s liberalism is both comprehensive and anti-perfectionist. For while he “shares Rawls’ view that governments should be neutral between the different and often conflicting convictions that citizens have about the right way to live . . . he justifies the neutrality of his state on the grounds that it best promotes a certain comprehensive conception of human well-being.” MULHALL & SWIFT, supra note 79, at 252-53. For Dworkin on liberal neutrality, see supra Part II.B.

241. See, e.g., Sandel, supra note 106, at 1777 (“Political liberalism insists on bracketing our comprehensive moral and religious ideals for political purposes, and on separating our political from our personal identities.”).


243. See Rawls, supra note 40, at 773-74 (“[T]he content of public reason is given by a family of political conceptions of justice and not by a single one. There are many liberalisms and related views, and therefore many forms of public reason specified by a family of reasonable political conceptions.”).
overlapping consensus and by placing limits on public reason.244 His own ambition—finding a philosophical solution to the practical problem of political instability in a pluralistic society like America—has prompted Rawls to revise his view on the limits of public reason more than once.245

Inclined originally to what he labels the “exclusive view” of public reason246—“on fundamental political matters, reasons given explicitly in terms of comprehensive doctrines are never to be introduced into public reason”247—Rawls in Political Liberalism rejects this view as “too restrictive”248 and opts for a more “inclusive” view249 that “allow[s] citizens, in certain situations, to present what they regard as the basis of political values rooted in their comprehensive doctrine, provided they do this in ways that strengthen the ideal of public reason itself.”250 Post-Political Liberalism, Rawls again recasts the limits of public reason and now supports a “wide” view,251 which holds that “reasonable comprehensive doctrines, religious or nonreligious, may be introduced in public political discussion at any time, provided that in due course proper political reasons—and not reasons given solely by comprehensive doctrines—are presented that are sufficient to support whatever the comprehensive doctrines introduced are said to support.”252

What are we to make of Rawls’ shifting views on the limits of public reason? His new account of public reason can be, and has been, challenged. So it would be naive to suppose that the wide view is Rawls’ final word on that topic. Yet, there is an important point here. The current Rawlsian framework affords provisional standing, previously reckoned

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244. See supra notes 225-37 and accompanying text.
245. Griffin argues that Rawls’ account of public reason shifted in response to certain accusations of moral “bracketing”—i.e., values emanating from incompatible comprehensive philosophical, religious and moral doctrines should be disregarded, or “bracketed,” by citizens when engaging in public reasoning. See Griffin, supra note 239, at 314-22. I think she may be right about this but I don’t need to consider the point here. Yet her insightful discussion of Rawls’ shifting views on public reason led me to take up this question.
246. RAWLS, POLITICAL LIBERALISM, supra note 101, at 247 n.36.
247. Id. at 247.
248. Id. at 247 n.36.
249. Id. at 248.
250. Id. at 247.
251. See id. at lli; Rawls, supra note 40, at 783 (labeled here “the wide view of public political culture”). In considering objections to the wide view of public reason, Rawls rejects the “open view with no constraints,” id. at 794, as incompatible with the ideal of public reason. See id. at 793-99; Rawls, POLITICAL LIBERALISM, supra note 101, at lIII-lvii.
252. Rawls, supra note 40, at 783-84. Rawls labels the “injunction to present proper political reasons . . . as the proviso.” Id. at 784. For a similar explanation of the proviso and the “wide” view, see RAWLS, POLITICAL LIBERALISM, supra note 101, at lli-llii.
unacceptable by most liberals, to comprehensive notions of the common
good if they are supported by proper political values. The jurisprudential
importance of this claim, for my purpose, does not lie in the novelty, but
just in the opportunity to formulate a political common good (or goods) for
American health care.

C. HEALTH CARE POLICY AND THE POLITICAL COMMON GOOD

Both the term “political common good” and the ideal expressed by it
require explanation. The political common good, as I use the term here, is
“political” in the Rawlsian sense, and a “common good” in the
contemporary Catholic sense with its organic vision of society which
mediates the extremes of both individualism and communitarianism.
Recall why Rawls now calls his liberalism “political.” A common good
that is political seeks Rawls’ overlapping consensus based on public
reason. And public reasoning, while not appealing solely to any particular
comprehensive doctrine, may include reasonable comprehensive doctrines
if these are supported by proper political reasons. That said, the political
common good also offers support for legitimate “first person plural”
thinking in a democratic society by rejecting liberal neutrality, fostering
debate among competing conceptions of the good life and, after public
deliberation, adopting a particular conception or congruous conceptions to
guide public policy (likewise explained in terms of a reasonable balance of
public political values).

The aim of the political common good, like Rawls’ theory of justice as
fairness, is practical: “it presents itself as a conception of justice that may
be shared by citizens as a basis of a reasoned, informed, and willing
political agreement. It expresses their shared and public political
reason.” And for persons qua citizens, it is likewise a freestanding
view— independent of their comprehensive religious, philosophical and
moral doctrines. Yet this political kind of common good separates itself
from Rawlsian liberalism over a conception of the good: It affirms the
straightforward possibility that a good (or goods) to be pursued in common
can be identified by a well-ordered, democratic society deliberating, and

253. Cf. supra notes 225-37 and accompanying text.
254. RAWLS, POLITICAL LIBERALISM, supra note 101, at 9.
255. See id. at xlv, 29-35.
256. See id. at xlv, 12-15, 374-76.
257. While insisting that in a liberal view citizens have “fundamental common aims,” Rawls is
clear that “[t]his common aim of political justice . . . must not be mistaken for (what I have called) a
conception of the good.” Id. at 146 n.13.
then defining that good with shared and public reason. So an effective political common good is not about the highest good, nor the value of life; nor does it “lead to the perfectionist state of a comprehensive doctrine.” Rather, this political conception draws upon various political ideas of the good to identify a reasonable basis in public reason as grounds to endorse certain goods to be pursued in common.

By allowing public agreement in judgment, or narrowing of differences, to specify political common goods, the conception of justice proposed here rejects the traditional notion that there is but one reasonable and rational good. Political common good thinking “does not offer an already-out-there, ready-to-be-grasped norm of justice but rather a set of goals to be arrived at through open debate and public consensus.” In a well-ordered society, as thus specified by the political common good, citizens (who likely do not affirm the same comprehensive doctrine) share the task of pursuing publicly recognized goods in common, and basic state institutions are not disabled from advancing this common task with certain political decisions. This is very different from Rawls’ liberalism and, in particular, his “thin theory of the good.” At this point, the contrast between political liberalism and the political common good becomes clear and fundamental.

We are now able to ask, in a provisional way, how the idea (and ideal) of the political common good might provide a more robust theoretical foundation for political discourse on health care reform.

The political common good refocuses the context of the health care debate on the social: “The sick individual is not only a patient with rights but a citizen with duties.” Granting this, persons qua citizens making health care decisions need to engage in an ecumenical dialogue with others (including those who do not share their convictions) to reach a consensus on the nature of good health care, common to all. Only then will political

258. See id. at xxvii.
259. See id. at 175.
260. Id. at 194.
261. See id. at 134-35.
262. Christiansen, supra note 155, at 74.
263. Rawls distinguishes a “thin theory of the good” in terms of “goodness as rationality” and the “priority of right” over ideas of the good. See RAWLS, supra note 57, at 395-99 (goodness as rationality); RAWLS, POLITICAL LIBERALISM, supra note 101, at 173-211 (priority of right and ideas of the good).
reasoning and deliberation over health care policy suitably decide our common destiny.

In other words, citizens deliberating over health care policy must first articulate, in the language of public reason, the value or values of health care, and only then assign rights, duties, and responsibilities confirming that value. This is the promise of the political common good. Can we gain a stable, overlapping consensus of reasonable comprehensive doctrines defining the value of health care? Does the conception of the political common good defended here deliver? The citizens of Oregon will help us answer these questions.

IV. HEALTH CARE AS A POLITICAL COMMON GOOD:
THE OREGON PLAN

With the exception of the Clinton Health Security Bill, no health reform policy of this decade has attracted as much attention or stirred as much controversy as the Oregon Health Plan (OHP). Enacted in 1989 and implemented in 1994, with this legislation Oregon promised to go where no other state had gone before, explicitly proposing to limit or ration health care for over 350,000 of the state’s Medicaid population.265

There is no doubt that Oregon’s Medicaid plan became “a focal point of debate on virtually every aspect of national health policy: access, cost, effectiveness, rationing, and basic care.”266 Add to this list my proposal—Oregon’s plan typifies common good thinking—and a more comprehensive debate can ensue.

The focus of this Part shifts from theory to practice. Section A describes the plan’s development, with particular attention given to various methods used to prioritize health services. Especially noteworthy is how state officials used a set of health-related social values, elicited through a series of community meetings, differently as their prioritization method evolved. Section B then discusses how the plan is an example of common good thinking.

A. THE OREGON HEALTH PLAN

1. Background

In 1987 Oregon legislators defunded optional Medicaid services for organ transplants (except kidneys and corneas).267 Though this decision was made without public debate,268 it initially aroused little reaction.269 That is until Coby Howard, a 7-year-old patient who was denied public funds for a potentially life-saving bone marrow transplant, died in December 1987.270 Predictably, the Oregon decision to curtail funding became a national issue. The reported failure of a private fund-raising campaign organized by the boy’s family, friends, and teachers to raise the $100,000 needed for his treatment only intensified the national media’s response.271 Without question, “[t]he case was a classic example of the

267. See Daniel M. Fox & Howard M. Leichter, Rationing Care in Oregon: The New Accountability, HEALTH AFF., Summer 1991, at 7, 14. The state legislature also increased funding for prenatal care during the same session. See id. at 15. As Fox and Leichter note:

Much would be made later on by national media and legislative leaders about how Oregon had eliminated organ transplants for a few patients to spend those dollars on prenatal care for many more women. The state increased funding for prenatal care during the session, but that decision was made by another subcommittee and was unrelated to the transplant decision. Id. at 14-15 (emphases added). But see OFFICE OF MED. ASSISTANCE PROGRAMS, OREGON DEP’T OF HUMAN RESOURCES, WAIVER APPLICATION: OREGON MEDICAID DEMONSTRATION PROJECT 2.7 (1991) [hereinafter WAIVER APPLICATION] (“prompted by a $20 million shortfall in available resources for human services . . . [t]he decision was made to augment the budget for prenatal care and new eligibles but to discontinue Medicaid coverage of major organ transplants.”); Marsha F. Goldsmith, Oregon Pioneers ’More Ethical’ Medicaid Coverage with Priority-Setting Project, 262 JAMA 176 (1988) (linking defunding of transplants with increased funding for prenatal care); H. Gilbert Welch & Eric B. Larson, Dealing with Limited Resources: The Oregon Decision to Curtail Funding for Organ Transplantation, 319 N. ENG. J. MED. 171, 171 (1988) (quoting then-Governor Neil Goldschmidt: “We all hate it, but we can’t walk away from this issue anymore. It goes way beyond transplants. How can we spend every nickel in support of a few people when thousands never see a doctor or eat a decent meal?”).


269. See Welch & Larson, supra note 267, at 171 (“The cases of two adults who were denied transplants in the summer and fall of 1987 were reported in the news, with little public response.”).


271. See, e.g., Timothy Egan, Rebuffed by Oregon, Patients Take Their Life-or-Death Cases Public, N.Y. TIMES, May 1, 1988, § 1, at 26; Michael Specter, Rising Cost of Medical Treatment Forces Oregon to ‘Play God’, WASH. POST, Feb. 5, 1988, at A1.
conflict between an individual and society.” 272 In the context of Oregon’s particular democratic traditions, citizens were already discussing the questions of who should get what type of care and how best to allocate medical resources as the public and emotional debate over Coby Howard’s death began. This would provide the necessary impetus for “Oregon Health Priorities for the 1990s” and especially “The Oregon Medicaid Priority-Setting Project.”

In the early 1980s, Oregon Health Decisions (OHD), a private non-profit organization dedicated to citizen education and action on ethical issues in health care, began holding community meetings to develop statewide awareness of significant bioethical dilemmas and to influence state health policy. 273 What continues to distinguish this “health decisions” effort from traditional public interest lobbying groups is the level of civic involvement and its original democratic workings. As a grass-roots effort at consensus building, the heart of the OHD process was community-based meetings (both small-group and larger town hall meetings) held throughout the state. Input from these meetings ultimately found expression in resolutions drafted for debate and voting at a final statewide “Citizens Health Care Parliament.” 274 In turn, final resolutions passed by the parliament were published and distributed widely in the state to facilitate implementation efforts and to influence Oregon legislators.

Held in October 1984, the inaugural Citizens Health Care Parliament passed thirty-four resolutions recommending that “health policy leaders . . . work on creative solutions to problems involving: [t]he autonomy and dignity of individuals[, p]revention of disease[, j]ustice in the distribution of health care services[, c]ost control in health care[, a]nd fairness in resource allocation and rationing policies.” 275 More importantly, this Parliament approved “a statement of Ethical Principles for Health

272. Eddy, supra note 266, at 417.
274. See HINES, OREGON AND AMERICAN HEALTH DECISIONS, supra note 273, at 19-32.
Decisions . . . intended in part to be a benchmark against which subsequent specific resolutions could be judged.”

These principles are to be applied with common sense born of community consensus, never hesitating “to return to the anvil that which has been hammered.”

1. The pursuit of good health is a basic right and responsibility of every individual.

2. Individuals are entitled to full information and liberty needed to decide on their own behalf about the use or refusal of available health services.

3. When necessary, the authority to decide about using or refusing health services should pass from the individual to the individual’s family and others closely involved in the individual’s life; only as a last resort should government make these decisions.

4. Since the health of the nation’s people is a top priority, society is responsible for organizing and financing a system of services, education, research and technological development to prevent disease, promote health and provide care to the sick and injured.

5. Given limited resources, society should decide what constitutes the adequate level of health services that should be guaranteed to all.

6. Community consensus should guide policies for allocating resources to health and controlling health care costs, and where necessary, for rationing health care services.

As expressive of basic values shared by Oregon citizens, one can regard this statement of ethical principles as the charter of the “health decisions” movement in Oregon.

In 1987 OHD tackled a second and more ambitious project—how to allocate scarce medical resources. “Oregon Health Priorities for the 1990s” set out “to determine which health services citizens considered the most important and therefore of the highest priority for government

276. HINES, OREGON AND AMERICAN HEALTH DECISIONS, supra note 273, at 31.

277. OREGON HEALTH DECISIONS, supra note 275, at 3.

Again, the process for consensus building relied on community-based meetings in which a survey developed by OHD determined the initial agenda of allocation issues to be discussed. For the record, completed surveys gave highest priority to preventive care for infants.

Yet, more significantly, the survey’s priority-setting exercise “became a gateway to a more basic question: why do people value a particular health service over another.” To uncover and process the underlying values used by meeting participants in determining their priorities was the ultimate goal of this OHD project. Hence, the consensus reported from the community meetings on these basic values was developed by OHD staff into draft public policy resolutions. In September 1988 the second Citizens Health Care Parliament debated and adopted these resolutions as “Principles for Health Care Resource Allocation.” As reported by Ralph Crawshaw, these fifteen principles espoused four general themes:

The role of government in health care is to maintain and improve the overall quality of life. Public decision makers should keep in mind the balance between length of life and quality of life when addressing the multidimensional nature of health care services.

The need for priorities exists so long as the public’s demand for health services exceeds its capacity, or willingness, to fund through third-party financing. Consequently, community consensus is necessary in deciding which services will be funded.

The process of the equitable determination of health care priorities demands broad participation by providing open, public forums that focus on maximizing the effective use of limited funds.

While clinical judgments remain in the domain of experts, value judgments of the general public must be integrated with expert technical judgments to produce practical, prudent, and fair health policy. Decision

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279. Crawshaw et al., Developing Principles, supra note 278, at 441.
280. See id. at 441-43. The survey presented the problem of health care allocation on three levels: What portion of the general budget should be assigned to health care? What portion of the health budget should be assigned to specific populations (infants, children, adults, and the elderly) and what portion should be assigned to specific health care approaches (acute care, long-term care, chronic care, and prevention)? What is the specific preference regarding state funding of organ transplants?
281. See QUALITY OF LIFE, supra note 278, at 1. Preventive care for children and adults, long-term care for the elderly, and critical care for children were the other priorities. See id.
282. Id.
283. For these principles, see infra app. A.
makers in the private sector should seek to allocate resources in a manner consistent with community values.284

This published set of principles plainly influenced a pilot prioritization study—known as “The Oregon Medicaid Priority-Setting Project”—and Oregon’s subsequent health care legislation.

Coby Howard’s death understandably prompted Oregon to reconsider its decision to eliminate transplant funding. During legislative hearings held to review this policy and to consider more fully Oregon’s Medicaid program, John D. Golenski, a medical ethicist and President of the Bioethics Consultation Group based in Berkeley, California, testified on behalf of Kaiser Permanente (a major health maintenance organization with 10,000 Medicaid patients in Oregon) concerning the ethics of denying soft tissue transplants.285 Golenski invited the Oregon legislators to review all health services and to prioritize them.286 Challenged to determine how best to allocate health care resources, John Kitzhaber, an emergency room physician and then state Senate President, responded by initiating “The Oregon Medicaid Priority-Setting Project” in September 1988.287 Designed and facilitated by Bioethics president Golenski and his Group, the project had what Golenski called a “‘utilitarian perspective—namely, advancing the health of the population as a whole as the fundamental principle, versus doing everything for each individual patient until you run out of funds and everybody else gets nothing, which is what we’re currently doing.’”288

284. Crawshaw et al., Developing Principles, supra note 278, at 444-46.
286. Golenski summarizes his testimony before the Joint Interim Committee on Human Resources as follows:
[I] testified that if the legislature wanted to fund health care services with a substantial probability of medical effectiveness, it should make appropriation decisions on the basis of a comprehensive review of all procedures in light of outcomes data, professional medical judgment, and social values. To eliminate funding for one medical procedure because of low predictable benefit was, in [my] view, irrational without an evaluation of the medical effectiveness of all other funded procedures. In addition, [I] questioned the morality of offering an extensive Medicaid benefits package to a section of the poor when basic health care services were still unavailable to thousands of other poor.
Golenski & Thompson, supra note 270, at 145 (testimony given on Feb. 18, 1988).
287. Kitzhaber obtained a grant to explore the potential of prioritizing health services, and the foundation administering the grant asked Golenski and the Bioethics Consultation Group to map out a plan. See id.
Conducted between December 1988 and March 1989, this priority-setting project was divided in three phases. Phase 1 began with the formation of four focus groups, each representing a Medicaid population segment: women in the reproductive years (obstetrics/gynecology); children from birth up to age eighteen (pediatrics); adults from eighteen to age sixty-four (adulthood); and the elderly, defined as persons over the age of sixty-five (geriatrics). Community volunteers—senior physicians, nurses, social workers, and health and social service program administrators—participated in each of these focus groups. Kitzhaber assigned these groups two duties: “first, to describe the elements of care necessary for their particular patient populations; and second, to assign ranks to these services in light of available outcomes and effectiveness research.” Not insignificantly, “[t]he focus groups were cautioned not to attempt to set health care priorities in light of social values, but only to rank them according to their judgments of effectiveness.”

In phase 2, an executive group, comprised of the chair of OHD’s board, a legal services attorney representing the Medicaid population, an epidemiologist from the Oregon Health Services University, and one elected representative from each of the four focal groups, combined and reordered the rankings established by the focal groups into one master priority list. To produce a single list, the executive group identified four broad areas of services necessary to any Medicaid program: reproductive services, health promotion and disease prevention, diagnosis and treatment of acute illnesses and episodic treatments, and chronic diseases and conditions. Within each area, benefits (any individual therapies,
procedures, interventions, or programs) were ranked from 10 (highest priority) to 1 (lowest priority). As reported by Golenski:

[A]cross the four services, 82% of all elements of care—such as prenatal care, immunizations, and the diagnosis and treatment of acute illnesses—were assigned a rank of 10. Approximately 90% of elements of care were assigned ranks of 7-10; 98% of elements of care were assigned ranks of 4 or higher.

The executive and focus groups in their deliberations used decision principles developed by the 1984 and 1988 Citizens Health Care Parliaments (as organized by OHD). As noted previously, each parliament articulated its findings on health care in the form of public policy principles: namely, an earlier statement of “Ethical Principles for Health Decisions” and the more influential “Principles for Health Care Resource Allocation.” In Golenski’s judgment, “project participants found these [later] principles, particularly 10, 11, and 12, very useful in the priority-setting process.” More to the point: “[t]hese principles were the crucial ‘social values’ upon which the executive group based its priorities.”

A full review of the actual priorities established by this rank-ordering process is not attempted here. However, given the political and moral crisis precipitated by Coby Howard’s death, the executive group’s consideration of organ transplantation is noteworthy. Within the diagnosis and treatment of acute illnesses and episodic treatments area, the group ultimately assigned transplants the rank of 3, lower than such benefits as dentures (with the rank of 7), foot care for the elderly (6), and routine dental care for adults (4). Parenthetically, this issue had divided the pediatric focal group, with the pediatricians present predictably ranking transplants as absolutely necessary (10) and other members of the group recommending a significantly lower ranking (3-6). Hence, the simple rationale articulated for this final decision remained controversial: “[t]he Executive Committee considered the very small number of individuals who would benefit, the low probability of individual benefit in many cases, the
poor quality of life post-procedure and the high costs of the procedures and after-care in deciding to rank transplantation low.”

In the third and final phase, an actuarial firm calculated specific cost data for each item on the executive group’s master priority list. Specifically, the actuarial report computed “[m]onthly capitation costs for the entire Oregon population aged 65 years or younger with incomes below the federal poverty level” for various health service packages to be managed in differing ways. These possible health-benefit packages included: a regular health maintenance organization (HMO); an aggressively managed HMO; the traditional fee-for-service model; and a managed care fee-for-service structure. Lastly, the priority-setting project submitted its master priority list and detailed actuarial report to the Oregon legislature. In short, project participants judged their priority-setting process “as prelude for the Legislature to make informed choices regarding how many individuals will be covered and how comprehensive the Medicaid coverage will be for Oregonians.”

The 1989 Legislature responded to the project’s priority list and actuarial calculations by enacting three pieces of legislation that became known as the Oregon Health Plan, and explicit prioritization of health care services became a permanent part of Oregon’s legislative process. This is the legacy of The Oregon Medicaid Priority-Setting Project. However, the Golenski project and Oregon’s final ranking of health services “must not be confused with one another.”

Although “Golenski and the other participants in the project were told that their work would determine the basic benefits package,” Golenski & Thompson, supra note 270, at 147, the Oregon Health Services Commission—charged with formulating a method to prioritize health services—judged Golenski’s system to be “inappropriate” for its objectives and used a different methodology to formulate the final list of priorities. See 1991 HSC REPORT app. G-1.

299. Id. at 15-16.
300. Golenski & Thompson, supra note 270, at 147.
301. See id.
302. Golenski & Blum, supra note 289, at 5 (emphasis added).
303. See Harvey D. Klevit, Alan C. Bates, Tina Castanares, E. Paul Kirk, Paige R. Sipes-Metzler & Richard Wopat, Prioritization of Health Care Services: A Progress Report by the Oregon Health Services Commission, 151 ARCHIVES INTERNAL MED. 912, 912 (1991) (“A pilot study, ‘The Oregon Medicaid Priority Setting Project,’ showed that a group of health professionals could rank the importance of general categories of care. This played an important role in convincing the legislature that priorities could be set and helped pave the way for innovation.”).
2. The Legislation

In the late 1980s, more than 400,000 Oregon residents lacked health insurance.\textsuperscript{304} Two-thirds of those uninsured were above the federal poverty level (FPL),\textsuperscript{305} then $11,140 for a family of three.\textsuperscript{306} This population primarily consisted of the working poor and their dependents. The remaining one-third were below the FPL but did not qualify for Medicaid.\textsuperscript{307} In the 1980s, Federal and Oregon law had narrowed eligibility requirements for Oregon’s Medicaid program, thereby restricting participation in the program to a small segment of citizens below the poverty level threshold.\textsuperscript{308} Absent federal action, the state of Oregon initiated its own health policy reform, with the hope of creating “a blueprint for universal access to basic and affordable health coverage.”\textsuperscript{309}

Beginning in 1989, the Oregon Legislature inaugurated the Oregon Health Plan (OHP) as a “comprehensive public/private approach to health care for the uninsured,”\textsuperscript{310} shaped by the following principles:

- All citizens should have universal access to a basic level of care
- Society is responsible for financing care for poor people
- There must be a process to define a “basic” level of care
- The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole
- The health care delivery system must encourage use of services and procedures which are effective and appropriate, and discourage overtreatment
- Health care is one important factor affecting health; funding for health care must be balanced with other programs which also affect health
- Funding must be explicit and economically sustainable
- There must be clear accountability for allocating resources and for the human consequences of funding decisions\textsuperscript{311}

\textsuperscript{304} See WAIVER APPLICATION, supra note 267, at 1.2.
\textsuperscript{305} See id.
\textsuperscript{306} See id. at 1.10.
\textsuperscript{307} See id. at 3.2 to 3.7 (discussing 1991 eligibility standards in Oregon).
\textsuperscript{308} In 1991, Medicaid income eligibility for most Oregonians was between 50 and 66% of FPL. See id. at 1.10.
\textsuperscript{309} OFFICE OF MED. ASSISTANCE PROGRAMS, DEP’T OF HUM. RESOURCES, OREGON HEALTH PLAN: AN OVERVIEW 4 (1998) [hereinafter OREGON HEALTH PLAN] (also available at <http://www.omap.hr.state.or.us/library/overview98.pdf> (visited Nov. 3, 1999)).
\textsuperscript{310} WAIVER APPLICATION, supra note 267, Abstract.
As such, OHP ambitions to change “the focus of health care from who is covered to what is covered.” 312

Oregon passed three pieces of legislation in 1989 designed to provide access to health insurance for all residents. Senate Bill 935 required employers to insure all permanent employees and their dependents. 313 Senate Bill 534 established a state-subsidized insurance risk pool to provide coverage for the medically uninsurables. 314 Senate Bill 27 (SB 27), the centerpiece of the Oregon plan, revamped the state’s Medicaid program. 315 Also known as the Oregon Basic Health Services Act (OBHSA), 316 Senate Bill 27 expanded Medicaid eligibility to all


312. Paige R. Sipes-Metzler, Oregon Health Plan: Ration or Reason, 19 J. Med. & Phil. 305, 313 (1994). See also Kitzhaber, supra note 311, at 76 (“What we have done is to change the debate from who is covered to what is covered.”).


The employer mandate required that all employers must either provide health insurance for employees (working 17.5 hours or more per week) and their dependents (i.e., “play”), or contribute to a state insurance fund that would offer coverage to those workers (i.e., “pay”). See Oregon Health Plan, supra note 309, at 6. It was designed to ensure that in time the “basic health care package” offered under Medicaid would be available to workers who were not entitled to Medicaid. See S. 935 § 1, 65th Leg. (Or. 1989) (“If Senate Bill 27 becomes law, services to Oregonians who do not have health insurance must include substantially similar medical services as those recommended by the Health Services Commission and funded by the appropriate legislative review agency . . . .”). The ambition of OHP, then, was to guarantee a basic level of health care coverage to all Oregonians as a matter of law. See Kitzhaber, supra note 311, at 79.

To implement the employer mandate, however, required Congress to exempt Oregon from the Employee Retirement Income Security Act (ERISA). Legislation passed in 1993 stipulated that the mandate would be rescinded if an ERISA waiver was not secured by January 2, 1996. No waiver was forthcoming, and the employer mandate was repealed. See Oregon Health Plan, supra note 309, at 6. This plainly leaves “a large hole in Oregon’s health insurance safety net,” Leichter, supra note 265, at 149, and tarnishes OHP’s lofty ambition.


316. In this Part, all references to the “Oregon Health Plan” (OHP) and the “Oregon Basic Health Services Act” (OBHSA) follow the nomenclature utilized by Oregon’s Office of Medical Assistance in its waiver application. See Waiver Application, supra note 267, at E.1. For present purposes, OBHSA refers only to Senate Bill 27, 1989, Or. Laws 836, and its 1991 legislative modifications, and not to 1989 and 1991 insurance legislation.
Oregonians with incomes below FPL, guaranteed a “Basic Health Care Package” based on a prioritized list of health services, required (where possible) that Medicaid provide services through managed care plans, and created the Oregon Health Services Commission to produce the prioritized list (from which the Legislature defines the “Basic Health Care Package”). The prioritization process itself—rank-ordering all health services in a list to allow for explicit funding decisions—is the most controversial feature of OHP and our focus here.

3. The Process and the 1991 Prioritized List

OBHSA is unique in its use of a “list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served,” to set the services provided under Oregon’s Medicaid program. The task of determining what should be on the list is entrusted to a Health Services Commission (HSC), whose eleven members include professional and lay people. Along with this rank-ordered list of health services, a report of an independent actuary “to determine [the] rates necessary to cover the costs of the services” is also submitted to the governor and legislative leaders. Based on these reports, the legislature must statutorily act “to determine funding levels and health services to be covered.” In reaching this political decision, the legislature cannot reduce “the

This clarification is necessary because Oregon’s public documents are inconsistent on this point. The Oregon Health Services Commission in its final report refers to Oregon Senate Bill (SB) 935, SB 534, and SB 27 collectively as the “Oregon Basic Health Services Act.” 1991 HSC REPORT, supra note 303, at xvii. However, Oregon’s Office of Medical Assistance in its waiver application introduces a new designation, the “Oregon Health Plan,” to identify its comprehensive health care strategy comprising six bills passed in 1989 and 1991 and refers to SB 27 exclusively as the “Basic Health Services Act.” (SB 935 and SB 534 are designated “The Health Insurance Partnership Act” and “The State Health Risk Pool Act,” respectively.) See WAIVER APPLICATION, supra note 267, at E.1, 1.1, 1.8.

OBHSA, as modified, is currently the subject of the “Oregon Health Plan Medicaid Reform Demonstration.” See OFFICE OF MED. ASSISTANCE PROGRAMS, DEP’T OF HUM. RESOURCES, PROGRESS REPORT: THE OREGON HEALTH PLAN, MEDICAID REFORM DEMONSTRATION, PART I—OVERVIEW OF KEY ACCOMPLISHMENTS 1 (1997) (also available at <http://www.omap.hr.state.or.us/library/progress1.6.5.pdf> (visited Nov. 3, 1999)). On Oregon’s protracted efforts to secure federal approval for its Medicaid plan, see infra notes 408-32 and accompanying text.

317. See OREGON HEALTH PLAN, supra note 309, at 6.
318. S. 27 § 4a(3) (Or. 1989).
319. See OR. REV. STAT. § 414.715(1) (1997). The members include five licensed physicians, one public health nurse, one social services worker, and four health care consumers. See id.
320. S. 27 § 4a(3) (Or. 1989).
321. WAIVER APPLICATION, supra note 267, at 2.2.
population of eligible persons determined by law” or alter the order of priorities established by HSC. Rather, by choosing the level of funding, legislators define the basic health care package available under Medicaid for all recipients, “starting at the top of the priority list and working down as far as available revenue will allow.” In short, “dwindling resources allocated to health care will reduce the benefits, but not the number of total recipients.”

The innovative quality of this proposal is formidable:
Under the new program, the state can no longer arbitrarily change eligibility for reasons of budgetary expediency. Everyone retains coverage. The debate centers on the level of that coverage—on what [Oregonians] as a society feel is “adequate,” on what level of health care [Oregonians] as a society are willing actually to fund and thus guarantee to all of [Oregon’s] citizens. It forces [Oregonians] to define the common good and to clarify the social contract as it relates to health care. Because, ultimately, the socially acceptable minimum level of care is what society is willing to pay for.

To say that the health care debate on universal access and cost containment should attempt to define what is “adequate” care only underscores the relevance of any prioritized list of health services and indeed the prioritization methodology itself. Judiciously, OBHSA did not specify a ranking methodology, only that HSC must conduct public hearings and “actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.” Beyond this important directive, the Commission was free to design its own ranking methodology and to generate any style of prioritized list. As the eleven commissioners candidly acknowledged in their first report, “such a task had never before been done.”

a. The methodology

HSC’s 1991 prioritization methodology involved six steps:
Step 1: Creation of condition/treatment pairs. The Commission generated a list of 709 line items based on condition and treatment codes.

324. Kitzhaber, supra note 311, at 78.
325. Dixon & Welch, supra note 268, at 892.
326. Kitzhaber, supra note 311, at 78 (second emphasis added).
328. 1991 HSC REPORT, supra note 303, at xiii.
Step 2: Development of inputs for the ranking process. Two key inputs were developed: (a) social values elicited through a series of community meetings and public hearings and (b) a net benefit formula used to calculate a numerical weight for each condition/treatment pair based on expected outcomes. A treatment cost-benefit ratio was also calculated.

Step 3: Development and ranking of health service categories. The Commission created and ranked 17 service categories (e.g., preventive care for children, comfort care) in accordance with social values.

Step 4: Assignment of condition/treatment pairs to service categories. This was carried out by the Commission with assistance from providers.

Step 5: Ranking of condition/treatment pairs within categories. The net benefit formula served to produce an initial ranking of the items within the health service categories.

Step 6: Final Line-by-Line Adjustments. Selected items were moved up or down the list based on public testimony, benefit to the population as a whole, a cost-benefit ratio, and Commissioner judgment.

i. Creating condition/treatment pairs

Each condition/treatment (CT) pair couples a health service with a medical condition that service is designed to treat. Initially, fifty-four volunteer provider groups in Oregon created approximately 1,600 CT pairs. Released in May 1990, a preliminary draft of the priority list actually included this larger number of pairs but HSC reduced the final list to a manageable 709 CT pairs.

ii. Developing inputs for the ranking process

This is the heart of the methodological controversy. As mandated by OBHSA, the Commission attempted for the first time to formally
incorporate both social values and clinical effectiveness into the health care delivery system.”

To determine social values, HSC used public input from three distinct sources: (1) testimony received at twelve public hearings held statewide by the Commission; (2) values generated in forty-seven community meetings conducted statewide by OHD; and (3) data generated by a random telephone survey of Oregonians’ health-state values.

With over 1,500 people attending, the public hearings allowed individuals and interest groups to express their particular views or to plead special circumstances. In brief, “[t]estimony generally was not useful in measuring treatment effectiveness objectively but was useful for understanding the general tone of public needs and concerns.”

As a more innovative attempt to encourage effective public involvement, the community meetings were designed to “build consensus on the values to be used to guide health resource allocation decisions.”

One thousand forty-eight Oregonians attended these meetings to express their values about health care, essentially responding to the question, “Why are certain health care services important to us?” In the course of each meeting, participants viewed a slide show providing background information on the health care crisis in Oregon and the proposed “Oregon Solution,” weighed a series of “health care situations” designed to stimulate conversation about why health services are important, completed a questionnaire soliciting their opinions on the relative importance of “sample health care categories” and engaged in small group discussions assessing their articulated values about health care.

Reporting on these meetings, OHD distinguished thirteen health-related values, including “prevention,” “quality of life,” and “cost effectiveness” as the most frequently discussed. It described these as

334. Kitzhaber, supra note 311, at 76.
336. 1991 HSC REPORT, supra note 303, at 22. For an overview of the public hearings, see id. app. E.
338. Id. Hasnain and Garland insist their question was always: “Why is this important to us as members of a community.” Id. at 3.
339. For a list of “health care situations,” see infra app. C.
340. For “sample health care categories,” see infra app. D.
341. See HASNAIN & GARLAND, supra note 337, at 8.
342. See infra app. F (compilation of values expressed at OHD community meetings).
expressions of community values developed to complement the expressions of individual values garnered from HSC’s hearings and telephone survey.\textsuperscript{343}

The scope of that claim, however, was controversial.\textsuperscript{344} OHD admitted that meeting participants did not represent a cross section of all Oregonians, and OBHSA’s target population—Oregonians at or below FPL—was notably underrepresented.\textsuperscript{345} While over a thousand Oregonians attended forty-seven meetings, almost 70\% were mental health and health care workers, 67\% were college graduates, and 34\% had incomes of $50,000 or more.\textsuperscript{346} Meanwhile, 9.4\% of the meeting participants were medically uninsured (compared to about 16\% of the state’s 1990 population) and 4.4\% were Medicaid eligibles (compared to 6.8\% of the state’s 1990 population).\textsuperscript{347} Despite failing to accomplish two of its three goals for the community meetings,\textsuperscript{348} OHD pronounced the meetings “successful in eliciting values Oregonians possess about why health care services are important, broadening the scope of information related to Oregon Health Care Legislation, and establishing a legacy of community involvement in an open process which will impact future health policy.”\textsuperscript{349}

That HSC used community values distilled from OHD meetings to shape its 1991 priority list is clear. But how these values in fact influenced the Commission’s deliberations remains somewhat vague. Remarkably, even before its first meeting, HSC “reserved the right to ‘pursue [its] own course of action if not satisfied with the values being elicited by the Oregon Health Decisions.’”\textsuperscript{350} In its first priority ranking (May 1990) developed

\begin{itemize}
\item 343. See HASNAI & GARLAND, supra note 337, at 3.
\item 345. See HASNAI & GARLAND, supra note 337, at 26.
\item 346. See id. at 29-30 tbls.2-3.
\item 347. See WAIVER APPLICATION, supra note 267, at 2.15.
\item 348. The primary goals of the community meetings were:
\begin{itemize}
\item 1) to ensure broad attendance by a cross section of the Oregon public to elicit values pertaining to why Oregonians find health care services important;
\item 2) to attempt to ensure that the demographic characteristics of community meeting participants are representative of county demographics; and
\item 3) to ensure that the target population of Senate Bill 27, those Oregonians below the federal poverty level, participate in community meetings.
\end{itemize}
\item 349. Id.
\item 350. Golenski & Thompson, supra note 270, at 148 (quoting Health Services Commission: Minutes of the Social Value Subcommittee, Nov. 22, 1989).
\end{itemize}
through a cost-benefit analysis with a quality-of-life component. HSC “officially” manipulated these community values as a “‘check on the quantitative data’ drawn from medical outcomes studies, cost-benefit analyses, and the Kaplan Quality of Wellbeing Scale.” Or, in the words of several commissioners, “the information garnered from community meetings and public hearings [served] as an important qualitative determinant in the final ‘fine-tuning’ of the list.” Whether distinguished as a “check on quantitative data” or a “qualitative determinant,” the force of these expressed community values in HSC’s 1990 methodology testing was still dubious.

Indeed, the commissioners acknowledged as much when they abandoned their initial method of cost-benefit analysis for a more subjective categorization approach. Both commissioners and most outside reviewers agreed the initial method failed because several technical problems caused it to generate a clinically counterintuitive priority order. In addition, the Commission conspicuously recognized “that a ranking based on benefit or a cost-benefit ratio did not comprehensively reflect public values.” For these reasons, HSC adopted an alternative method to generate a revised priority list (February 1991). In the commissioners’ judgment, an alternative methodology—the categorization approach—incorporated social values into the priority-setting process with greater clarity and meaning.

352. Dougherty, supra note 344, at 6. For discussion on Kaplan’s Quality of Well-Being Scale, see infra notes 359-62 and accompanying text.
353. Klevit et al., supra note 303, at 915.
355. WAIVER APPLICATION, supra note 267, at 2.11. See also 1991 HSC REPORT, supra note 303, at 11, G-1.
356. See Eddy, supra note 266, at 417.
357. See Klevit et al., supra note 303, at 916. For discussion on this approach, see infra notes 373-83 and accompanying text.
As a third mechanism used to solicit citizens’ values, HSC collected “quality of life” data from a telephone survey of 1,001 Oregonians. 358 Surveyors administered a modified version of the Quality of Well-Being (QWB) Scale 359 by asking respondents “to imagine themselves to be permanently affected by a functional limitation or symptom and to rate the limitation/symptom on a scale from 0 (‘as bad as death’) to 100 (‘good health’).” 360 Examples of these “QWB states” (disabling functional and/or health states) include: “You have to stay at a hospital or nursing home, have to be in bed or in a wheelchair controlled by someone else, need help to eat or go to the bathroom, and have losses of consciousness from seizures, blackouts or coma”; and “You can go anywhere and have no limitations on physical or other activity, but have pain or discomfort in your eyes or vision problems that corrective lenses can’t fix.” 361 The survey results, in effect, “assigned a ‘weight’ (W) [to each QWB state] to reflect the quality of life associated with any symptoms or limitations related to that category.” 362

Significantly, in contrast to the solicitation of shared social values in the community meetings, the telephone survey’s “resultant-weighted values, standardized and incorporated into the mathematical prioritization model, reflect Oregon specific public input about the health status of individuals, without reference to the question of one individual’s health problems or needs when viewed in the context of societal resource allocation.” 363

358. See 1991 HSC REPORT, supra note 303, at 23, app. C.
359. See id. at 26, C-1. The QWB is presented in Robert M. Kaplan & John P. Anderson, A General Health Policy Model: Update and Applications, 23 HEALTH SERVS. RES. 203 (1988). Below is a simplified description of the QWB Scale:
Simply stated, it measures how an individual functions independently and how he/she feels normally and during illnesses. Its advantage over other tools is that it will provide an interface between scientific fact provided by informed practitioners in terms of symptoms and disabilities and the public’s perception of the relative importance of them.
Kaplan’s QWB system is a measure of an individual’s or population’s overall state of health at a point in time. The method assigns a score of 1.0 to a perfectly healthy individual and a score of 0 for death . . . . The severity of certain limitations in physical activity, mobility, social activity, and/or the presence of physical or mental symptoms derived from a list of 24 categories allows the calculation of the QWB score. Each disability and symptom was weighed on the basis of information supplied by Oregon residents during a telephone survey.

Klevit et al., supra note 303, at 913.
360. WAIVER APPLICATION, supra note 267, at 2.16.
361. 1991 HSC REPORT, supra note 303, at C-15. For a copy of the complete telephone questionnaire, see id. at C-13 to C-21.
362. Eddy, Oregon’s Methods, supra note 354, at 2136.
363. Klevit et al., supra note 303, at 915.
HSC incorporated these resultant-weighted values with its determination of clinical effectiveness for each of the 709 CT pairs to calculate the “net benefit” of each service for a particular condition. First, data on the probability of expected outcomes was collected from health care experts in various specialities. Then, a net benefit formula combined known data on the likelihood of expected clinical outcomes with resultant-weighted public values on the relative importance of expected outcomes. The result was the net benefit, indicating the benefit of the treatment in terms of the change in QWB score with and without treatment.

In the first priority list (May 1990), net benefit was one component of a cost-benefit ratio. HSC abandoned the cost-benefit ratio for technical reasons and because “the resulting ranking did not adequately reflect social values.” Instead, the Commission adopted a categorization of health services approach. This method involved three steps: (1) identifying and ranking categories of health services that “depict varying types or degrees of expected health benefit from treatments,” (2) assigning each CT pair to a single category, and (3) ranking CT pairs within each category according to net benefit. Officially, “[t]reatment costs and associated cost/benefit ratios were eventually used on a case-by-case basis to help guide Commission revisions of the list, but cost factors were not included in the final net-benefit formula.”

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364. See WAIVER APPLICATION, supra note 267, at 2.16.
365. See 1991 HSC REPORT, supra note 303, at 23, app. D. Below is a simplified version of the net-benefit calculation.

\[
\text{Net benefit} = [(\text{outcome with treatment}) \times (\text{QWB with treatment})] - [(\text{outcomes without treatment}) \times (\text{QWB without treatment})]
\]

367. See Eddy, Oregon’s Methods, supra note 354, at 2136-37.
368. See supra notes 354-56 and accompanying text.
369. WAIVER APPLICATION, supra note 267, at 2.19.
370. David Hadorn originally proposed this method in an unpublished grant proposal. See Hadorn, Setting Health Care Priorities, supra note 354, at 2220; Klevit et al., supra note 303, at 916.
372. WAIVER APPLICATION, supra note 267, at 2.19. Despite this official line, how these cost-benefit ratios were used in the February 1991 rankings remains somewhat ambiguous. See, e.g., Veatch, supra note 344, at 203-04 n.1. Hadorn explains the influence of cost as follows:

To a very minor extent, cost was reintroduced in the concluding step of the process, during which OHSC rearranged line items “by hand.” . . . [T]he commissioners of OHSC moved individual line items higher or lower on the priority list based on their collective judgment concerning the overall importance of each item in relation to the others. These judgments were guided informally by several factors (as articulated by the commissioners during their discussion and debate), including the number of people who were expected to benefit from a
iii. Identifying and ranking health service categories

As a preliminary matter, HSC’s Alternative Methodology Subcommittee developed two basic types of categories:

The first group was made up of unique types of care that had few, if any, defined condition/treatment pairs. These included preventive services, comfort care, preventive dentistry, maternity care and others. The second group included treatment of acute and chronic conditions divided on the basis of effect of treatment on both the quality of well-being and the potential morbidity of the condition (i.e., did the treatment prevent death and/or improve the quality of well-being).

After paring the subcommittee’s initial set of twenty-six categories to seventeen, HSC ranked the final set of categories in order of importance using the following process:

1) classifying community values to arrive at a manageable number of broad value-laden attributes
2) weighting of attributes
3) assigning a score to each category of health services
4) using a modified Delphi technique to achieve consensus
5) calculation of averaged, weighted scores for each health service category

First, HSC grouped the thirteen community values distilled from OHD’s meetings into three attributes: value to society, value to an individual at risk of needing the service, and essential to basic health care. Although Health Care in Common (OHD’s summary report) apparently ranked these thirteen values in terms of frequency of mention at the community meetings, HSC received them unranked because “[i]t is acknowledged that the frequency of discussion of a topic has no direct

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375 See id.
376 Id. app. G-7.
377 For attributes derived from community meeting values, see infra app. E.
378 See HASNAI & GARLAND, supra note 337, at 6. For a compilation of values expressed at these community meetings, see infra app. F.
inference as to the importance of a value.**380 Second, each commissioner assigned a relative weight from zero to 100 to these service attributes. Third, the commissioners rated each health services category three separate times, assigning a score from one to ten (highest rank) for each of the attributes. Consider a typical example: “A Commissioner might have assigned a 10 to infertility services based on ‘value to an individual,’ a two based on ‘value to society,’ and a one based on ‘essential to a basic health care package.’”**381 Notably, this step enabled each commissioner to consider in the category ranking process community values expressed at OHD meetings and individual values voiced in testimony at public hearings.

Fourth, to reach a final consensus on the category rankings, the commissioners reviewed their one to ten scores assigned to each health service category and the weighted scores of zero to 100 distributed among the three attributes to identify major discrepancies (if any) among commissioners’ scoring. This modified Delphi technique afforded the commissioners a final opportunity to change any responses or to advocate for a higher or lower score. Fifth, to establish a preliminary ranking of categories, “[s]taff applied the weights of the attributes to the 1 to 10 scoring [and] then . . . summed the weighted scores (11 scores—one score per Commissioner) for each category and averaged the result.”**382

In short, the Commission prepared the final priority list “by ‘stacking’ categories on top of each other in rank order so that all the line items in the top-ranked category were deemed to be of higher priority than all the items in the second-ranked category, and so on.”**383

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380. Klevit et al., supra note 303, at 915.
382. Id. app. G-10. HSC provided the following model calculations:

<table>
<thead>
<tr>
<th>Value Perspective</th>
<th>Perspective Weight</th>
<th>X</th>
<th>Category Score</th>
<th>Total (100 total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value to society</td>
<td>40</td>
<td>2</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Value to individual</td>
<td>20</td>
<td>9</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td>Essential to basic health</td>
<td>40</td>
<td>2</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>One commissioner’s weighted score</td>
<td>340</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example: Infertility services may have been weighted and scored as follows:
For the same category of service, other Commissioner’s weighted scores were 260, 180, 470, 260, 110, 200, 320, 360, 215, and 175. These add to 2890. This total divided by 11 results in an average weighted score of 263 for the category of infertility services.
The categories were ordered from the largest score (highest rank) to the lowest.
Id. (adapted).
383. Hadorn, Setting Health Care Priorities, supra note 354, at 2220. For the ranked list of health service categories, see infra app. G.
iv. Assigning CT pairs to service categories

HSC next assigned each of the 709 CT pairs to a single category. Among the seventeen categories, seven are “service-specific” (for example, maternity care or preventive care for children), “allowing for relatively straightforward placement.”\(^\text{384}\) The remaining ten categories are defined by whether the condition is acute or chronic and by degrees of fatality (fatal or nonfatal) and improvement in quality of life.\(^\text{385}\) Using a computer algorithm based on provider-generated outcomes data,\(^\text{386}\) HSC initially sorted the CT pairs into these ten categories. Finally, the commissioners relied on their collective professional judgment to make further adjustments in these line item assignments.

v. Ranking of CT pairs within categories

CT pairs were initially ordered within each category according to net benefit and so listed within categories from highest to lowest net benefit. After reviewing this initial ranking, commissioners again rearranged line items within categories “based on a group consensus following a consideration of provider recommendations and community values.”\(^\text{387}\)

vi. Final line-by-line adjusting

HSC performed some necessary “list jockeying”\(^\text{388}\) in this final step—rearranging line items in the overall list regardless of their category ranking. To reorder the final priority list “by hand,”\(^\text{389}\) the commissioners used a reasonableness test:

The position of each item was assessed for “reasonableness” based on its public health impact [for example, prevention or early treatment of a condition], the cost of medical treatment, incidence of the condition, effectiveness of treatment, social costs[,] . . . costs of non-treatment[, and] in some cases[,,] . . . the cost-benefit ratios developed during earlier ranking efforts.\(^\text{390}\)

As a result, “[a]pproximately 33% to 50% of the line items contained in the final list were rearranged, although only about 5% to 10% were

\(^{384}\) W AIVER APPLICATION, supra note 267, at 2.21. An example: “[CT pairs] related to children’s preventive care or to reproductive care . . . were placed within those categories.” Id.
\(^{385}\) See infra app. G.
\(^{387}\) W AIVER APPLICATION, supra note 267, at 2.22.
\(^{388}\) See Hadorn, Setting Health Care Priorities, supra note 354, at 2220.
\(^{389}\) See id.
\(^{390}\) W AIVER APPLICATION, supra note 267, at 2.22. On the role of cost in the concluding step, see supra note 372.
moved more than 50 positions from the locations arrived at by the prioritization method just described.\textsuperscript{391}

In sum, HSC generated its 1991 priority list of health services using ranked categorization and the expected net benefit of treatment as the most significant factors.\textsuperscript{392}

b. The prioritized list

In May 1991, HSC submitted its then-final priority list and an independent actuarial report to the governor and state legislature.\textsuperscript{393} As noted earlier, the list identified and ranked 709 CT pairs in order of priority.\textsuperscript{394} In its report, the Commission formally recommended “the prioritized list as the basis for the benefit package of the [OBHSA].”\textsuperscript{395} But, exceeding its authority,\textsuperscript{396} HSC also urged that “[a] benefit package be funded which includes all services in categories considered essential and most of those considered very important.”\textsuperscript{397} Defining “basic health care as ‘a floor beneath which no person should fall,’”\textsuperscript{398} the Commission insisted that “the categories of ‘essential’ and ‘very important’ are critical to basic health care,”\textsuperscript{399} and funding of these categories “will produce a minimum health benefits package.”\textsuperscript{400} Finally, the commissioners left the governor and legislature with this prescient counsel:

[The Commission’s definition of basic health care is from a societal perspective rather than the individual’s perspective. What is essential for the overall well-being of society may not meet the desires of specific individuals. Responding to the needs of both society and the individual may mean earmarking more funds for investment in Oregon’s medical assistance programs than has previously been the case.\textsuperscript{401}]

\textsuperscript{391} Hadorn, Setting Health Care Priorities, supra note 354, at 2220.
\textsuperscript{393} See 1991 HSC REPORT, supra note 303.
\textsuperscript{394} See id. app. J (“Prioritized Health Services List of May 1, 1991”). For selections from the 1991 list, see infra app. H.
\textsuperscript{395} 1991 HSC REPORT, supra note 303, at xiii.
\textsuperscript{396} See id. at 69 (“Although this recommendation is beyond the Commission’s mandate, it believes ethical considerations extend its responsibilities beyond simply building a ranked list of health services with no further comment.”); WAIVER APPLICATION, supra note 267, at 2.3. (“[T]he Commission is not authorized to establish the actual benefit package . . . .”)
\textsuperscript{397} 1991 HSC REPORT, supra note 303, at xiv.
\textsuperscript{398} Id.
\textsuperscript{399} Id.
\textsuperscript{400} Id. at xv.
\textsuperscript{401} Id. (emphasis added).
Early in the debate over funding, the state legislature appropriated $33 million in new revenue to the Medicaid program. Then, in June 1991, the legislature determined that Oregon could afford to fund 587 of the 709 CT pairs for all Oregonians living at or below FPL. The funded benefits incorporated almost all CT pairs considered “essential” and “very important” by HSC, with top priority given to services for acute conditions with high expectations of recovery, preventive care, children and expectant mothers. How the state characterized unfunded services is equally significant:

Services excluded from coverage are the least likely to make a substantial improvement in the quality of life. These low priority services may have potential benefit to certain individuals but are significantly less likely to be effective, to produce substantial long-term gain, or to be of substantial societal value.

In short, these 587 funded CT pairs defined Oregon’s basic health care package in 1991.

404. See WAIVER APPLICATION, supra note 267, at 2.6; Sipes-Metzler, supra note 403, at 13 (attributing to OHD’s Michael Garland the view that the legislature “voted to fund 98 percent of ‘essential’ services and 82 percent of ‘very important’ services, along with some services ‘valuable to certain individuals’”).
405. See WAIVER APPLICATION, supra note 267, at 2.6. Oregon’s Medicaid waiver application highlighted the following “included” services:
   At the top of the list are life-threatening conditions for which treatment will return a person to health, maternity and infant services, preventive care for children, and effective preventive care for adults. Also high are treatments for HIV disease and cancer when they can be treated early. These diseases are ranked lower, however, when they have progressed to the point where no treatment is effective. On the other hand, comfort care (e.g., hospice, pain management) is very high on the list and is included in the benefit package.
   Id.
406. Id. Excluded services include: “medical treatment for infertility, medical treatment for a viral sore throat, routine screening (e.g., colon cancer) for adults not otherwise at risk, and aggressive treatment for the end-stages of AIDS and cancers and for newborns weighing less than 500 grams and having less than 23 weeks gestation.” Id.
407. As originally intended, this basic package was to be offered to Medicaid recipients upon receipt of federal waivers, and was to form (as of July 1995) the minimum benefit package to be offered by all employees under OHP’s employer mandate. See Sipes-Metzler, supra note 403, at 13. Oregon didn’t secure the necessary waivers until 1993, see infra notes 408-27 and accompanying text, and the (never implemented) employer mandate was rescinded in 1996. See supra note 313. So when OHP finally went into operation in 1994, funded CT pairs—565 of 696 pairs—defined only Oregon Medicaid’s basic package.
4. **Subsequent History**

In 1991, Oregon submitted its Medicaid plan (OBHSA) to the Bush Administration for federal approval. The following year, the Department of Health and Human Services (HHS) rejected the plan on the grounds that its priority list undervalued the quality of life of people with disabilities, and so violated the Americans with Disabilities Act of 1990 (ADA). HHS contended that “any methodology that would intentionally ration health care resources by associating quality of life considerations with disabilities does not comport with the mandate of the ADA.”

In particular, HHS lawyers singled out two health services unfunded by OBHSA—liver transplants for alcoholics and life support for premature babies weighing less than eighteen ounces—in concluding that the Oregon

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408. In this section, I am indebted to helpful papers from two Georgetown Law students: Kimberlee A. Cleaveland, A Disabling Doctrine: The Impact of the Americans With Disabilities Act on State Efforts to Allocate Limited Medicaid Resources (Dec. 7, 1998) (unpublished manuscript, on file with author); Tracy Johnson, Breathing Quality of Life into Oregon’s Health Care Rationing Plan: A Proposal Complying with the Americans with Disabilities Act (Jan. 16, 1996) (unpublished manuscript, on file with author).

409. Because OBHSA tampered with various federal Medicaid regulations, federal approval was necessary for its implementation. Oregon attempted to secure federal approval on two fronts: the Health Care Financing Administration (HCFA) and Congress. See WAIVER APPLICATION, supra note 267, at 7.1 to 7.6 (requesting HCFA waive 11 statutory and regulatory requirements, and continue four previously granted waivers); W. John Thomas, The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program, 72 OR. L. REV. 47, 55-58 (1993). Congress asked the Office of Technology Assessment (OTA) to evaluate OBHSA, and the OTA reported “serious reservations about the overall” plan. Id. at 56 (quoting OFFICE OF TECHNOLOGY ASSESSMENT, EVALUATION OF THE OREGON MEDICAID PROPOSAL 21 (1992)). See also Robert Pear, Study Sees Problems in Rationing of Health-Care Services, N.Y. TIMES, Feb. 25, 1992, at A1.


411. Sullivan Letter, supra note 410, at 31,779. HHS specifically criticized the use of “quality of life” data acquired from the telephone survey because such data “quantifie[d] stereotypic assumptions about persons with disabilities,” and hand adjustments made by HSC based on “community values, including ‘quality of life’ and ‘ability to function.’” HSC had noted that it moved treatments for “‘severe or exacerbated condition’—almost the very definition of a disability—to a ‘relatively unfavorable position.’” For HHS it couldn’t be clearer—OBHSA violated the ADA. Id. Still, some Oregonians thought differently. They “suspected that the plan was denied because George Bush, about to wage a presidential campaign against Bill Clinton, was afraid to be labeled the ‘rationing president.’” Thomas Bodenheimer, M.D., The Oregon Health Plan—Lessons for the Nation (First of Two Parts), 337 NEW ENG. J. MED. 651, 652 (1997).
rankings valued “the life of a person with a disability . . . less than the value of the life of a person without a disability.”

In 1992, HSC grudgingly accepted HHS’s recommendations and reformulated its methodology. Purged from the prioritization process were all quality of life and public values data (obtained through the telephone survey), the seventeen health service categories, and any post-treatment symptom severity information. As an alternative methodology, HSC “relied on a computer ranking based on modified health outcomes data that were adjusted using the Commissioners’ judgment.”

The Commission produced another version of the priority list with two considerations in mind: “[T]he plan’s focus [is] to preserve life, and the most desirable outcome after treatment is for the patient to be asymptomatic.” So each CT pair was analyzed with regard to the probability of three changes in health status after treatment—death to non-death, death to asymptomatic, and symptomatic to asymptomatic—and then ranked by “(1) descending value of the death to non-death state; if tied, by (2) descending value of the death to asymptomatic state; if tied, by (3) descending value of the symptomatic to asymptomatic state, and if tied, by (4) the cost of the treatment, with the most expensive treatments ranking lowest.”

As with its 1991 methodology, HSC also performed some line-by-line adjusting. It promoted or demoted some CT pairs on the list based, in

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413. See OREGON HEALTH SERVS. COMM’N, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE (1993) [hereinafter 1993 HSC REPORT]. Despite believing that “the process was biased in favor of the disabled and was fair,” id. at 8, the Commissioners responded to HHS’s chief recommendation that Oregon not use community values such as quality of life and ability to function in ranking CT pairs. See Sullivan Letter, supra note 410, at 31,779. See also Diane S. Lund, Oregon Tries Again: Medicaid Reform Plan Revised, Resubmitted, AM. MED. NEWS, Dec. 7, 1992, at 11.

414. See 1993 HSC REPORT, supra note 413, at 9. See also Moossy, supra note 365, at 308.

415. Moossy, supra note 365, at 308 (citing 1993 HSC REPORT, supra note 413, at 12).

416. Id. at 10 (citing 1993 HSC REPORT, supra note 413, at 10).

417. See 1993 HSC REPORT, supra note 413, at 11. Health care professionals provided the necessary data on treatment outcomes and costs. See id. at 9-10.

418. Moossy, supra note 365, at 309 (citing 1993 HSC REPORT, supra note 413, at 11-12).
certain instances," on values that the Commission felt were indicative of the goals of Oregonians."  

In March 1993, the new Clinton Administration approved Oregon’s Medicaid plan contingent on again reordering the prioritized list. Within a month, HSC revised the prioritization methodology (for the second time) and reordered the list which was approved by HHS. This time HSC had to modify its 1992 method “by removing the values for the health outcome state of ‘death to asymptomatic’ and ‘symptomatic to asymptomatic,’ leaving only a value for the treatment’s ability to prevent death (mortality) . . . .” To reorder the list, HSC ranked each CT pair “either by 1) the treatment’s effectiveness in the prevention of death and/or its average lifetime cost; or 2) the application of a set of subjective criteria to the service being prioritized.” Even with this entirely different method, 85% of the items on the 1993 list were ranked almost the same as they had been in the 1991 version.

419. For other considerations guiding HSC in hand adjustments, see 1993 HSC REPORT, supra note 413, at 12-14; Moossy, supra note 365, at 309-10.
420. Moossy, supra note 365, at 310 (citing 1993 HSC REPORT, supra note 413, at 13). Relying on a publicly influenced value judgment, HSC increased the placement for maternity care, general preventive services, comfort care, and family planning services; and decreased the placement for cosmetic and infertility services. See Moossy, supra note 365, at 310.
422. Moossy, supra note 365, at 311 (citing 1993 HSC REPORT, supra note 413, at 15). HSC also had to remove any bias against infertility. See id.; Shalala Letter, supra note 421, at 34,987.
423. OREGON HEALTH SERVS. COMM’N, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND THE 70TH OREGON LEGISLATIVE ASSEMBLY 18 (1999) [hereinafter 1999 HSC REPORT] (reporting on methodology approved by HHS in April 1993, and still used by HSC) (also available at <http://www.ohppr.state.or.us/ohsc/report/index.htm> (visited Nov. 3, 1999)). In greater detail, the 1993 (and still current) method is as follows:

In creating the Prioritized List, an initial sort was performed following these steps:
a) The condition/treatment pairs were ranked according to the likelihood that treatment would prevent death;
b) Those remaining condition/treatment pairs whose treatments have an equivalent ability to prevent death or whose conditions have no risk of mortality were rank ordered by the average lifetime cost of treatment, from the least expensive to the most expensive; and,
c) Any condition/treatment pairs not separable by both of these measurements were sorted alphabetically by diagnosis.

The Commission then reviewed the initial sort of the condition/treatment pairs line-by-line to determine whether the data resulted in an appropriate relative ranking of the line item. If the Commission felt that the initial placement of the line did not properly reflect its importance as a health service, the subjective criteria listed in Table 2 [see infra app. I] were used to move the condition/treatment pair up or down the list. These criteria were developed using the values expressed at the public hearings and community meetings held throughout the State. Id. at 18-19 (emphasis added).
On February 1, 1994, five years after its initial passage in the state legislature, Oregon’s Medicaid Demonstration went into operation as the Office of Medical Assistance Programs (OMAP) began implementing Phase I of the Demonstration. With funds available from the legislature to provide 565 out of 696 treatments on the 1993 list, Oregon Medicaid began to provide “medical and surgical services to all eligibles whose income was 100% or less of the federal poverty level.” And poor Oregonians were quick to enroll.

Priority setting in Oregon did not end in 1994—HSC is legally required to review the prioritized list every two years. Nor is the Demonstration static. Begun in January 1995, Phase II integrated seniors, persons with disabilities, children in foster care, and chemical dependency and mental health services into the basic health care package. This increased the length of the priority list from 696 to 745, with the 1995 Legislature funding through line 581. In comparison, the current (1997-99) revised list consists of 743 CT pairs, with the basic health care package (as of May 1, 1998) covering the first 574 of these pairs.

For the future, the Oregon Medicaid Demonstration, and explicit priority setting, will continue (at least) until 2001.

424. See 1999 HSC REPORT, supra note 423, at 5; OREGON HEALTH PLAN, supra note 309, at 8.
425. See 1999 HSC REPORT, supra note 423, at 9 n.22 (reporting that the 1993 HSC report included “both a physical health services prioritized list, which the legislature funded through line 565 of 696 and an integrated health services prioritized list, including mental health and chemical dependency services, funded through line 606 of 745”); OREGON HEALTH PLAN, supra note 309, at 7.
426. 1999 HSC REPORT, supra note 423, at 5.
428. See 1999 HSC REPORT, supra note 423, at 19.
429. See id. at 5; OREGON HEALTH PLAN, supra note 309, at 7.
431. See 1999 HSC REPORT, supra note 423, at 12, 13; OREGON HEALTH PLAN, supra note 309, at 14. HSC’s most recent biennial review (1997-99) produced a revised list (April 12, 1999) with significant changes in line placement and line composition from the May 1998 list. See 1999 HSC REPORT, supra note 423, at 21-23, app. F. HSC also recommended that the Legislature use this list to determine Oregon Medicaid’s benefit package for the 1999-2001 biennium. See id. at 49.
432. Originally approved as a five-year demonstration in 1994, HCFA accepted a three-year extension for it in 1998. See 1999 HSC REPORT, supra note 423, at 14. For reviews on the current status of the Oregon plan as a health policy innovation, see OFFICE OF MED. ASSISTANCE PROGRAMS, DEP’T OF HUM. RESOURCES, PROGRESS REPORT: THE OREGON HEALTH PLAN, MEDICAID REFORM DEMONSTRATION, PART I—OVERVIEW OF KEY ACCOMPLISHMENTS (Jan. 1997) (also available at <http://www.omap.hr.state.or.us/library/progressi1.6.5.pdf> (visited Nov. 3, 1999)); OFFICE OF MED. ASSISTANCE PROGRAMS, DEP’T OF HUM. RESOURCES, PROGRESS REPORT: THE OREGON HEALTH PLAN, MEDICAID REFORM DEMONSTRATION, PART II—THE HEALTH CARE PROGRAM (June 1997); Thomas Bodenheimer, M.D., The Oregon Health Plan—Lessons for the Nation (Second of Two Parts), 337 NEW ENG. J. MED. 720 (1997); Bodenheimer, supra note 411; Chris Ham, Retracing the Oregon
B. THE OREGON PLAN AND THE POLITICAL COMMON GOOD

Oregon’s original Medicaid plan changed the national debate over American health care for the better by introducing the promise of political common good thinking. That embryonic notion was particularly evident in OHD’s innovative efforts “to discover whether Oregonians do in fact share a living tradition of values about health care that can help define some package of health services as constituting a *common good.*”\(^{433}\) It was likewise present in the political understanding of John Kitzhaber, OHP’s architect and now Oregon’s governor, who often reminded the citizens of Oregon that the criteria used to determine what constitutes a “basic” level of care “must be publicly debated, must reflect social values, and must consider the common good of society.”\(^{434}\) Oregonians qua citizens first articulated collective health care values supported by publicly accessible reasons, and only then permitted state officials to define a basic health care package based on those values.

To be sure, the Oregon plan with its 1991 prioritized list triggered widespread interest among ethicists and policymakers,\(^ {435}\) with proponents and critics furiously debating the pros and cons of what still “may be the most ambitious attempt ever in this country to provide universal health coverage.”\(^ {436}\) At a minimum, the persistent controversy in the early 1990s produced somewhat predictable arguments repeated ad nauseam by defenders and opponents alike. For proponents:

The legislation substantially expands access to health care by creating virtually universal health insurance coverage in Oregon.

Unlike the process in nearly all other states, if funds are insufficient, low priority services are cut from Medicaid coverage, but eligibility for Medicaid is *not* cut.


\(^{434}\) Kitzhaber, *supra* note 311, at 75.

\(^{435}\) During 1990-91, at least two conferences dedicated exclusively to OHP were convened and subsequently reported their findings. *See The “Oregon Plan”: A Symposium,* 1 HEALTH MATRIX 135 (1991) (reporting on The Cleveland Conference on Bioethics, June 3-5, 1990); Dougherty, *supra* note 344, at 1 (reporting on a conference sponsored by The Hastings Center and the Wesley Foundation, January 1991).

A public process of prioritization of health services is created that focuses on clinical effectiveness and Oregonians’ values. It will lead to a more stable and effective package of Medicaid services.

The prioritization process allows for the definition of basic health care and will reduce the provision of services that are medically ineffective and are not valued highly by the community.

OBHSA is a useful state experiment in health policy reform.437

Opponents’ arguments included:
OBHSA rations health care for the poor and will have a disproportionately negative impact on poor women and children.
Prioritization is an inappropriate method for distributing health care.
Prioritizing health services and eliminating coverage for those with low priorities will distort the doctor-patient relationship and lead to poor care.

While the poor get less, Oregon’s providers and taxpayers are benefitted.
There are better ways to expand access and cut costs.438

Three issues in particular dominated the public debate over Oregon’s plan: who was to be the object of rationing, what was to be rationed, and how rationing outcomes were to be determined.439 Not surprisingly, most observers in the early 1990s agreed that:

several aspects of [the] plan—especially the limited scope of the population to which it applies, controversy over the list [of prioritized services] and the line [drawn by the legislature], and the questionable validity of state’s methodology and the uses it makes of it—[would] trigger doubts about equity and efficacy alike.440

Critics, of course, were more uncompromising. In brief, they argued that the prioritization approach was “unfair, impossible to perform, or set[ ] a dangerous precedent.”441

These criticisms, while important to the moral

437. Dougherty, supra note 344, at 1.
438. Id.
440. Id. at 43.
441. Golenski, Report, supra note 270, at 13. For a representative review of the most sustained criticisms of Oregon’s plan, see Michael J. Garland, Setting Health Care Priorities in Oregon, 1 HEALTH MATRIX 139, 146-56 (1991). In particular, Garland identified “five areas of serious ethical concern”:
First, because of its primary focus on Medicaid and the currently uninsured population, and because the legislative package makes no front end commitment of new dollars to pay for expanded access, the plan is at high risk of being grossly unfair to the poor, and, in particular, to women and children who are major recipients of Medicaid support.
story then unfolding in Oregon, are not fully reviewed here. Rather, in this Section, I focus on Oregon’s plan and the political common good.

The politics of health care in Oregon, at least in the 1980s, was not privatized or marginalized but clearly had a dominant public space. Open debate and public consensus building in OHD community meetings arguably illustrated a common good system of moral and political bargaining. In these meetings, rational and self-interested citizens with different (comprehensive) religious or moral convictions were able to reach a consensus on the nature of good health care, common to all. Through a system of voluntary and self-interested cooperation, these citizens mediated between individual and societal health care interests in order to identify, in the language of publicly accessible reasons, the values of health care. And these values (or goods) were then used to define a basic health care package. Innovation at the state level resulted in Oregon becoming a laboratory for political common good thinking.

This experiment with the common good was not without its critics. One recurrent criticism of the community meeting procedure, as noted earlier,\(^{442}\) was that meeting participants did not represent a cross section of all Oregonians and the target population was clearly underrepresented. That accusation, I agree, continues to sting: “the ‘haves’ [were] deciding . . . .

A second concern raised by critical observers is that the plan may seriously corrupt community spirit by legitimizing a mean spirited attitude toward the poor.\ldots .

A third concern focuses on a subset of the community, namely health care providers, and urges that their basic ethic of patient advocacy will be corrupted if they play an active part in rationing health care.\ldots .

A fourth concern asserts that the Oregon Plan, which requires considerable societal effort, amounts to a futile tinkering with a fundamentally defective system.\ldots .

A fifth moral concern is rooted in the technical difficulty of constructing a prioritized list of health services.


\(^{442}\) See supra notes 344-47 and accompanying text.
what is ‘important’ to give the ‘have nots.’” 443 With social solidarity undermined in this fashion, 444 the criticism is serious, though not necessarily fatal. That is because “[w]e worry less about who is making the decision if it has an equal impact on everyone, including the decision makers.” 445 So Oregon’s original intention to extend its proposal beyond the poor and to blur “the distinction between care for Medicaid and non-Medicaid patients” 446 with the employer mandate would have softened this criticism enough to encourage a qualified moral acceptance of Oregon’s plan. That Oregon ultimately rescinded the mandate 447 should not lessen the original, innovative spirit of the proposal.

Oregon’s attempt to define a basic health care package using prioritization also reveals a clear societal perspective. Oregonians set aside the reigning vision of American health care with its value complex of individualism and recovered “first person plural” thinking. No longer viewed exclusively as a private good to be safeguarded, health care is now a public good to be shared in common. The value of social solidarity, long dormant, entered the public debate. Yet, the language of entitlements is not foreign to the Oregon model. By insuring “universal access for the state’s citizens to a basic level of health care,” 448 Oregon defined a moral and political right to health care, a right that is inalienable yet contingent on the social matrix in which it is exercised. This right to health care is a right in community. And that tension is faithful to reformed common good thinking. 449

Predictably, plan opponents have challenged the authenticity of this alleged social morality. A principal criticism is that the Oregon plan promises universal access not to adequate health care, but only to “whatever the amount of healthcare the state legislature funds and governor approves on a biennial basis.” 450 Thus, Oregon’s brand of universal access “includes no commitment to a right to basic healthcare.” 451 This remains Oregon Medicaid’s Achilles’ heel.

444. See Dougherty, supra note 344, at 5.
445. Daniels, supra note 443, at 2234.
446. Dougherty, Setting Health Care Priorities, supra note 344, at 5-6.
447. See supra notes 313, 407 and accompanying text.
448. Kitzhaber, supra note 311, at 75.
449. See supra notes 184-204 and accompanying text (discussing a moderate communitarian variant on human rights—rights of persons in community).
450. Dougherty, supra note 441, at 29.
451. Id.
Not to legislate a minimum definition of basic health care for all—
independent of the state’s budgetary process—is admittedly troubling. For
instance, what is to prevent the legislature during a budgetary crisis or
when the plan becomes commonplace and the legislators are out of the
media spotlight to draw a very different priority line which excludes
“important” care.\footnote{Cf. Leichter, supra note 265, at 153 (“In 1995, faced with a budgetary shortfall, the state
requested and received permission [from HCFA, as required by the federal waivers from Medicaid
rules] to reduce the number of services by twenty-five lines, from 606 to 581.”). Despite this reduction
the basic benefit package remained generous, as the state still funded about 80% (i.e., 581 of 745) of all
CT pairs on the list. See 1999 HSC REPORT, supra note 423, at 10.}
Because the plan is still a demonstration—HCFA is
watching closely—and Oregon’s economy remains robust, this has not yet
happened.\footnote{Cf. Leichter, supra note 265, at 153 (“Even if fiscal and political circumstances within
Oregon forced state lawmakers to consider significantly reducing the benefit package, the federal
government probably would not let them do so.”).} But prior experience is clear that budget reductions in state
human service programs generally take benefits away from the poor.
Without legislating a basic health care package, Oregon is likely to
aggravate the real potential present with the plan to match its two-tiered
economic society with a two-tiered health care system.\footnote{See Daniel Callahan, Ethics and Priority Setting in Oregon, HEALTH AFF., Summer 1991, at
78, 80.} And, again, the employer mandate designed, in some respects, to address this concern has
been rescinded.\footnote{See supra notes 313 & 407 and accompanying text. Because of an original statutory linkage
between private insurance in Oregon and the Medicaid package, it was assumed that political interest
groups, such as labor unions, would actively monitor HSC’s biennial review of the priority list and,
more importantly, the Legislature’s redrawing of the funding line. In lobbying for their own interests,
well-represented political interest groups could easily advance the health care agenda of the
underrepresented poor.}

So, there are no absolute guarantees for the poor under the Oregon
plan. “[E]xperience drives real Medicaid eligible persons to want some
guarantees about a floor or ‘stop loss’ point below which service reductions
would not go.”\footnote{Michael J. Garland, Justice, Politics and Community: Expanding Access and Rationing
Health Services in Oregon, LAW MED. & HEALTH CARE, Spring-Summer 1992, at 67, 75.} And several commentators agree that “a floor of services
below which no citizen can fall . . . must be defined prior to and outside of
the prioritization process.”\footnote{Dougherty, supra note 344, at 8. See also Callahan, supra note 454, at 83; Veatch, supra
note 344.} In effect, “[s]ome forms of care . . . would be
allowed to trump the priority-setting process,”\footnote{Callahan, supra note 454, at 83.} thus threatening the
credibility of the entire process.

\footnote{452. Cf. Leichter, supra note 265, at 153 (“In 1995, faced with a budgetary shortfall, the state
requested and received permission [from HCFA, as required by the federal waivers from Medicaid
rules] to reduce the number of services by twenty-five lines, from 606 to 581.”). Despite this reduction
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456. Michael J. Garland, Justice, Politics and Community: Expanding Access and Rationing
Health Services in Oregon, LAW MED. & HEALTH CARE, Spring-Summer 1992, at 67, 75.
457. Dougherty, supra note 344, at 8. See also Callahan, supra note 454, at 83; Veatch, supra
note 344.
458. Callahan, supra note 454, at 83.}
Of course, much of what is most exciting, and particularly novel, with Oregon’s original prioritization process—namely, using publicly influenced value judgments in the process—was gutted in subsequent methodological iterations. These value judgments about health care, once central to the original process, are now marginalized in the current HCFA-approved methodology. This comes as no surprise. To permit any state to act on a publicly influenced value consensus—to enforce a particular vision of the good—is a direct challenge to liberalism. When the Bush administration invoked the ADA to force modifications in the original prioritization process, rights language was the talk of Washington. But this misses the point.

The ADA was used here, instead, as a proxy instrument for liberal neutrality: Oregon was instructed to stand down from enforcing any vision of the good (in health care). So the political saga over Oregon seeking federal approval for its Medicaid plan was really a coming-out party for the political common good. The resulting rift only reinforces the novelty and controversy of that unfolding notion.

CONCLUSION: RECOVERY OF OUR SOCIAL ECOLOGY IN HEALTH CARE POLICY

American health care requires a new public philosophy. Liberalism with its abiding confidence in neutrality and individual rights is spent. This Article has endorsed an alternative paradigm for deliberating about health policy—one that deemphasizes the notion of an individual’s claim to health care, lowers the volume on rights talk, and champions a more explicit social understanding of health and health care. The aim of the political

459. See supra Part IV.A.3(a)(ii).
460. See supra notes 413-23 and accompanying text.
common good is practical. It presents itself as a conception of justice that affirms the possibility that a good (or goods) to be pursued in common can be identified by a well-ordered, democratic society, and then defined with shared and public reason. Looking to, and then beyond, Rawls’ political liberalism, the politics of the common good likewise looks beyond individual choices made by bargain-hunters and recaptures much of “first person plural” thinking without its misbegotten, coercive tendencies. It makes a clear, public commitment to the common good of health care. In changing the national debate over health care, the Oregon Health Plan, while imperfect, points to the potential this fresh way of thinking has in overcoming the limits of liberalism and providing a new deliberative foundation for health policy.

To recover the social is not a panacea, but the condition of health care in this country is critical and liberal-inspired minimalist interventions have not hastened recovery. The political common good is a workable alternative medicine that America’s health policy makers should now try.
APPENDIX A

PRINCIPLES FOR HEALTH CARE RESOURCE ALLOCATION

Purpose of health services

(1) The responsibility of government in providing health care resources is to improve the overall quality of life of people by acting within the limits of available financial and other resources.

(2) Overall quality of life is a result of many factors, health being only one of these. Others include the economic, political, cultural, environmental, aesthetic and spiritual aspects of a person’s existence.

(3) Health-related quality of life includes physical, mental, social, cognitive and self-care functions, as well as a perception of pain and sense of well-being.

(4) Allocations for health care have a claim on government resources only to the extent that no alternative use of those resources would produce a greater increase in the overall quality of life of people.

(5) Health care activities should be undertaken to increase the length of life and/or the health-related quality of life during one’s life span.

(6) Quality of life should be one of the ethical standards when allocating health care resources involving insurance or government funds.

Why priorities need to be set

(7) Every person is entitled to receive adequate health care.

(8) It is necessary to set priorities in health care, so long as health care demands and needs exceed society’s capacity, or willingness, to pay for them. Thus an “adequate” level of care may be something less than “optimal” care.

How to set health priorities

(9) Setting priorities and allocating resources in health care should be done explicitly and openly, taking careful account of the values of a broad spectrum of the Oregon populace. Value judgments should be obtained in such a way that the needs and concerns of minority populations are not undervalued.

(10) Both efficiency and equity should be considered in allocating health care resources. Efficiency means that the greatest amount of appropriate and effective health benefits for the greatest number of persons are provided with a given amount of money. Equity means that all persons have an equal opportunity to receive available health services.

(11) Allocation of health care resources should be based, in part, on a scale of public attitudes that quantifies the tradeoff between length-of-life and quality-of-life.

(12) In general, a high priority health care activity is one where the personal and social health benefits/cost ratio is high.

Who sets what priorities

(13) The values of the general public should guide planning decisions which affect the allocation of health care resources. As a rule, choices among available alternative treatments should be made by the patient, in consultation with health care providers.

(14) Planning or policy decisions in health care should rest on value judgments made by the general public and those who represent the public, and on factual judgments made by appropriate experts.

(15) Private decision-makers, including third-party payors and health care providers, have a responsibility to oversee the allocation of health care resources to assure their use is consistent with the values of the general public.
APPENDIX B

A SAMPLING FROM THE PRIORITY LIST OF
THE OREGON MEDICAID PRIORITY-SETTING PROJECT

<table>
<thead>
<tr>
<th>Rank</th>
<th>Reproductive Services</th>
<th>Health Promotion and Disease Prevention</th>
<th>Acute Illness and Episodic Therapies and Treatments</th>
<th>Chronic Disease Management</th>
</tr>
</thead>
</table>
| 10   | Family Planning Services  
     Prenatal Care  
     Labor and Delivery Services in Certified Birth Settings  
     High Risk Pregnancy Services | Immunizations  
     Nutritional Supplements  
     Periodic Screenings for Infants and Children | Diagnosis and Treatment of Acute Illnesses Including In-Hospital Care, Diagnostic Radiology, and Lab and Pathology Studies  
     In-Patient Admissions | Procedures, Therapies or Interventions as Specified under Acute Care which Can Restore Patients to Near-full or Manageable Levels of Function and Independence |
| 9    | Periodic Focused Screening | | Physical Therapy with Predictable Return to Full or Acceptable Level of Function  
     Durable Medical Equipment  
     Preventive Dentistry  
     Restorative Dental Care  
     Occupational Therapy  
     Eye Exams and Glasses for Children and the Elderly Every Two Years  
     Hearing Exams and Hearing Aides for Children and the Elderly Every Three Years | Procedures, Therapies or Interventions as Specified Under Acute Care Which Will Maintain Patients in the Most Appropriate Environment |

463. Adapted from Golenski & Blum, supra note 289, at 8-17. See also Golenski & Thompson, The Impossible Solution, supra note 285, at 77 tbl.1.
<table>
<thead>
<tr>
<th>#</th>
<th>Programs</th>
<th>Orthopedic Procedures for Total Hip Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Programs Addressing STD’s (including HIV)</td>
<td>Restorative Dentistry for Children’s Permanent Teeth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Restorative Dentistry for Children’s Orginal Teeth, Only for Nutritional Purposes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine Dental Care for the Elderly Necessary Reconstructive Surgery</td>
</tr>
<tr>
<td>7</td>
<td>Periodic Screenings According to the Professional Guidelines of Appropriate Medical Organizations (i.e. Pap Smears, Mammograms)</td>
<td>Dentures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation for Improvement of Function</td>
</tr>
<tr>
<td>6</td>
<td>Programs Addressing Smoking Cessation and Alcohol and Drug Abuse</td>
<td>Therapeutic Programs for Alcohol and Drug Abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Foot Care for the Elderly</td>
</tr>
<tr>
<td>5</td>
<td>Programs which Address Safety, Suicide Prevention, and Physical and Sexual Abuse</td>
<td>Eye Exams and Glasses for All Others Once Every Two Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hearing Exams and Hearing Aides for All Others Once Every Three Years</td>
</tr>
<tr>
<td>4</td>
<td>Programs Targeting Eating Disorders</td>
<td>Routine Dental Care for Adults</td>
</tr>
<tr>
<td>3</td>
<td>Infertility Counseling and Workup Services</td>
<td>Heart, Lung, Liver, and Bone Marrow Transplantation</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Cosmetic Plastic Surgery</td>
</tr>
</tbody>
</table>
Please read the following examples of health care situations. These are individual cases in which people need health services. They are listed to help start our thinking about why health services are important.

— A heavy user of crack cocaine wants help for drug addiction. Immediate treatment will help stop use. A month of intensive in-hospital treatment and outpatient treatment for a year will help stop the alcohol and drug use for the long term.

— A collapsed lung and internal bleeding have resulted from an accidental bullet wound through the chest. This person is conscious. Surgery to repair the lung and take care of the bleeding is likely to be successful; giving less treatment is likely to cause death or permanent damage.

— A person wishes to have a face-lift, saying that keeping the job absolutely depends on having a youthful appearance.

— A person has an advanced brain disease (Alzheimer’s Disease). Normal communication and function are impossible. The person has just started vomiting from a blocked intestine. Surgery to remove part of the intestine could help. The outlook is only fair to poor because of chronic bad health and nutrition.

— A depressed parent of two preschool children is feeling hopeless, confused. The person is obsessed with thoughts of killing the children and him/herself. A week of hospital care and six months of outpatient treatment will allow the person to function as a parent and on the job.

— A child needs routine immunizations which include polio, diphtheria and whooping cough. Without immunizations the child may become ill and spread the disease to others. Sometimes these illnesses cause death.

— After 3 heart attacks, a patient is getting worse despite taking several medicines daily. An operation to put in a pacemaker would probably help the heart’s rhythm but not the general condition of the heart. The day-to-day activities of the patient may improve.

464. HASNAI & GARLAND, supra note 337, app. A.
—A severely mentally ill person is now unemployed and homeless. The person hears voices and feels threatened by “evil spirits.” Regular treatment and medicine probably will help the person return to work and to a stable living situation.
APPENDIX D

SAMPLE HEALTH CARE CATEGORIES\textsuperscript{465}

Please classify the categories below as essential (1), very important (2), or important (3). Try to place three (3) categories in each classification. Your ranking should be based on your beliefs and values about which categories are most important for your community as a whole.

___ A. Treatment of conditions which are fatal and can’t be cured. The treatment will not extend the person’s life for more than five years.

___ B. Treatment of conditions where the health care is likely to extend life by more than two years or to improve the person’s quality of life.

___ C. Treatment for alcoholism or drug addiction.

___ D. Treatment of sudden or ongoing conditions where the person is likely to get well. If the person does not receive care, the length or quality of their life will be reduced.

___ E. Treatment not likely to extend life or make any big improvement in quality of life.

___ F. Treatment of conditions where the health care is not likely to extend life by more than two years or to improve the quality of life.

___ G. Treatment provided in or out of the hospital for mental illness or emotional disturbance, which will restore the person’s health.

___ H. Preventive care which definitely can prevent early death or a reduction in quality of life.

___ I. Treatment for chronic ongoing conditions where health care will improve quality of life for the person’s remaining years.

\textsuperscript{465}\textsuperscript{465} HASNAIN & GARLAND, supra note 337, app. A.
APPENDIX E

ATTRIBUTES DERIVED FROM COMMUNITY MEETING VALUES

**Value to Society:** this attribute takes into account the costs to society if a category of health services is not provided.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Cost Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits Many</td>
<td>Community Compassion</td>
</tr>
<tr>
<td>Impact on Society</td>
<td>Personal Responsibility</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Mental Health and Chemical</td>
</tr>
<tr>
<td></td>
<td>Dependency</td>
</tr>
</tbody>
</table>

**Value to an Individual at Risk of Needing the Service:** certain categories of services may be very important to a person seeking the service (e.g., services for infertility) but make very little difference on a societal level.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Life</td>
<td>Effectiveness of Treatment</td>
</tr>
<tr>
<td>Ability to Function</td>
<td>Personal Choice</td>
</tr>
<tr>
<td>Length of Life</td>
<td>Community Compassion</td>
</tr>
<tr>
<td>Mental Health and Chemical</td>
<td></td>
</tr>
<tr>
<td>Dependency</td>
<td></td>
</tr>
</tbody>
</table>

**Essential to Basic Health Care:** the categories of service essential to basic health care are those, with respect to public input and expert testimony, below which no person shall fall.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Cost Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits Many</td>
<td>Impact on Society</td>
</tr>
<tr>
<td>Quality of Life</td>
<td></td>
</tr>
</tbody>
</table>

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466. *WAIVER APPLICATION, supra note 267, at 2.20 exhibit 2.3.*
This report is a compilation of the values expressed at all of the health decisions community meetings held in Oregon. Some values were expressed more frequently than others. All are included in this report. What values do Oregonians want the Health Services Commission to use in guiding the process of prioritizing health care services? The following are values Oregonians indicated should be considered. (The frequency of discussion of each value is shown in parenthesis.)

1. Prevention (very high—all community meetings)
2. Quality of life (very high—all community meetings)
3. Cost Effectiveness (high—more than 3/4 of community meetings)
4. Ability to Function (moderately high—3/4 of community meetings)
5. Equity (moderately high—3/4 of community meetings)
6. Effectiveness of treatment (medium high—more than 1/2 of community meetings)
7. Benefits (medium—1/2 of community meetings)
8. Mental Health and Chemical Dependency (medium—1/2 of community meetings)
9. Personal Choice (medium—1/2 of community meetings)
10. Community Compassion (medium low—less than 1/2 of community meetings)
11. Impact on Society (medium low—less than 1/2 of community meetings)
12. Length of Life (medium low—less than 1/2 of community meetings)
13. Personal Responsibility (medium low—less than 1/2 of community meetings)

467. HASNAIN & GARLAND, supra note 337, at 5-6.
## APPENDIX G

### CATEGORIES AND EXAMPLES OF SERVICES USED IN PRIORITIZATION PROCESS

<table>
<thead>
<tr>
<th>Category</th>
<th>Example Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Essential</strong></td>
<td></td>
</tr>
<tr>
<td>1. Acute Fatal - treatment prevents death with full recovery</td>
<td>Appendectomy for appendicitis; repair of deep, open wound in neck; medical therapy for myocarditis</td>
</tr>
<tr>
<td>2. Maternity Care - including most disorders of the newborn</td>
<td>Obstetrical care for pregnancy; care of the newborn</td>
</tr>
<tr>
<td>3. Acute Fatal - treatment prevents death without full recovery</td>
<td>Surgical treatment for head injury with prolonged loss of consciousness; medical therapy for acute bacterial meningitis; reduction of an open fracture of a joint</td>
</tr>
<tr>
<td>4. Preventive Care for Children</td>
<td>Immunizations, screening for specific problems such as vision or hearing difficulties or anemia</td>
</tr>
<tr>
<td>5. Chronic Fatal - treatment improves life span and quality of life</td>
<td>Medical therapy for Type I Diabetes Mellitus; medical and surgical treatment for treatable cancer of the uterus; medical therapy for asthma</td>
</tr>
<tr>
<td>6. Reproductive Services - excludes maternity and infertility services</td>
<td>Contraceptive management; vasectomy; tubal ligation</td>
</tr>
<tr>
<td>7. Comfort Care - palliative therapy for conditions in which death is imminent</td>
<td>Pain management and hospice care</td>
</tr>
<tr>
<td>8. Preventive Dental Care - adults and children</td>
<td>Exams, cleaning and fluoride applications</td>
</tr>
</tbody>
</table>

9. **Proven Effective Preventive Care for Adults**  
   Mammograms; blood pressure screening; medical therapy and chemoprophylaxis for primary tuberculosis; Pap smear

<table>
<thead>
<tr>
<th>Very Important</th>
</tr>
</thead>
</table>
| **10. Acute Nonfatal** - treatment causes return to previous health state  
   Medical therapy for acute thyroiditis; medical therapy for vaginitis; restorative dental services for dental caries |
| **11. Chronic Nonfatal** - one-time treatment improves quality of life  
   Hip replacement; laser surgery for diabetic retinopathy; medical therapy for rheumatic fever |
| **12. Acute Nonfatal** - treatment without return to previous health state  
   Relocation of dislocated elbow; arthroscopic repair of internal derangement of knee; repair of corneal laceration |
| **13. Chronic Nonfatal** - repetitive treatment improves quality of life  
   Medical therapy for chronic sinusitis; medical therapy for migraine; medical therapy for psoriasis |

<table>
<thead>
<tr>
<th>Valuable to Certain Individuals</th>
</tr>
</thead>
</table>
| **14. Acute Nonfatal** - treatment expedites recovery of self-limiting conditions  
   Medical therapy for non-fungal diaper rash; medical therapy for acute conjunctivitis; medical therapy for acute pharyngitis |
| **15. Infertility Services**  
   Medical therapy for anovulation microsurgery for tubal disease; in-vitro fertilization |
| **16. Less Effective Preventive Care for Adults**  
   Dipstick urinalysis for hernaturia in adults less than 40 years of age; screening of non-pregnant adults for Type I Diabetes Mellitus |
| **17. Fatal or Nonfatal** - treatment causes minimal or no improvement in quality  
   Repair fingertip avulsion that does not include fingernail; medical therapy for gallstone without cholecystitis; medical therapy for viral warts |
### Model Selections from Prioritized List

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Treatment</th>
<th>ICD-9</th>
<th>CPT</th>
<th>Line</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PNEUMOCOCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA, INFLUENZA WITH PNEUMONIA</strong></td>
<td>MEDICAL THERAPY</td>
<td>020.3-5.022.1,073,466,481-483,485-486,487.1</td>
<td>90000-99999</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>TUBERCULOSIS</strong></td>
<td>MEDICAL THERAPY</td>
<td>010-012</td>
<td>90000-99999</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>ESOPHAGITIS</strong></td>
<td>MEDICAL THERAPY</td>
<td>530.1</td>
<td>90000-99999</td>
<td>587</td>
<td>13</td>
</tr>
<tr>
<td><strong>INTERVERTEBRAL DISC DISORDERS</strong></td>
<td>THORACIC-LUMBAR LAMINECTOMY, MEDICAL THERAPY</td>
<td>722.0-1,722.7,952.1-.9</td>
<td>63003,63005,63016,63017,63030-31,63035,63042,63046-48,63056-57,63064,63066,63077-78,63085-91,63170,63173,90000-99999</td>
<td>588</td>
<td>13</td>
</tr>
</tbody>
</table>

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469. 1991 HSC REPORT, supra note 303, app. J.
Diagnosis: EXTREMELY LOW WEIGHT (UNDER 500 GM) AND UNDER 23 WEEK GESTATION
Treatment: LIFE SUPPORT
ICD-9: 765.0, 765.11
CPT: 0
Line: 708 Category: 17

Diagnosis: ANENCEPHALOUS AND SIMILAR ANOMALIES AND REDUCTION DEFORMITIES OF THE BRAIN
Treatment: LIFE SUPPORT
ICD-9: 740.742.2
CPT: 0
Line: 709 Category: 17

What are all those numbers?
The first thing you might notice is all the numbers. The numbers are standard code numbers used as a form of shorthand to describe the huge numbers of conditions and treatments. You will see three basic treatments. You will see three basic types of codes.

**ICD** (*International Classification of Diseases-9th edition*) codes are used to describe the types of conditions or diseases which are to be treated. . . .

**CPT-4** (*Physician’s Current Procedural Terminology, Fourth edition*) codes are used to accurately capture the procedure(s) used to treat the condition. . . .

The line numbers represent the rank order of the condition/treatment pairs, with line item 1 most important and line item 709 least important to the population to be served.

The last set of numbers you will notice, is the **category number** (e.g.: 1, 2, 3). Categories have been used by the Health Services Commission to organize the 709 condition/treatment pairs into types of health services (e.g., comfort care) or health services for types of conditions (e.g., acute, fatal with full recovery). The Commission ranked them in order of most to least important. You will notice that while many line items from the same category are grouped together others are scattered throughout the list. This is the result of the Commissioners bringing public values and their professional judgment to bear in their final decision-making process.
APPENDIX I

**TABLE 2**

**SUBJECTIVE CRITERIA**[^170]

<table>
<thead>
<tr>
<th>A. General Preventive Services: This judgment determines the placement of three lines: children, adult, and dental preventive services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Comfort Care: This judgment determines the placement of one line.</td>
</tr>
<tr>
<td>C. Maternity Care: This judgment considers the placement of services required from conception through the first 28 days of life. Examples are pregnancy care and neonatal services.</td>
</tr>
<tr>
<td>D. Family Planning Services: This judgment determines the placement of services for preventing pregnancy or planning families. There were four lines involved and this is a high priority for the Federal government.</td>
</tr>
<tr>
<td>E. Prevent a Condition Before Treatment: This judgment considers the importance of interceding early in the process before the condition develops. An example is placing the treatment for dysplasia of the cervix before the treatment of cervical cancer.</td>
</tr>
<tr>
<td>F. Medical Ineffectiveness: This judgment considers the fact that the specified treatment for the condition does not achieve its objective in the majority of the cases. An example is the dental services that provide only marginal improvement.</td>
</tr>
<tr>
<td>G. Prevent Additional Complications: This judgment considers the importance of interceding in order to stabilize or to prevent deterioration of a condition. An example is the treatment of glaucoma.</td>
</tr>
<tr>
<td>H. Prevent Future Costs: This judgment considers the importance of interceding early before resources must be spent in crisis. An example is the treatment of insulin dependent diabetes.</td>
</tr>
<tr>
<td>I. Cosmetic Services: This judgment reflects the fact that cosmetic services are not a covered benefit for Medicaid in Oregon.</td>
</tr>
<tr>
<td>J. Self-limiting Conditions: This judgment considers the fact that these conditions will run their course without, or in spite of, medical intervention. An example is the treatment of acute upper respiratory infections.</td>
</tr>
</tbody>
</table>

K. *Congruent Conditions:* This judgment considers the fact that the organ system and/or etiology of the conditions are similar to that of another condition/treatment pair elsewhere on the List or that the outcomes of the condition/treatment pairs are congruent.

L. *Public Health Risk:* This judgment reflected the fact that prevention of communicable diseases is a high priority for the state and federal government. An example is the treatment of syphilis.