For and against Equal Access to Health Care

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THERE IS A FAIRLY WIDESPREAD CONSENSUS AMONG empirical analysts that access to health care in this country has become more equal in the last quarter century. Agreement tends to end here; debate follows as to whether this trend will or should persist. But before debating these questions, we ought to have a clear idea of what equal access to health care means. Since equality of access to health care cannot be defined in a morally neutral way, we must choose a definition that is morally loaded with a set of values (Daniels, 1981b). The definition offered here is by no means the only possible one. It has, however, the advantage not only of clarity but also of having embedded within it strong and commonly accepted liberal egalitarian values. The debate is better focused upon arguments for and against a strong *principle* of equal access than disputes over definitions, which tend to hide fundamental value disagreements instead of making them explicit.

An equal access principle, clearly stated and understood, can serve at best as an ideal toward which a society committed to equality of opportunity and equal respect for persons can strive. It does not provide a blueprint for social change, but only a moral standard by which to judge marginal changes in our present institutions of health care.

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My purpose here is not only to evaluate the strongest criticisms that are addressed to the principle, ranging from libertarian arguments for more market freedom to arguments supporting a more egalitarian principle of health care. I also propose to examine the sorts of theoretical and practical problems that arise when one tries to defend an egalitarian principle directed at a particular set of institutions within an otherwise inegalitarian society. Since it is extremely unlikely that such a society will be transformed all at once into an egalitarian one, there ought to be room within political and philosophical argument for reasoned consideration and advocacy of "partial" distributive justice, i.e., of principles that are directed only to a particular set of social institutions and whose implementation is not likely to create complete justice even within those institutions.

The Principle Defined

A principle of equal access to health care demands that every person who shares the same type and degree of health need must be given an equally effective chance of receiving appropriate treatment of equal quality so long as that treatment is available to anyone. Stated in this way, the equal access principle does not establish whether a society must provide any particular medical treatment or health care benefit to its needy members. I shall suggest later that the level and type of provision can vary within certain reasonable boundaries according to the priorities determined by legitimate democratic procedures. The principle requires that if anyone within a society has an opportunity to receive a service or good that satisfies a health need, then everyone who shares the same type and degree of health need must be given an equally effective chance of receiving that service or good.

Since this is a principle of equal *access,* it does not guarantee equal *results,* although it probably would move our society in that direction. Discriminations in health care are permitted if they are based upon type or degree of health need, willingness of informed adults to be treated, and choices of lifestyle among the population. The equal access principle constrains the distribution of opportunities to receive health care to an egalitarian standard, but it does not determine the total level of health care available or the effects of that care (provided

the care is of equal quality) upon the health of the population. Of course, even if equality in health care were defined according to an "equal health" principle (Veatch, 1976), one would still have to admit that a just health care system could not come close to producing an equally healthy population, given the unequal distribution of illness among people and our present medical knowledge.

Practical Implications

Since the equal access principle requires equality of effective opportunity to receive care, not merely equality of formal legal access, it does not permit discriminations based upon those characteristics of people that we can reasonably assume they did not freely choose. Such characteristics include sex, race, genetic endowment, wealth, and, often, place of residence. Even in an ideal society, equally needy persons will not use the same amount or quality of health care. Their preferences and their knowledge will differ as will the skills of the providers who treat them.

A One-Class System

The most striking result of applying the equal access principle in the United States would be the creation of a one-class system of health care. Services and goods that meet health care needs would be equally available to everyone who was equally needy. As a disincentive to overuse, only small fees for service could be charged for health care, provided that charges did not prove a barrier to entry to the poorest people who were needy. A one-class system need not, of course, be a uniform system. Diversity among medical and health care services would be permissible, indeed even desirable (Starr, 1975), so long as the diversity did not create differential access along nonconsensual lines such as wealth, race, sex, or geographical location.

Equal access also places limits upon the market freedoms of some individuals, especially, but not exclusively, the richest members of society. The principle does not permit the purchase of health care to which other similarly needy people do not have effective access. The extent to which freedom of the rich must be restricted will depend upon the level of public provision for health care and the degree of

income inequality. As the level of health care guaranteed to the poor decreases and the degree of income inequality increases, the equal access standard demands greater restrictions upon the market freedom of the rich. Where income and wealth are very unevenly distributed, and where the level of publicly guaranteed access is very low, the rich can use the market to buy access to health care goods unavailable to the poor, thereby undermining the effective equality of opportunity required by an equal access principle.

The restriction upon market freedoms to purchase health care under these circumstances creates a certain discomforting irony: the equal access principle permits (or is at least agnostic with respect to) the free market satisfaction of preferences for nonessential consumer goods. Thus, the rigorous implementation of equal access to health care would prevent rich people from spending their extra income for preferred medical services, if those services were not equally accessible to the poor. It would not prevent their using those same resources to purchase satisfactions in other areas—a Porsche or any other luxurious consumer good. In discussing additional problems created by an attempt to implement a principle of equal access to health care in an otherwise inegalitarian society, I return later to consider whether advocates of equal access can avoid this irony.

Hard Cases

As with all principles, hard cases exist for the equal access principle. Without dwelling upon these cases, it is worth considering how the principle might deal with two hard but fairly common cases: therapeutic experimentation in medicine, and alternative treatments of different quality.

Each year in the United States, many potentially successful therapies are tested. Since their value has not been proved, there may be good reason to limit their use to an appropriate sample of sick experimental subjects. The equal access principle would insist that experimenters choose these subjects at random from a population of relevantly sick consenting adults. A randomized clinical trial could be advertised by public notice, and individuals who are interested might be registered and enrolled on a lottery basis. The only requirement for enrollment would be the health conditions and personal characteristics necessary for proper scientific testing.

How does one apply the principle of equal access when alternative treatments are each functionally adequate but aesthetically or socially quite disparate? Take the hypothetical case of a societal commitment to adequate dentition among adults. Replacement of carious or mobile teeth with dentures may preserve dental function at relatively minor cost. On the other hand, full mouth reconstruction, involving periodontal and endodontal treatment and capping of affected teeth, may be only marginally more effective but substantially more satisfying. The added costs for the preferred treatment are not inconsiderable. The principle would seem to demand that at equal states of dental need there be equal access to the preferred treatment. It is unclear, however, whether the satisfaction of subjective desire is equivalent to fulfillment of objective need.

In cases of alternative treatments, proponents of equal access could turn to another argument for providing access to the same treatments for all. A society that publicly provides the minimal acceptable treatment freely to all, and also permits a private market in more expensive treatments, may result in a two-class system of care. The best providers will service the richest clientele, at the risk of inadequate treatment for the poorest. Approval of a private market in alternative treatments would rest upon the empirical hypothesis that, if the publicly funded level of adequate treatment were high enough, few people would choose to short-circuit the public (i.e., equal access) sector; the small additional free market sector would not threaten to lower the quality of services universally available.

Most cases, like the one of dentistry, are difficult to decide merely on principle. Proponents of equal access must take into account the consequences of alternative policies. But empirical knowledge alone will not decide these issues, and arguments for or against a particular policy can be entertained in a more systematic way once one exposes the values that underlie support for an equal access principle. One can then judge to what extent alternative policies satisfy these values.

Supporting Values

Advocates of equal access to health care must demonstrate why health care is different from other consumer goods, unless they are willing to support the more radical principle of equal distribution of all goods. Norman Daniels (1981a) provides one foundation for distinguishing

between health care and other goods. He establishes a category of health care needs whose satisfaction provides an important condition for future opportunity. Like police protection and education, some kinds of health care goods are necessary for pursuing most other goods in life. Any theory of justice committed to equalizing opportunity ought to treat health care as a good deserving of special distributive treatment. Equal access to health care provides a necessary, although certainly not a sufficient, condition for equal opportunity in general.

A precept of egalitarian justice that physical pains of a sufficient degree be treated similarly, regardless of who experiences them, establishes another reason for singling out certain kinds of health care as special goods (Gutmann, 1980). Some health conditions cause great pain but are not linked to a serious curtailment of opportunity. The two values are, however, mutually compatible.

A theory of justice that gives priority to the value of equal respect among people might also be used to support a principle of equal access to health care. John Rawls (1971:440), for example, argues that without self-respect "nothing may seem worth doing, or if some things have value for us, we lack the will to strive for them. . . . Therefore the parties in the original position would wish to avoid at almost any cost the social conditions that undermine self-respect."

Conditions of Self-Respect

It is not easy to determine what social conditions support or undermine self-respect. One might plausibly assume that equalizing opportunity and treating similar pains similarly would be the most essential supports for equal respect within a health care system. And so, in most cases, the value of equal respect provides additional support for equal access to the same health care goods that are warranted by the values of equal opportunity and relief from pain. But at least some kinds of health care treatment not essential to equalizing opportunity or bringing equal relief from pain may be necessary to equalize respect within a society. It is conceivable that much longer waiting time, in physicians' offices or for admission to hospitals, may not affect the long-term health prospects of the poor or of blacks. But such discriminations in waiting times for an essential good probably do adversely affect the self-respect of those who systematically stand at the end of the queue.

Some of the conditions necessary for equal respect are socially rel-

ative; we must arrive at a standard of equal respect appropriate to our particular society. Universal suffrage has long been a condition for equal respect; the case for it is independent of the anticipated results of equalizing political power by granting every person one vote. More recently, equal access to health care has similarly become a condition for equal respect in our society. Most of us do not base our self-respect on the way we are treated on airplanes, even though the flight attendants regularly give preferential treatment to those traveling first class. This contrast with suffrage and health care treatment (and education and police protection) no doubt is related to the fact that these goods are much more essential to our security and opportunities in life than is airplane travel. But it is still worth considering that unequal treatment in health care, as in education, may be understood as a sign of unequal respect even where there are no discernible adverse effects on the health or education of those receiving less favored treatment. Even where a dual health care system will not produce inferior medical results for the less privileged, the value of equal respect militates against the perpetuation of such a system in our society.

Challenges

Equality of opportunity, equal efforts to relieve pain, and equal respect are the three central values providing the foundation of support for a principle of equal access to health care. Any theory of justice that gives primacy to these values (as do many liberal and egalitarian theories) will lend prima facie support to a health care system structured along equal access lines.

We are now in a position to consider alternative values and empirical claims that would lead someone to challenge, or reject, a principle of equal access to health care. These challenges also enable us to elaborate further the moral and political implications of the principle.

Proponents of the Market

The most radical and vocal opposition comes from those who support a pure free market principle in health care. A foundation of support

for the free market principle is the idea that the relative importance of satisfying different human desires is a purely subjective matter: we can distinguish between one person's desire for good medical care and another person's desire for a good Beaujolais only by the price they are willing to pay for each. If no goods are special because there is no way of ranking desires except by individual processes of choice, then what better way than the unconstrained market to allow us to decide among the smorgasbord of goods society has to offer (Fried, 1979; Nozick, 1974; Sade, 1971)?

Health care goods and services are likely to be more equally allocated through the market if income and wealth are more equally distributed. Several defenders of the market as a means of allocating goods and services also support a moderate degree of income redistribution on grounds of its diminishing marginal utility, or because they believe that every person has a right to a "basic minimum" (Friedman, 1962; Fried, 1978). Neither rationale for redistribution takes us very far toward a principle of equal access to health care. If one retains the basic assumption that human preferences are totally subjective, then the market remains the best way to order human priorities. Only the market appropriately decentralizes decision-making and eliminates all nonconsensual exchanges of goods and services (Fried, 1978: 124–26).

Although a minimum income floor under all individuals increases *access* to most goods and services, even at a higher level than that supported by Friedman and others, a guaranteed income will be inadequate to sustain the costs of a catastrophic illness. An exceptionally high guaranteed minimum might result in almost universal insurance coverage at a fairly high level. Supporters of free market allocation do not, however, press for a very high minimum for at least two reasons. They fear its effects on incentives, and they cannot justify a high guaranteed income without admitting that there are many expensive goods that are essential to all persons, and are not just mere consumer preferences.

The first reason for opposing an exceptionally high minimum is probably a good one. A principle approaching equality of income and wealth is likely to have serious disincentive effects on productive work and investment. There are also better reasons for treating health care as a special good, a good that society has an obligation to provide equally to all its members, than there are for equally distributing most consumer goods.

A significant step beyond the pure free market principle is a position that preserves the role of the market in allocating different "packages" of health care according to consumer preferences, but concedes a role for government in supplying every adult with a "voucher" of a certain monetary value redeemable exclusively for health care goods and services. Proponents of health vouchers must assume that there is something special about health care to justify government in taxing its citizens to provide universally for these goods, and not all others. But if health care is a more important good, because it preserves life and expands opportunity, then what is the rationale for effectively limiting the demand a sick but poor person can make upon the health care system? Why should access to health care be dependent upon income or wealth at all?

Opponents of equal access generally imply that more than minimal access will unjustly curtail the freedom of citizens as taxpayers, as consumers, and as providers of health care. Let us consider separately the arguments with regard to the many citizens who are taxpayers and consumers, and the few citizens who are providers of health care.

The Charge of Paternalism

Charles Fried (1976:31) has argued that equal access to health care is a particularly intrusive form of paternalism toward citizens. He claims further that "apart from a rather general commitment to equality and, indeed, to state control of the allocation and distribution of resources, to insist on the right to health care, where that right means a right to equal access, is an anomaly. For as long as our society considers that inequalities of wealth and income are morally acceptable, . . . it is anomalous to carve out a sector like health care and say that *there* equality must reign."

Would an equal access system necessarily be intrusive or paternalistic in its operation? A national health care system simply cannot be said to take away the income entitlement of citizens, since citizens are not entitled to their gross incomes. We can determine our income entitlements only after we deduct from our gross income the amount we owe the state to support the rights of others. To the extent that the rationale of an equal access principle is redistributive, those individuals who otherwise could not afford certain health care services will experience an expansion of their freedom (if we assume an adequate

level of social provision). Of course, part of the justification of a national health care system is that it would also guarantee health care coverage to people who could afford adequate health care but who would not be prudent enough to save or to invest in insurance. Even if we accept the common definition of paternalistic actions as those that restrict an individual's liberty so as to further his or her interest, we still have to assess the assertion that this (partial) rationale for an equal access system entails a restriction of individual liberty. Unlike a law banning the sale of cigarettes or forcing people to wear seat belts, the institution of a national health care system forces no one to use it. If a majority of citizens decide that they want to be taxed in order to ensure health care for themselves, the resulting legislation could not be considered paternalistic: "Legislation requiring contributions to some cooperative scheme (such as medical care) . . . is not necessarily paternalistic, so long as its purpose is to give effect to the desires of a democratic majority, rather than simply to coerce a minority who do not want the benefits of the legislation" (Thompson, 1980:247). It is significant in this regard that for the past twenty years the Michigan survey of registered voters has found a consistent and solid majority supporting government measures designed to ensure universal access to medical care.

The charge of paternalism levied against an equal access system is therefore dubious because it is extremely difficult, if not impossible, to isolate the self-protectionist rationale from the redistributive and the democratic rationales. Those who object to a national health care system on the grounds that it is coercing some people for their own good forget that such a system still could be justified as a means to avoid the threat to a one-class system that exempting the rich would create. To condemn such a system as paternalistic would commit us to criticizing all legislation in which a democratic majority decides to protect itself against the wishes of a minority when exemption from the resulting policy would undermine it. Other critics wrongly assume that people have an entitlement to the cash equivalent of the medical care to which society grants them a right. People do not have such an entitlement because taxpayers have a right to demand that their tax dollars are spent to satisfy health needs, not to buy luxuries. Indeed, our duty to pay taxes is dependent upon the fact that certain needs of other people must be given priority over our own desires for more commodious living.

Other Restrictions

Nonetheless, two restrictions upon consumer freedom are entailed in an equal access system. One is the restriction imposed by the taxation necessary to provide all citizens, but especially the poorest, with access to health care goods. This restriction does not raise unique or particularly troublesome moral problems so long as one believes that the freedom to retain one's gross income is not an absolute right and that the resulting redistribution of income to the health care sector increases the life chances and thereby the effective freedom of many citizens.

But there is a second restriction of consumer market freedom sanctioned by the equal access principle: the limitation upon freedom to buy health care goods above the level publicly provided. Aside from reasserting the primary values of equality, there is at least one plausible argument for such a restriction. Without restricting the free market in extra health care goods, a society risks having its best medical practitioners drained into the private market sector, thereby decreasing the quality of medical care received by the majority of citizens confined to the publicly funded sector. The lower the level of public provision of health care and the less elastic the supply of physicians, the more problematic (from the perspective of the values underlying equal access) will be an additional market sector in health care.

Without an additional market sector, would the freedom of physicians and other providers to practice wherever and for whomever they choose be unduly restricted? The extent of such restrictions will also vary with the level of public provision and with the diversity of the health care system. Public funds already are crucial to providing many physicians with basic income (through Medicare and Medicaid fees), research opportunities through the National Institutes of Health (NIH), and many with hospitals and other institutions in which to practice (through the provisions of the Hill-Burton act). In place of the time and resources now directed to privately purchased add-ons, an equal access system would redirect providers toward meeting previously unserved needs. These types of redirections of supply and redistributions of demand are commonly accepted in other professions that are oriented toward satisfying an important public interest. The legal and teaching professions are analogous in this regard. The equal access principle, strictly interpreted, however, adds another restriction, a limitation upon private practice that supplies health care goods

not equally accessible to the entire population of relevantly needy persons. This restriction upon the freedom of providers does not have an analogue in the present practice of law or of education, although the arguments for equal access to the goods of these professions might be similar. And so, one's assessment of the strength of the case for such a restriction is likely to have implications beyond the health care system.

It is hard to see why one ought to prevent people, rich or poor, from spending money upon health care goods while permitting them to spend money on consumer goods that are clearly not essential, and perhaps even detrimental to health. One reason might be the possible systemic effect, mentioned above, that such additional expenditures would deprive the less advantaged of the best physicians. The freedom of providers as well as consumers would have to be restricted in order to curtail this effect. But beyond this empirically contingent argument for restricting any market in health care goods that are not equally accessible to all, the strict limitations upon market freedom in "extra" health care goods are hard to accept if one believes that medical services are at least as worthy items of expense as other consumer goods. One could argue that physicians ought to be free to meet the demand for additional medical goods, especially when that demand is a substitute for demand for less important goods.

This criticism illuminates a more general problem of attempting to equalize access to any good in an otherwise inegalitarian society. The more unequal the distribution of income and wealth within our society, the more likely that the freedom of consumers and providers to buy and sell health care outside the publicly funded sector will result in inequalities that cannot properly be regarded merely as the product of differences in consumer preferences. Therefore, in an inegalitarian society, we must live with a moral tension between granting providers the freedom to leave the publicly funded sector and achieving more equality in the satisfaction of health care needs.

A principle of equal access to health care applied within an otherwise egalitarian society might give little or no reason to restrict the freedom of providers or consumers. One argument often voiced against a publicly funded system that permits a marginal free-market sector is that the government is a less efficient provider of goods than are private parties. But the equal access principle does not require that the government directly provide medical services through, for example,

a national health service. Government need only be a regulator of the use and distribution of essential health-care goods and services. This is a role that most people concede to government for many other purposes deemed essential to the welfare of all individuals.

Government regulation may, of course, be more expensive and hence less efficient than government provision of health care services of similar extent and quality. The tradeoff here would be between the additional market choice facilitated by government regulation of private providers and the decreased public cost of government provision. Despite utilitarian claims to the contrary, no simple moral calculus exists that would enable an impartial spectator to determine where the balance of advantage lies. Philosophers ought to cede to a fairly constituted democratic majority the right to decide this issue. What constitutes a fair process of democratic decision-making is an important question of procedural justice that lies beyond the scope of this paper.

Liability for Voluntary Risks?

Another important criticism of the equal access principle cuts across advocacy of the free market and government regulation of health care. Supporters of both views might consistently ask whether it is fair to provide the same level of access for all people, including those who voluntarily adopt bad health habits, and who quite knowingly and willingly take greater-than-average risks with their lives and health. Even if it might be unjust not to provide health care for those people once the need arises, why would it not be fair to force those who choose to drink, smoke, rock climb, and skydive also to bear a greater burden of their ensuing medical costs than that borne by people who deliberately avoid these risky pursuits? An equal access principle seems to neglect the distinction between voluntary and nonvoluntary health risks in its eagerness to ensure that all people have an equal opportunity to receive appropriate health care.

Gerald Dworkin (1979) extensively and convincingly argues that it would not be unfair to force individuals to be financially liable for voluntarily undertaken health risks, but only under certain conditional assumptions. These include our ability 1) to determine the relative causal role of voluntary versus nonvoluntary factors in the genesis of illness; 2) to differentiate between purely voluntary behavior and what

is nonvoluntary or compulsive; and 3) to distinguish between genetic and nongenetic predispositions to illness. For example, to satisfy the first condition one would have to determine the relative causal role of smoking and environmental pollution in the genesis of lung cancer; to fulfill the second, one must know when smoking (or drinking or obesity) is voluntary and when it is compulsive behavior; and to satisfy the third condition, one must distinguish among those who smoke and get cancer, and those who smoke and do not. In addition, so long as there are no good institutional mechanisms for monitoring certain risky activities or for differentiating between moderate and immoderate users of unhealthy substances, qualifying the equal access principle to take account of voluntary health risks is likely to create more unfairness rather than less. Finally, given great inequalities in income distribution, the poor will be less able to bear the consequences of their risky behavior than will the rich, creating a situation of unfairness at least as serious as the unfairness of equally distributing the burdens of health care costs between those who voluntarily impose risks upon themselves and those who do not. With respect to the health hazards of overeating and obesity, for example, the rich have recourse to expensive programs of weight control unavailable to the poor. Since we have such scanty knowledge of situations when sickness can be attributable to voluntary health risks, criticisms of the equal access principle from this perspective have more weight in principle than they do in practice.

Equal Access to All Health Goods

All criticisms considered so far are directed at the equal access principle from a perspective suggesting that government involvement and public funding of health care would be too great and the role of the market too small in an equal access system. Now let us consider a powerful criticism of the principle for including too little, rather than too much, in the public sector. The criticism can be posed in the form of a challenge: if one crucial reason for supporting a principle of equal access is that health goods are much more essential than many other goods because they provide a basis for equalizing opportunity and relieving substantial pain, then why not require a government to provide equal access to *all* those health goods that would move a society further in the direction of equalizing opportunity and relieving

pain for the physically and mentally ill? Without pretending that our society could ever arrive at a condition of absolute equality of health (or therefore strict equality of opportunity), proponents of this principle could still argue that we should move as far as possible in that direction.

In a society in which no tradeoffs had to be made between health care and other goods, equal access to *all* health goods might be the most acceptable principle of equity in health care (Veatch, 1976:127–153). Of course, we do not live in such a society. Given the advanced state of our medical and health care technology, and the prevalence of chronic degenerative diseases and mental disorders in our population, a requirement that society provide access to every known health care good would place an enormous drain upon social resources (Somers, 1971).

Costliness per se is not the main issue. The problem with the principle of equal access to all health goods is that it demands an absolute tradeoff between satisfaction of health care needs and other needs and desires. The simplest argument against this principle is that other needs, such as education, police protection, and legal aid, will be sacrificed to health care, if the principle is enforced. But this argument is too simple. A proponent of equal access to all health goods could consistently establish some priority principle among these goods, all of which satisfy needs derived in large part from a principle of equal opportunity. The weightier counterargument is that, above some less-than-maximum level in the provision of opportunity goods, it seems reasonable for people to value what, for want of a better term, one might call "quality of life" goods: cultural, recreational, noninstrumental educational goods, and even consumer amenities. A society that maximized the satisfaction of needs before it even began to provide access to "quality of life" goods would be a dismal society indeed. Most people do not want to devote their entire lives to being maximally secure and healthy. Why, then, should a society devote all of its resources to satisfying human *needs*?

Democracy and Equal Access

We need to find some principle or procedure by which to draw a line at an appropriate level of access to health care short of what is socially and technologically possible, but greater than what an unconstrained

market would afford to most people, particularly to the least advantaged. I suspect that no philosophical argument can provide us with a cogent principle by which we can draw a line within the enormous group of goods that can improve health or extend the life prospects of individuals.

This problem of determining a proper level of guaranteed social satisfaction of need is not unique to health care. Something similar can be said about police protection or education in our society. Philosophers can provide reasons why police protection and education are rightly considered basic collective needs and why they should be given priority over individual consumer preferences. But no plausible philosophical principle can tell us what level of police protection or how much education a society ought to provide on an egalitarian basis.

The principle of equal access to health care establishes a criterion of distribution for whatever level of health care a society provides for any of its members. And further philosophical argument might establish some criteria by which to judge when the publicly funded level of health care was so low as to be unfair to the least advantaged, or so high as to create undue restrictions upon the ability of most people to live interesting and fulfilling lives. The remaining question of establishing a precise level of priorities among health care and other goods (at the "margin") is appropriately left to democratic decision-making. The advantage of the democratic process in determining the precise level of health care provision is that citizens have an equal and collective voice in determining a decision that, according to the equal access principle, ought to be mutually binding. Citizens not only reap the benefits; they also share the burdens of the decision to expand or limit access to health care.

There is yet another advantage to this procedural method of establishing a fair level of health care provision. If the democratic decision will be binding upon all citizens, as the equal access principle assumes it must be, then one might expect the most advantaged citizens to exercise more political pressure to increase access to health care and hence increase the opportunity of the least advantaged above the level that they could afford in a free market system, or in a system where the rich were not included within the publicly funded health care sector. One finds some evidence to support this hypothesis in comparing the relative immunity from budget cutbacks of the program under universal entitlement of Medicare compared with the income-

related Medicaid program. Of course, if costliness to the taxpayer is one's only concern, this added political pressure for health care expenditures is a liability rather than a strength of a one-class system. But from the perspective of equal access, the cost of a two-class system, one privately and one publicly funded, is an inequitable distribution of quantity and quality of care according to wealth, not need. The added nonproductive costs required merely to keep the two classes apart are seldom taken into account. And from the perspective of those supporters of an equal access principle who also want to increase the total level of health care provision, the two-class system threatens to work in the opposite direction, siphoning off the pressure of citizens who have a disproportionate share of political influence. A democratic decision, the results of which are constrained by the principle of equal access, will give a relatively accurate reading of what most people believe to be an adequate level of health care protection. The major disadvantage of the equal access constraint is that the decision of the majority or its representatives binds everyone, even those people who want more than the socially mandated level of health care.

Given the great economic inequalities of our society, it is politically impossible for advocates of equal access to fulfill their task. No democratic legislator could possibly succeed in winning support for a proposal that restricted market freedom as extensively as a strict interpretation of the equal access principle requires. And it probably would be a mistake to insist upon strict philosophical standards: one thereby risks throwing the possibility of greater access to health care for the poor out with the insistence upon curtailing access for the rich.

Conclusion

I began by arguing that a principle of equal access to health care was at best an ideal toward which our society might strive. I shall end by qualifying that statement. A sufficiently high level of public provision of health care for all citizens and a sufficiently elastic supply of health care would significantly reduce the threat to universal provision of quality health care of a private market in extra health care goods, just as a very high level of police protection and education

reduces the inequalities of opportunity resulting from purchase of private bodyguards or of private school education by the rich.

In the best of all imaginable worlds of egalitarian justice, the equal access principle would be sufficiently supported by other egalitarian social and economic institutions that a market in health care would complement rather than undercut the goals of equal respect and opportunity. But philosophers ought to resist basing their political recommendations solely upon a model of the best of all imaginable worlds.

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