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LIVING DANGEROUSLY: A DEFENSE OF *MORTAL PERIL*

*Richard A. Epstein**

As one of the most controversial writers of our time, just the name Richard Epstein draws immediate attention from all sectors of academia. But if the hallmark of great ideas is the criticism they engender, Professor Epstein's words and thoughts are powerful indeed. In Mortal Peril, *Professor Epstein outlined a fundamental shift in thinking that he claimed needed to occur before any discussion of health care could take place. The final consensus of the validity of Professor Epstein's views may still be a matter for history to judge, but in many ways, he has already won; with the strength of his logic and convictions, he has forced other scholars to address his concerns, and in doing so, he has refocused the debate on health care. At the symposium, Professor Epstein proved his indisputable eloquence and debating skill in answering and refuting the various points made by his many critics. Now, in writing, he thoughtfully considers and analyzes the views submitted by his colleagues, and solidifies the ideas that first found their expression in* Mortal Peril.

The papers in this symposium issue have followed the organization that I adopted in *Mortal Peril*. The first part of that book dealt with the broad dispute over the status of a positive right to health care; the second section examined the pitfalls of that approach by looking at a range of health-care regulations and reforms now firmly entrenched in the United States. The third section focused on various issues of individual choice by addressing issues of organ transplantation, physician-assisted suicide, and physician and hospital liability for medically related accidents. Without further ado, I think that it is best to follow that order in responding to the papers in the symposium,[1] along with several others published elsewhere.[2]

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[1] Omitted from this list is Professor Robert Rich's paper on federalism and health-care policy, which, while it addresses critical issues in health care, does not speak directly to any of the points I made in *Mortal Peril*.

[2] *See also* Uwe E. Reinhardt, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, 278 JAMA 1446 (1997); Troyen A. Brennan, *Moral Imperatives Versus Market Solutions: Is Health Care a Right?*, 65 U. CHI. L. REV. 345 (1998) (review of *Mortal Peril*).

I. THE POSITIVE RIGHT TO HEALTH CARE

A. *Positive and Negative Rights to Health Care*

The first portion of *Mortal Peril* addresses what is meant by a claim that all individuals have a right to health care. Stating the proposition in this fashion, however, conceals an important ambiguity by failing to specify the correlative duties associated with that right. In one sense, a claim that an individual has a right to health care means that he is entitled to obtain it from another individual who is willing to supply it in a voluntary transaction, be it by gift or purchase. Individuals can make offers to supply or receive health care, but no one else is under a duty to accept the offers so made, just as they are under no duty to accept contractual offers made to them. Often times this legal regime is described, somewhat misleadingly, as one of negative rights, to emphasize the proposition that no individual may be compelled by the state to transact with another. In its second sense, the correlative duty to an individual's right to health care requires individuals to supply the needed health-care services at their own expense to other individuals who are unable to purchase those services. In practice, these positive rights do not run against discrete individuals, but against the state, which collects the needed revenues from taxes on the general population.

In *Mortal Peril*, I defended the first conception of health-care rights and attacked the second. Both halves of the proposition can be somewhat controversial. In understanding negative rights, the basic intuition is that voluntary exchange generates net benefits for all participants to a transaction. Accordingly, the state should be highly reluctant to interfere with these transactions when and as they occur. Of course, this defense of the contractual health-care right is not absolute but accepts the common-law defenses of duress, fraud, infancy, and incompetence, applicable to other contractual situations. Within the health field, however, the incessant attacks against voluntary agreements go far beyond these unproblematic qualifications to attack the negative external effects that ordinary contractual transactions are said to have on third parties. In this context, we are not speaking of contracts to kill or maim third persons; nor are we speaking of the creation of cartels or other forms of antitrust violations. Rather, the position is quite simply that whenever some individuals make transactions advantageous for themselves, they necessarily make the world more difficult for other (but hardly all) individuals. More concretely, the fear is that healthy individuals will enter into health-care transactions that reduce the opportunities of less fortunate individuals to receive the subsidies that come from lumping high- and low-risk individuals together in a single insurance pool.[3] In effect, the voluntary pairing of the healthy individuals with their health-care providers imposes a negative externality that is felt most keenly by the most sick and the most vulnerable. Restricting ordinary contracts for health care is needed to preserve subsidies to unhealthy persons. As such, limitation on contractual rights is parasitic of the antecedent claim for positive rights. It is therefore fair to ask whether these positive rights can be defended in the first place.

The difficulties in the analysis start with the description of the rights that all individuals have in the state of nature, or, if one prefers, in the original position, behind the veil of ignorance. The simple libertarian position starts from the proposition that all individuals own their own persons, including their own talents and abilities. The theory, of course, recognizes that genetic endowments and environmental influences generate benefits by luck as well as hard work. Nonetheless, that theory does not seek to equalize natural fortune, but limits its claims for rectification to those wrongs that one person commits against another, typically by force or fraud. *A* does not generate a claim for legal relief against *B* by showing that she is worse off than before. It is necessary to show that *B* had brought about her condition, and that cannot be shown if *A* is a victim of genetic defect, natural disaster, or the abuse of some third party (who could be held liable if both caught and solvent). This limited scope of rectification neatly directs state force against one (or very few) persons for the benefit of one (or very few persons). Public enforcement leads most individuals to veer away from destructive and aggressive conduct from which the winners gain less than the losers surrender. The system thus discourages negative-sum games, while encouraging positive-sum games, most notably trade and voluntary association. A thought experiment helps show why no one doubts the kernel of truth to this legal regime. Ask individuals whether they would rather possess negative rights that guarantee the security of their person or positive rights to health care after they are maimed by another. By failing to guarantee protection against force and fraud, no system of purely positive rights could supply all needed entitlements. Rather, positive rights must be justified, if at all, as superstructure on an underlying theory of negative rights.

In making this claim for positive rights, it is important to distinguish, as many do not, claims for positive rights from those for standard public goods, such as law enforcement, public roads, and defense. Yet all too often health-care analysts seek to piggyback their claims for a positive right to health care on the narrower economic conception of a public good. Alain Enthoven and Sara Singer, for example, do just that by writing, "[i]n a sense, universal access to nec-

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[3] *See, e.g.*, ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE 5 (1988).

essary health care is a public good."[4] But the argument is no more than a play on words. The traditional account of the public good speaks about the underprovision of goods and services that produces nonexcludable benefits. No individual will build an ideal system of street lights at private expense when others, who contribute nothing, can share their gains. Taxation is justified to control the free-rider problem and to prevent the misallocation of resources that otherwise would result from the underprovision of these public goods. The creation of public goods in the traditional economic sense is not designed to achieve redistributive ends.[5]

In contrast, Enthoven and Singer's newer definition has nothing to do with allocative inefficiencies that come from the inability to internalize benefits of private action. Rather, it starts with the different proposition that the initial endowments of various individuals were unearned, and should therefore be treated as though they are social and collective, instead of individual assets. In their view, requiring some individuals to lend support to another should not be viewed as a subsidy, for to take that position is to buy into the theory of negative rights that the positive-rights theorist denies. Instead, the view claims that these systems for the collective provision of goods and services, including the provision of health care, should mirror the proper social distribution of talents and abilities across individuals. Since genetic luck and family circumstances are matters of random happenstance, they do not ground the simple distribution of rights normally defended from a Lockean perspective.

So the issue is joined. At the most theoretical level, Russell Korobkin's thoughtful paper, *Determining Health Care Rights from Behind a Veil of Ignorance*,[6] uses the Rawlsian veil of ignorance framework to adjudicate between negative and positive rights. After careful examination, Korobkin insists that this framework points to the recognition of at least some positive rights to health care. His basic approach is one that surely commands respect. Suppose that individuals do not know whether they will be born in good health or in bad health. Being risk averse, surely they would have some incentive to participate in some large insurance pool whereby the individuals who were healthy would give up some of their good fortune to help those in need. That private judgment is not made solely out of some ill-defined sentimentality. Rather, it is the self-interested judgment of a rational individual behind the veil forced to choose between the world with and without that insurance. Stated otherwise, Korobkin

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[4] Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, HEALTH AFF., Nov.-Dec. 1997, at 26, 27.

[5] *See* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 16-19 (1997).

[6] Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801.

treats social insurance as a precontractual form of implicit, in-kind exchange that leaves all individuals behind the veil better off than they were before. Since transactional obstacles block the formation of this comprehensive system by voluntary contract, the state should come in and broker the deal through a system of social insurance, just as it uses compulsory taxation to fund the night watchman who protects against force and fraud. The logic of collective action is extended beyond the nonexcludable public goods (public order and highways) acknowledged in thoughtful accounts of laissez-faire,[7] to cover programs of public rectifications of differences in fortunes and talents. This approach to pooling good fortunes need not in principle be limited to health, but easily extends to intellectual, artistic, literary, or athletic endeavors. But it exerts some special hold to Korobkin and others because the downside from poor health carries devastating consequences, some of which at least mandatory social insurance seeks to mitigate.

Substantively, I think that Korobkin's way of raising the challenge about positive rights has much to commend it. Oddly enough, the case for some form of redistribution is even stronger than the Rawlsian approach suggests, for I agree with those writers who (taking a leave from Adam Smith)[8] insist that human empathy induces individuals to care about the fates of others, wholly without regard to any return benefit, past or future, from those presently in need.[9] We need not ground positive rights to health care solely by assessing individual self-interest from behind a veil of ignorance, but can bolster it by allowing for sentiments of benevolence, which go a long way toward easing social dislocations in any system of legal entitlements. By the same token, it is equally important not to denigrate ordinary charitable efforts by falsely assuming that narrow self-interested models fully explain all of human behavior. The case for a positive legal right to health care draws on the wellsprings of empathy.

Yet just how do these sentiments play out? Noting the role of human empathy eases the task of erecting positive rights. By the same token, however, it also eases the task of implementing a strong libertarian system, which uses the phenomenon of empathy to ground a strong moral duty of charitable assistance. To the modernist, the sheer size of the social burden compels use of some comprehensive system of public financing, in which wealth transfers are exacted from the earnings of those who can afford to pay for the benefit of those who cannot. At its best, that program of positive rights does not pre-

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[7] *See, e.g.*, Jacob Viner, *The Intellectual History of Laissez Faire*, 3 J.L. & ECON. 45 (1960).

[8] *See* ADAM SMITH, THE THEORY OF MORAL SENTIMENTS 159 (1976).

[9] *See* ROBERT KUTTNER, EVERYTHING FOR SALE: THE VIRTUES AND LIMITS OF MARKETS 110-11 (1997). *See generally* Milton Fisk, *Health Care as a Public Good*, 27 J. SOC. PHIL. 14 (1996).

suppose that the less fortunate pay nothing; rather it demands from them what they can afford, but further stipulates that individuals should not go without needed health care, solely because of their inability to pay. Needed health care could be defined as that which is sufficient to allow these individuals to weather grave personal emergencies and to maintain some overall level of health.

In *Mortal Peril*, I defended the libertarian approach against its collectivist alternative, and in so doing exposed myself to Henry Greely's charges of being the retrograde descendant of Ebenezer Scrooge,[10] and to Troyen Brennan's charge of embracing a mean-spirited political philosophy.[11] These charges target the outspoken nature of my views. One theme seems to set off the most sparks: "philosophical questions of health care do not begin and end with the passionate observation 'that you can't just let anyone die.' The short answer is that you can, and indeed in some cases, you should."[12] Is that position defensible against a charge of callous indifference to human suffering?

B. You Can't Let People Die

In one sense, the commonplace observation, "you just can't let people die," suffers from an ambiguity of the pronoun: who is the you? In *Mortal Peril*, the clear target of that pronoun is the government insofar as it backs positive rights to health care with its coercive power. Any given individual may, of course, freely spend himself into poverty in order to save the life of another. And it is certainly possible to hold that the ethical duty of compassionate care is strong enough to bind physicians to follow this approach even if the law allows them to do otherwise. The real question is whether that impulse, however strong and commendable, should be backed by legal force. For Greely, the issue is not worth a second thought, and he gives it none. But his dismissive approach is a mistake. As a logical matter, if we can identify *some* cases in which a moral individual or institution might properly choose to let a person die, then the categorical duty of compassionate care is no longer defensible, either as a moral or a legal matter. The issue is fairly joined by the common situation that Troyen Brennan advances in his review of *Mortal Peril*.

> I have several patients, among a patient panel that includes numerous intravenous drug abusers and individuals infected with HIV through use of dirty needles, who have required valve replacement as a result of endocarditis from injection. Should any of them reinfect an artificial valve, I will advocate (I suspect successfully) that the artificial valve be replaced. Hospitalization

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[10] *See* Henry T. Greely, *Richard Epstein's* Mortal Peril: *Ebenezer Scrooge Meets the American Health Care System*, 1998 U. ILL. L. REV. 727, 730.

[11] *See* Brennan, *supra* note 2, at 356.

[12] EPSTEIN, *supra* note 5, at 4.

> and professional costs for this episode will likely run over $75,000. Very little of this will be reimbursed by welfare programs, especially if the patient is a nondisabled male who does not qualify for Medicaid.
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> The overall majority of physicians would do exactly the same thing. They would do so because they are committed to the individual patient, and respect the principles of compassion that are central to medical ethics. Perhaps more importantly, I know each of these intravenous users as individual human beings. Most are clean for long periods of time, many slip back into episodes of a couple of weeks of drug abuse, and a reinfection could be seen as just a matter of poor luck. Almost none fit the metaphor of ghoulish irresponsibility that Epstein rails against.[13]

Brennan's powerful passage provokes a number of replies. First, if the ethic of compassionate care is as powerful as Brennan claims it is, then why does he feel compelled to prop it up with the coercive power of the state? Public sanctions are expensive to wield and in some cases at least could easily be misapplied to cases perhaps where further medical treatment is futile, or where adequate efforts to save lives turned out to be unsuccessful.[14] It is better on this view to take the extra funds of enforcement and use them directly for compassionate care.

But a closer look at Brennan's argument shows fissures in the supposed moral coalition in favor of unconditional compassionate care. Brennan (an academic) will advocate the replacement of the reinfected valve, as have others before him.[15] Yet if his position were universally accepted, why his lingering doubt ("I suspect successfully") that his plea might be rejected? If only "an overall majority of physicians" would follow his lead, just how many physicians would turn him down? And would they do so out of mere willfulness, or claim some higher moral ground?

I vote for the latter. Seventy-five thousand dollars buys an awful lot of medical care for indigent people, many of whom are victims of circumstance and bad chance. Yet Brennan's absolutist position prevents him from stopping at one single valve replacement. Let reinfection follow, then he must opt for a second replacement, not only for patients who are clean for a long time, but even for repeat abusers who vow to revert to their old habits if saved again. My reaction to these abusers is equal parts rage and resentment at their utter indifference to the plight of others whom they displace on the queue. As a

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[13] Brennan, *supra* note 2, at 356.

[14] For these risks, see generally David Hyman, *Lies, Damned Lies and Narrative*, 73 IND. L.J. 797 (1998).

[15] *See* John La Puma et al., *Ethics, Economics, and Endocarditis: The Physician's Role in Resource Allocation*, 148 ARCHIVES INTERNAL MED. 1809 (1988).

physician, I might decide to treat (once) but not without giving a clear piece of my mind.

Why the rage? Not to spend that money on my vacation to the Bahamas. No, it is because unthinking compassion rewards conduct that is both self-destructive and antisocial. To be sure, if health budgets were unlimited, I should not give the extra care a second thought. But the brutal fact is that money spent on one heroic endeavor cannot be spent on more worthy individuals or causes. Suppose that the $75,000 spent on a single operation could fund a counseling program that reduces the number of reinfections by five percent, and increases the survival rate of its target population by ten percent. Now the refusal to replace that valve in the moment of crisis has collateral benefits to the same target population. Why then (from behind the friendly veil of ignorance) would any potential recipients prefer misguided compassionate care to systematic prevention, when all the money, both ways, will be spent on the same individuals. The issue here is no longer the cause of redistribution; it is the simple means/ends question of what relief works best for a targeted population.

Unfortunately, to say that you (the hospital) will never let an individual die is to commit yourself in advance to using resources in cases of dire emergency instead of spending them to reduce the number of occasions in which emergencies arise. That same state mandate also stipulates that government has so little confidence in the compassionate judgment of physicians that government arrogates that task for itself in complete and self-enforced ignorance of the trade-offs involved. More concretely, the current position allocates resources by the order in which people walk through the hospital door. As such, it clashes uncomfortably with the standard system of wartime triage, which gave up on some hopeless cases to conserve resources for sick persons with greater prospects for good health. In the modern context we do not face the stark wartime limitations on personnel and resources, but the nettlesome question of priorities cannot be evaded. Do we have so little faith in the moral judgments of emergency-room physicians that we require a public commitment to the first-come, first-serve principle? Or do we husband some resources for occasions where they could perhaps save multiple lives—lives of other individuals who are genuine victims—people hit by falling bricks at a construction site, people felled by eating contaminated restaurant food, or people hurt saving a drowning child? To deny that the institutions can "just let someone die" is to sweep these countervailing conditions to one side in the name of compassionate care.

I am baffled as to why anyone would want to take that position. Do we really think that popular morality pays no attention to *why* people fall into conditions of desperate need or *how many* times they do? Should we ignore the unidentified lives lost to save one immediate life? Should we ignore the risk that a very small percentage of the population could drain the resources available to others? Voluntary redistribution is alert to these risks. But state systems of coerced redistribution are forced to ignore these critical differences because of their inability to administer these rules from afar. The Brennan-Greely position, that you just can't let anyone die, strikes me as hopelessly absolutist and self-destructive. At the very least, sensible private institutions might want to take different views on this question. I do not seek state power to tell Brennan how he and his colleagues should practice medicine in Cambridge or anywhere else. But I do resist their claim that the duty of compassionate care should be converted into a moral absolute that denies to other physicians and other institutions the rights and duties of allocating their own resources. Why taking this position makes me mean-spirited (as opposed to tough-minded) escapes me. And as to Scrooge, his Christmas transformation did not make him an early supporter of national health care (which, it appears, will often let people die for reasons of cost).

My rejection of a positive right to health care is often attacked from a second point of view. Even if we put aside dubious interventions in certain crisis situations, the needs of the sick and poor are so enormous that private charitable efforts could not take up the slack left by the abolition of Medicaid for the poor and Medicare for the elderly and disabled. In answering this question, I want to put aside the awkward transitions from the current state, which, as I noted in *Mortal Peril*, make cowards of us all.[16] My reason is quite simple. Whatever its soundness, my basic libertarian position did not create today's massive dependence on public support for these target populations. The very fact that it is difficult to reduce the level of dependence once it is created speaks volumes against the soothing assurances that new entitlement programs will not commandeer additional resources: there is little reason to rail at length against the now moribund Clinton proposal to extend some form of Medicare to persons between the ages of fifty-five and sixty-five.[17]

More concretely, Professor Greely makes just this error when he writes as though the proper question is whether any system of private commercial and charitable care could pick up the slack in the current

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[16] *See* EPSTEIN, *supra* note 5, at 174-81.

[17] *See* John M. Broder, *Clinton Proposes Open Medicare to Those 55 to 65*, N.Y. TIMES, Jan. 7, 1998, at A1. That proposal is, however, at least worth a short denunciation. The program itself invites private firms to discontinue their coverage of employees and retirees within this age group. Adverse selection then guarantees that the sickest portion of the target population will sign onto the program, which in turn will throw off kilter whatever financial projections are made on the basis of age alone. Once the program is in place, the "moral" question will be deemed solved, so that direct tax contributions will be deemed appropriate. In consequence, the Medicare tax will increase (reducing the money for general care available to uncovered individuals with small children) in a manner that imitates the rapid expansion of Medicare taxes notwithstanding the rosy financial projections that accompanied its original adoption. *See* EPSTEIN, *supra* note 5, at 147-84; Steven Hayward & Erik Peterson, *The Medicare Monster: A Cautionary Tale*, REASON, Jan. 1993, at 19, 21-23.

public welfare programs. His implicit assumption is that the current level of resource commitment is about right, so that the only real inquiry is whether the present funding system is superior to any alternative that market and charitable institutions could cobble together. This approach completely misstates the nature of the underlying problem. The correct question is not how to fund the massive liabilities of Medicare, Medicaid, and other programs for medical assistance. Rather, the question of first principle is what would happen to prices and quantities of services supplied if none of these programs had been introduced in the first place. That critical distinction is missed by Greely when he observes that Medicaid now costs $175 billion per year at a time when charitable giving to health care amounts to only $12.6 billion dollars.[18] Greely then makes some allowance for gifts of physician services, which at ten percent of the current $600 billion tab could cover perhaps half of that difference.

Nor is Greely alone in analyzing the situation. Professor Mark Hall echoes this error when he notes that Medicare couples would have to pay on average $15,000 per year if the program were not in place. (He never asks why the burden shrinks when placed on nonusers of the program.) Similarly, Medicaid costs its recipients an average of $4200 per year, based on the calculation of $150 billion in expenditures for 36 million individuals.[19]

But what should the correct calculations look like? Start by asking what happens to the overall demand for medical services if the heavy subsidies found in Medicare, Medicaid, and elsewhere are bled from the system. That change should markedly reduce overall price levels and with it the price tag even if the current level of services is maintained, which of course it would not be. Cutting both price and quantity of medical services should have a substantial effect on the overall situation. Next, removing these programs could cut both the fraud and the massive inefficiencies that have crept into the government system.[20] And, since more health costs would be privately borne, most individuals will take more care to avoid illness and injury than before. Owing to the high level of medical expenditures related to the use of alcohol, tobacco, and drugs, reduced demand in this dimension could be quite great. And finally, the charitable impulses of American medicine (which may prove difficult to revive) could have picked up much of the slack that remained.

Hard numbers are very difficult to get on this last question, but *no one* with whom I have talked on the matter (and the total number is about twenty physicians and physician family members) thinks that

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[18] *See* Greely, *supra* note 10, at 748, 750.

[19] *See* Mark Hall, *Public Choice and Private Insurance: The Case of Small Group Market Reforms*, 1998 U. ILL. L. REV. 757, 759.

[20] *See* Bonita Brodt et al., *Medicare Gobbles Money as Other Programs Starve*, CHI. TRIB., Nov. 8, 1993, at N1 (discussing the skyrocketing costs of Medicare).

physicians in the pre-Medicaid days donated as little as ten percent of their time to charitable work. The usual estimates that I have heard range from fifteen to forty percent of time donated, with the median estimate between twenty and twenty-five percent. The exact calculations are hard to pin down for a number of reasons. Often times patients were billed at regular rates but paid only a fraction of the bill and were never dunned, let alone sued, for the residue. In some cases, fee reductions were explicitly calibrated to a patient's ability to pay. In other cases, individuals paid for medical services by supplying goods or rendering services in return, all of which were difficult to value.

The price calculations are not what is critical: what we do know is that ends were met most of the time because we did not have widespread death in dark alleyways before the advent of Medicaid, even when the overall wealth levels in the United States were far lower than they are today. So somehow that huge shortfall was made up, even if we do not know exactly how. It is difficult to estimate the overall levels of demand and supply in a world so utterly foreign from our own. But we can say with complete confidence that Greely's steady-state calculations vastly and consistently overstate the difficulties of operating in a world devoid of the assistance programs he champions. The analysis has to go astray whenever we fall into the trap of assuming that the *only* real questions at stake for health care in the United States involve the distribution of costs for a fixed supply of services, and not the basic allocation of resources.

Just that mistake was made in yet another challenge to *Mortal Peril* by Uwe Reinhardt writing in the *Journal of the American Medical Association*. "As a matter of national policy, and to the extent that a nation's health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?"[21] Reinhardt notes that the "'yeas' in all other industrialized nations had won that debate hands down decades ago,"[22] and that it is only the recalcitrant free market economics of the disciples of Milton Friedman (of whom, for these purposes, I surely count as one), who have prevented the United States from seeing the light.

Alas, the issue is more complex than Reinhardt's heartfelt denunciation suggests. At the outset, "free market economics" does not describe my position to the extent that it suggests that markets allow for voluntary exchange but preclude voluntary charitable transactions. Indeed, I went to great lengths in *Mortal Peril* to explain why I reject any norm of wealth maximization, especially in the context of medical care: it ignores the obvious utility of medical treatment to the young

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[21] Reinhardt, *supra* note 2, at 1446.

[22] *Id.*

and helpless who have no wealth of their own.[23] Nonetheless Reinhardt regards me as a covert defender of the wealth standard, for in my chapter "Wealth and Disability," he quotes a sentence that reads,

> But allowing wealth to matter [in the allocation of health] is likely to do far better in the long run than any policy that insists on allocating health care without regard to the ability to pay. To repeat, any effort to redistribute from rich to poor in the present generation necessarily entails the redistribution from the future to the present generation . . . .[24]

Reinhardt concedes the force of the last proposition, but incorrectly treats the first sentence quoted as embracing the "harsh algorithm" of wealth maximization for health care.[25] Conveniently, he does not quote the prior sentences in the paragraph, which give a fuller sense of my meaning and intentions:

> The refusal to allow wealth to be a determinant of health care expenditures thus prejudices the rich and poor of the second generation for the benefit of the poor of the first generation. The stark allocation just proposed for the first generation will, and should, be softened in practice by charitable care, which in part responds to the difference between utility and wealth. Medical assistance is not, and should not be, an all-or-nothing set of choices.[26]

The complete passage should make evident that the import of my remarks was only that wealth should be *one factor* that private institutions take into account in allocating health care. I certainly have no intention of banning charitable allocations, or even knowing just what trade-offs should be universally regarded as appropriate on this most delicate question. Quite the opposite, it is the absence of any clear direction on this question that counsels in favor of a decentralized approach that is necessarily blocked when health care receives the egalitarian dimension that Reinhardt attributes to it.

It is also instructive to take up Reinhardt's first challenge: why allow any differences in health care levels at all, regardless of the ability to pay? His strong egalitarian position need not be confined to health care, but could cover food, clothing, shelter, and education, as well. Yet all industrialized nations have shied away from that position for good reasons. Redistributing wealth once acquired ignores the initial obstacles to wealth creation. The incentive effects do not control all discussion, for one could easily support a modified form of progressive taxation on the ground that some redistribution is desirable even if perfect equality of incomes is not. Reinhardt, however, gives no reason why these intermediate solutions (some of which are achieved

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[23] *See* EPSTEIN, *supra* note 5, at 31-37.

[24] *Id.* at 115.

[25] *See* Reinhardt, *supra* note 2, at 1447.

[26] EPSTEIN, *supra* note 5, at 115.

in part by voluntary means) should be rejected in favor of his more categorical command. In so doing, he reveals his own political tin ear, by failing to locate the key popular objection that helped to doom the Clinton Health Security Act in 1994. Many Americans were quite happy to support a system that guaranteed some degree of *minimum* rights of health care to the poor, but were very reluctant to take the next step of embracing a system of *equal* rights to health care.[27] Reinhardt never examines the trade-offs between wealth creation and wealth distribution. Nor does he offer a public-choice explanation as to how a legal system that allows state-coerced redistribution will go as far as some imagined social optimum, but no further. General programs for income redistribution have not done well; why expect them to prosper here?

Reinhardt's position suffers from additional difficulties in that it may well require that *more* money be spent on the health care of the poor than on that of the rich. Thus Reinhardt does not factor in the frequency of accident or illness as a function of wealth. But these adverse consequences surely occur with higher frequency among the poor than the rich, if only because the rich can spend more on disease and accident prevention before entering the health-care system. Any egalitarian system should also seek to control the *probability* of suffering adverse events, and thus should be required to authorize the massive shifts in wealth needed to equalize these life chances. How much more redistribution should be required and why?

These problems are only compounded by the occurrence of disease and injury. The successful treatment of illness and injury does not depend solely on the level of expenditures for health care. It also depends on the level of care that the individual patient and his family supply as well. Keeping an adequate diet, doing exercises, avoiding forbidden foods, following medical regimes, and a thousand other things large and small also help improve the prospects of success from medical or surgical treatment. The human capital that parents bring to the care of their children makes a great difference in their rates of recovery. Equalizing health outcomes among children requires, in addition to equal medical care, the provision of extensive nonmedical services that invade every area of private life. And still the incentive problem remains.

Just how much do we value equality? Would we prefer a system in which all children have a success rate (however defined) of fifty percent, to one in which some children succeed at sixty percent and others at ninety percent? The pure egalitarian has to favor the former to the latter. Concerned parents of all income brackets will favor the latter. But perhaps that scenario is too optimistic. It could be that the second system helps poor children only forty percent of the time, and

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[27] *See id.* at 199-200.

rich eighty. Behind a veil of ignorance could we still prefer the egalitarian approach even though it reduces overall levels of health-care success, and, of course, overall life chances? It takes a lot of risk aversion to drive that conclusion.

The problems of this aggressive egalitarian regime also bite at the personal level. Let us suppose that parents are willing to spend their entire income in order to save the life of their own child. Are they bound to put all this money into some public trust for children at large, from which they can capture only a minuscule fraction of the total gains for their own child? A strong egalitarian position requires just that result, and it is defensible only on a view of human nature that presupposes that individuals should not, and do not, have any preference for their own flesh and blood relative to the welfare of total strangers. I submit that this extravagant position is so far removed from anyone's conception of human obligation and morality that it should be rejected out of hand. This is *not* to say that human empathy plays no role in helping strangers. Many charitable initiatives are funded by wealthy people who do not want others to suffer from the diseases that have afflicted them or their family members.

The richer psychology rejects the egalitarian position in favor of one that allows private individuals to work out their conflicting impulses as well as they can. And here the outcome makes sense. To see why, consider this functional test to see whether health is a special good. Compare the distribution of resources devoted to health care to that of resources devoted to other activities. My guess is that across the board, even in societies without any coerced redistribution, the distribution of health-care services is tighter than the income distribution. But it is one thing to guess at tendencies, and quite another to support them with hard empirical proof. But even if this point is wrong, we still know the major efficiency costs of coercive, state redistribution. The burden still remains on those who think that state-run programs can outperform the combination of market mechanisms and charitable behavior that I defend in *Mortal Peril.*

II. CONCRETE PROGRAMS

One way in which to make this case for positive rights is, therefore, to look at concrete programs that seek to advance them. The papers in this symposium seek to make that case with three different programs: community rating, the provision of emergency care under the Emergency Medical Treatment and Active Labor Act (EMTALA), and by reference to Medicare. I think that these arguments largely fail.

A. *Community Rating*

Of all the recent programs regulating access to health care, community rating appears to receive the highest level of public support. Community rating cuts against the grain of a market system because it refuses for insurance purposes to allow firms to categorize individuals in accordance with their individual risk; instead it requires that all individuals within certain broad bands be treated in the same fashion regardless of individual differences among them, including those attributable to diagnosed preexisting conditions.[28] Accordingly, individuals are combined into larger groups whose members are charged rates, which if not uniform, nonetheless do not reflect the variation in risk of their individual members. The healthier members of these groups thus supply an implicit subsidy to the sicker members of these groups. No direct public expenditures are involved, at least as long as the overall rate covers the losses generated within the pool.

In *Mortal Peril*, I took the position that these programs should be rejected as a matter of first principle.[29] My opposition comes in two forms. The first, and more extreme version of the criticism, is that the state has no business at all to engage in redistribution from one group of individual citizens to another, regardless of need. As such we do not have to worry about the size or the direction of the cross-subsidy. All are subject to equal condemnation. The weaker version of the position (which should have greater public appeal) takes a different tack by allowing subsidies payable from general revenues while rejecting cross-subsidies limited to individual participants of a given insurance pool. This position rejects requiring individuals to pay for each other's health coverage simply because they are lumped together, perhaps involuntarily, in a common employer health plan. Ultimately, this argument favors transparency, which requires the government body that authorizes the transfer to fund the shortfalls from public revenues. Mark Hall questions why I should be opposed to community rating given that it avoids direct tax contributions and seeks to preserve private insurance markets by fine-tuning their rate structures.[30] But as a defender of small government, I am less worried about the nominal dollars funneled through the tax system than the secret dislocations brought about by "off-budget" regulations. By putting the expenditure on budget, the state can no longer say to plan members "let's you and him fight." Rather, the parties that dictate the transfer payment are required to foot the bill. The feedback mechanism is therefore more direct: the inability to gain political support for general revenues reduces the size and impact of the program,

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[28] *See* MARK A. HALL, IS COMMUNITY RATING ESSENTIAL TO MANAGED COMPETITION? 9 (1994).

[29] *See* EPSTEIN, *supra* note 5, at 121-46.

[30] *See* Hall, *supra* note 19, at 766.

which is the preferred normative position. No one claims that this tax-driven feedback mechanism will stop all programs of redistribution, and, in a sense, that is just the point. The per se objection to the practice is relaxed, but the price for the program must be paid by those who champion its adoption.

The usual justification for community-rating programs speaks of their need to overcome market failure. But once again the question of definition is crucial. I have already commented on the mistaken equivalence between classical nonexcludable public goods and transfer programs.[31] Here it is only necessary to add that market failure does not include the incomplete penetration of insurance into all private markets. Rational individuals, with knowledge of their resources, behavior, and prospects need not all wish to acquire that insurance. And health insurers with similar knowledge may not wish to supply it. Thus for persons with known disabilities of a given severity, insurance is not possible in the absence of uncertainty as to the size of the loss. Health insurance here is not insurance at all, but a prepayment of medical expenses coupled with (perhaps) a management obligation to reduce their extent.

There is no self-evident reason why these contracts are preferable to private savings (or loans) coupled with personal management of expenditures. To show market failure requires a demonstration that potential transactions with gains on both sides do not occur. It is not sufficient to show that individuals cannot afford the coverage at a price they are willing to pay if the insurer loses money on that coverage. Here, as elsewhere, a voluntary market in exchange (charity to one side) works only to the extent that each party regards himself as a winner from the ex-ante perspective. The refusal of an insurance company to write coverage at a known loss to individuals who need it most is not a market failure if the premium offered does not cover the risk at hand, which under community-rating programs it does not. As I stressed in *Mortal Peril*, the objection to markets in this case is not that they suffer from imperfect or asymmetrical information. Rather, their information is so reliable that few bargains are available in the voluntary market. The issue with community rating is redistribution, not market failure. One way to defend that position conceptually is to side with Russell Korobkin in insisting that from behind a veil of ignorance all individuals would accept a system of social insurance that has some form of community rating at its core.[32] His basic argument makes good conceptual sense. Risk-averse individuals may want insurance to help them weather the storm in bad future states, even if they must sacrifice some income and wealth that they might enjoy in

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[31] *See* EPSTEIN, *supra* note 5, at 123-31.

[32] *See* Korobkin, *supra* note 6, at 817 (stating that the "benefits of community rating to individuals behind the veil of ignorance are relatively clear").

some good future state. Since people cannot voluntarily enter into community-rating programs at birth, the government must structure these transactions to leave everyone better off behind the veil.

That conceptual conclusion speaks, however, only to possibilities, not to practicalities. One possibility is that the utility of any given unit of wealth in the sick state is less than that in the healthy state, which counsels against community rating even if it supports some measure of redistribution in other domains.[33] That point is not one to which I attach great weight in the health-care context, for we are not speaking about mammoth tort awards that go to the family of the injured or deceased. We are talking about first-dollar protection for persons who need basic health care. I suspect that here the gains from wealth in the sicker state is one for which people would happily pay, which is why we have first-party insurance that covers out-of-pocket losses, even if it leaves uncompensated losses attributable to pain and suffering.

Yet the isolation of one positive effect of community rating does not make the comprehensive case for the practice without some sense of its overall incentive effects and administrative costs. These effects do not have to be uniformly negative, and indeed Hall has suggested that community-rating initiatives are often welcomed by insurance companies and brokers who do not wish to face the unpleasant task of telling individuals desperate to find coverage the grim news.[34] These gains, if true, cannot be overlooked simply because of some strong a priori sense that all programs of redistribution are designed to fail.

More critically, Hall is correct in claiming that the success or failure of community-rating programs could well depend on their details. Crude programs that require all insurers to take all comers at some fixed rate of insurance is an invitation for disaster that can roil an otherwise viable insurance market, just as Hall reports in his own studies of the fate of community rating for individual policies.[35] But

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[33] *See* David Friedman, *What Is "Fair Compensation" for Death or Injury?*, 2 INT'L REV. L. & ECON. 81, 81-83 (1982) (arguing that injured individuals receive comparatively lower benefits from monetary gain than uninjured individuals).

[34] *See* Hall, *supra* note 19, at 770.

[35] *See id.* at 774. The dislocations are not small. Some of the data contained in MERRILL MATHEWS, JR., BRIEF ANALYSIS NO. 251, EXPLAINING THE GROWING NUMBER OF UNINSURED (1998), show the gravity of the issue. The individual situation in New York state is reported as follows:

> - Before community rating was instituted in New York, a 25-year-old male on Long Island paid $81.64 a month for health insurance, and a 55-year-old paid $179.60.
> - After community rating, both paid $135.95, a 67 percent increase for the 25-year-old and a 25 percent decease for the 55-year-old.
> - Because young, healthy people began cancelling policies, by 1994 both paid $183.79—more than the 55-year-old was paying *before* community rating was implemented—and by 1997 that community-rated premium had risen to $217.59 per month.
>
> As a result of the departure of thousands, the uninsured population in New York City grew from 20.9 percent in 1990 to 24.8 percent in 1995, according to the report, while the national rate grew from 16.6. percent to 17.4 percent over the same period.

he claims that programs crafted with significant insurance company input can avoid these disasters by building in enough protections for the insurer so that the market remains viable notwithstanding the duty to take individual cases at a loss. In his view, this added measure of government complexity is well worth tolerating for the added peace of mind that it is able to provide.[36]

I have done no empirical work to evaluate his findings, but I still think that his analysis overlooks a number of critical factors that bear on the soundness of community rating, and our willingness to adopt it from behind the veil of ignorance. First, we cannot assess the soundness of the legislative initiatives on community rating without first asking how well an unregulated market would operate. In *Mortal Peril*, I urged readers to imagine a series of tripartite voluntary long-term contracts between firms and their employees that would facilitate the shift in employment without the loss of coverage.[37] If the change in jobs produces a net social benefit, without increasing the risk of adverse medical consequences, then some set of voluntary arrangements should be able to capture those gains. Both John Cochrane and I (he with more formal rigor than I possess) independently hit on a market scheme that could achieve that result.[38] Use long-term contracts whereby the insurer agrees to make a supplemental payment to the insured who switches jobs: in effect the first insurer pays the second to cover some portion of the known risk. This position does not differ markedly from common insurance policy riders that suspend payments of life insurance premiums during periods of disability. The long-term contract takes into account future risks that occur after its formation, as these can be priced by standard insurance practices.

The inability of firms and employees to form with these long-term contracts is something of a mystery that needs further investigation. It could be that the mechanics are too complicated to implement on a voluntary basis. If so, the case for community-rating plans is somewhat strengthened as a means to overcome the high transaction costs

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Once again note that the deterioration takes time to set in. The more graduated group programs of which Hall writes could easily have a less steep descent, but still end up in the same low place.

[36] I cannot resist protesting Hall's basic misunderstanding of the arguments I made in *Simple Rules for a Complex World*. He says that complexity is often welcome, and gives the example of newer automobile engines that have a more complex design, but which outperform earlier and simpler engines. Who could disagree? But my defense of simplicity in *Simple Rules* was not designed to direct the flow of automotive progress. It was to speak about the proper operation of legal regimes. A regime that respects contracts and prevents pollution is what is needed. If that takes complex engines, then fine. My book was about legal rules, not about technological improvements. The real question with the engines is the extent to which command-and-control technology makes them more complex than they ought to be, a common result of governmental regulation of environmental risks.

[37] *See* EPSTEIN, *supra* note 5, at 136-40.

[38] *See* John H. Cochrane, *Time-Consistent Health Insurance*, 103 J. POL. ECON. 445 *passim* (1995).

that block efficient voluntary exchanges. But alternatively, as I suspect is the case, state and federal regulation may make it difficult or impossible to enter into long-term contracts—which would bolster the case for deregulation instead of community-rating programs. After all, transaction costs should be low between parties who have already entered into a contractual relationship, as pricing the lump-sum payment needed on termination, while tricky, should not prove an insuperable task. But there are limits to this form of academic speculation. Some nonlawyer needs to find out how the long-term health-care market works, both with and without regulation.

But let us concede for the moment that the high-transactions-cost story is correct, and the regulatory obstacle story is false. We still have not completed the case for a community-rating system. It is still necessary to know just how well these will fare in practice. In making this calculation, we have to consider all the costs associated with the initiative as well. Legislative activity, replicated and refined from state to state, is never cheap; and the tab only gets higher with the proliferation of regulations needed to make the program operate. Those costs do not appear on the budget of the individual insurer or insured, but they are incurred as part of the social costs of the system. And it is worth noting that the much heralded Health Insurance Portability and Accountability Act of 1996 (the Kennedy-Kassebaum legislation or HIPAA) divides the task of enforcement among three departments of the federal government: Labor, Health and Human Services (HHS), and Treasury.[39] These costs, taken together, have to be far higher than the simple enforcement of ordinary contracts of insurance in accordance with their basic terms.

The problems cut still deeper. In his comments, Hall praised those programs that succeeded, and condemned those that failed. But before embarking down the road to community rating, one has to make some estimate of the relative chances of success or failure, given the danger of regulatory capture and excess that can subvert a legislative program from any direction. Here, if the dislocations are large, then the net improvements that Hall detects in some programs may be substantially reduced or completely offset by the disasters introduced in others. Worse, nothing guarantees that successful programs with built-in safeguards today will remain successful in the long run. On this score we can take a lesson from Medicare, whose financial difficulties did not begin instantly with passage, but rather grew out of the major restructuring of its finances that took place in relative obscurity about eight years after it passed.[40] That political risk can never be ignored. The sound programs that Hall praises are more likely to be

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[39] For an account, see General Accounting Office, *Health Insurance Standards, New Federal Law Creates Challenges for Consumers, Insurers, Regulators*, 19 (visited Oct. 26, 1998) <http://www.access.gpo.gov/su_docs/aces/aces160.shtml>.

[40] *See* Epstein, *supra* note 5, at 147-52; Hayward & Peterson, *supra* note 17, at 13-24.

corroded over time as interest groups seek to bend the rules in their own direction. Private markets are more resistant to these pressures because exit and entry possibilities keep established players in line. State monopolies, on the other hand, can easily misbehave because exit and entry options are effectively constrained, and private parties will dodge and squiggle to avoid entering into known losing contracts. This showing that the program worked in the first three years of its operation would, if true, therefore be the source of only limited comfort. The danger of its disintegration over time is too large to ignore.

Whether that will happen is hard to say, but some evidence contradicts Hall's sunny appraisal. In his report, Hall uneasily claims that the New York rating program, which went

> cold-turkey to pure community rating (no variation for health status or for age/gender), experienced no significant rate shock and no substantial loss of enrollment in the small group market. Since the law was adopted, small group enrollment grew from 927,000 in 1993 to 950,000 in 1995 but has dropped to 851,000 in 1996.[41]

That last figure might not be accurate and 1997 could be better, but New York is a large state, and the one year drop is in excess of ten percent of the covered population.

Nor is that distressing evidence alone. The HIPAA removed the power of individual insurance companies to deny coverage to individual members because of their health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of a participant or beneficiary—dumb in my view, but designed to insure portability of coverage between jobs and coverage for preexisting conditions for individuals who left the work force. Hall rightly corrects my earlier error in saying that the Act covered rate regulation as well as the inability to decline coverage.[42] The statutory omission may prove important. The Kennedy-Kassebaum bill was widely hailed at the time of its passage, when it commanded 421 to 2 votes in the House and 98 to 0 in the Senate (yet another reason why no one should ever call me a Republican). Yet, the current situation is not as rosy as Hall's earlier analysis suggests. The General Accounting Office (GAO) study suggests that all is not well with the program. Thus, Robert Pear wrote in the *New York Times* "that people who exercised their rights under the law were often charged premiums far higher than the standard rates. And the GAO study said that some companies discouraged insurance agents from selling policies to people with medical problems, the very people who were supposed to benefit from the law."[43] More generally, insurers insisted on

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[41] Hall, *supra* note 19, at 772.

[42] *See id.* at 765 & n.15.

[43] Robert Pear, *High Rates Hobble Law to Guarantee Health Insurance*, N.Y. TIMES, Mar. 17, 1998, at A1. For corroboration, see General Accounting Office, *supra* note 39, at 1-8.

increases in the "range from 140 to 600 percent of the standard rate" to cover the additional risks. Those moves were promptly denounced by Senator Kennedy, who then urged a general system of price controls, whose ravages he is incapable of understanding.[44]

Amid all the clamor, however, there was no showing that the premiums in question were excessive in relation to the risk covered, and naturally, Senator Kennedy showed no willingness to use public funds to make up the predictable short fall. The situation already could be quite grave, because the strong protections offered by the federal program could easily preempt the more delicate compromises worked out under state law, for which Hall rightly shows more affection. But once the door to systematic redistribution by cross-subsidy is unlocked, then runaway programs remain a political risk. And if so, the ensuing turmoil will be unfortunate. Individuals will seek to exit insurance plans that do not give them a fair shake. The premiums that must be charged to those who remain will have to increase to reflect the loss of healthy members. Some plans will go belly up in the process, making it all the more difficult to get coverage for hard-to-place risks. The total level of insurance coverage will go down, and the calls for general state intervention, including comprehensive price controls, could lead to systems that would make Hall blanch, but which could pave the way for the Byzantine forms of national health-care insurance that went down in ashes with the Clinton Health Security Act of 1994. These are large costs to pay for sharing in Hall's optimism of legislative fine-tuning.

B. EMTALA

A second source of concern that is exhibited in these papers concerns the response to EMTALA, which was passed in 1986, during the second Reagan administration. EMTALA requires hospitals to provide a preliminary medical screening to any person who requests treatment in an emergency department, and, if necessary to hospitalize and provide treatment to any person suffering from an emergency medical condition or who is in active labor until his or her condition is "stabilized."[45] The obligation in question is imposed without regard to the ability to pay, and is excused only if the individual patient requests in writing a transfer after being informed of his rights under the Act, or, in the alternative, if the treating physician certifies that the transfer is in the best interests of the patient, even if his condition is unstabilized.[46] EMTALA does not require any hospital to establish

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[44] *See* Pear, *supra* note 43, at A1.

[45] *See* 42 U.S.C.A. § 1395dd(c)(1) (West 1992).

[46] *See id.* For an account of the statute, see BARRY R. FURROW ET AL., HEALTH LAW §§ 12-2 to 12-12 (1995).

an ED, but it does require that all "available" facilities be used to discharge its obligation.

In *Mortal Peril,* I attacked EMTALA and urged a return to the common-law rule, which allows all hospitals and charitable institutions to determine which cases they will treat, and how they will treat them. My main argument was, and is, that private institutions will do a better job in providing emergency care if freed of the uncompensated, state-imposed obligations. To be sure, EMTALA may supply some individuals treatment that they might not have otherwise received. But the net social benefits are sure to be overstated if EMTALA's negative consequences are ignored because they are deemed indirect. Most hospitals are likely to provide some level of emergency care free of charge wholly without regard to the statutory obligation, especially those with religious affiliations. Indeed, most of the studies that led to the passage of EMTALA were flawed in serious ways. In examining the situation, Congress relied far too much on anecdotes of individuals being improperly turned away at the ED door. At their best, these anecdotes are only single data points. At their worst, they are stories spun to mesh with the political position that they are designed to bolster. In *Mortal Peril*, for example, I mentioned my unformed doubts about the death of Terry Takewell, who did not receive treatment at the local Methodist Hospital, which had received such prominence in the EMTALA hearings.[47] Professor David Hyman's far more exhaustive account of that case, and of several similar incidents, shows that my skepticism was, to say the least, warranted.[48]

Hyman was equally critical of the more systematic studies of the patients "dumped" from private to public hospitals. He noted that these tended (1) to ignore the number of cases treated by the hospitals charged with dumping, (2) to ignore the good medical reasons that might have explained some transfers, and (3) to overstate the costs to the recipient hospitals from the transfers by using the list price for services rendered in the paying market, and not the marginal cost of the services supplied—a far lower figure.[49]

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[47] *See* EPSTEIN, *supra* note 5, at 94.

[48] *See* Hyman, *supra* note 14, at 813-24. Among the particulars that were mentioned by Hyman were these: that Zettie Mae Hill, who testified against the hospital, did not observe the critical events, *see id.* at 817, that she had written a veiled threat to the hospital stating that it should "forget about my bill or I'm going to split the hospital wide open," *see id.* at 821; that Takewell had turned down offers to zero out his earlier bills; that he had been examined by several physicians; and that he had exhibited the erratic behavior, including lying and poor judgment of noncompliant diabetics who did not take their insulin, *see id.* at 814-16; that he had spent his money for insulin on alcohol and drugs, including cocaine, *see id.* at 816; and had walked out of the hospital on his own after speaking with administrators but against the advice of his own physicians. *See id.* at 817. It is not a pretty picture. There is certainly no EMTALA violation on these facts, and serious questions arise as to how much public funds should have been spent, let alone compelled, to keep Takewell alive.

[49] *See* Hyman, *supra* note 14, at 856-57. These studies include HUMAN RESOURCES DIV., GENERAL ACCOUNTING OFFICE, HEALTH CARE: PATIENT TRANSFERS FROM EMERGENCY ROOMS IN D.C. GENERAL HOSPITAL (1987); David U. Himmelstein et al., *Patient Transfers:*

Driven by these alarmist accounts of the actual situation, EMTALA implemented its statutory solution outlined above. How then should we think about the desirability of the statute? Korobkin once again places us behind the veil of ignorance and uneasily assumes that some level of risk aversion would lead people to favor the adoption of an EMTALA scheme. But here risk aversion does not speak with a clear voice. To be sure, *given* the existence of ED facilities, the risk-averse person would want to be assured access. But the question of concern to that person is not the legal entitlement, but the probability of securing that assistance when needed. If, therefore, the factual evidence on improper exclusion or patient dumping overstates the risks of the pre-EMTALA world, then the case for legal protection is surely diminished. The Rawlsian case against EMTALA is made more potent once it is recalled that efforts to reduce risks in one dimension may only enhance risks in a second. What risk-averse person would countenance the breakdown or even contraction of the entire system? Yet just that seems the likely scenario. Hospitals unable to meet the heavy obligations of EMTALA will seek to reduce their exposure by reducing the number of ED services that they make available.

One critical question, therefore, is whether the skeptical prediction of these indirect effects turns out to be accurate. In *Mortal Peril,* I recounted two sorts of evidence that tended to back up that pessimistic view. First, there is the experience at the University of Chicago hospitals, which after much deliberation withdrew from the emergency ambulance network rather than assume the heavy burdens that the city wanted to impose on it as a condition of participation.[50] Second, I noted the GAO study reporting the extensive decline in the number of trauma centers in high-crime urban centers.[51] Brennan does not deny these figures, but notes that in many urban centers, "it does not make any economic sense to close the emergency department," given that such a center is needed for regular patients and for well-insured persons in need of medical care.[52] He then notes in particular that when the University of Chicago withdrew from the ambulance network, it did not close down its ED, nor did it escape the

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Medical Practice as Social Triage, 74 Am. J. Pub. Health 494 (1984) (study of Highland General Hospital, Alameda, California); Arthur L. Kellerman & Bela B. Hackman, *Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee*, 78 Am. J. Pub. Health 1287 (1988); William Gary Reed et al., *The Effect of a Public Hospital's Transfer Policy on Patient Care*, 315 New Eng. J. Med. 1428 (1986); Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 New Eng. J. Med. 552 (1986) (study of transfers to Cook County Hospital, Chicago).

[50] *See* Epstein, *supra* note 5, at 96-98.

[51] *See* Human Resources Div., General Accounting Office, Trauma Care: Life Saving System Threatened by Unreimbursed Costs and Other Factors (1991); Epstein, *supra* note 5, at 96.

[52] *See* Brennan, *supra* note 2, at 354-55.

obligations of EMTALA.[53] He further notes that "the hospitals that are closing are those [that] do *not* have emergency departments, just the opposite of what Epstein would predict."[54] In support of this hypothesis, he presents tabular evidence, which indicates that from 1981 to 1994 the decline in the number of hospitals has been 14.2%, and the decline in the number of EDs has only been 9.1%, such that the percentage of hospitals with EDs increased from 85.1% to 90.1%, with a number of twists and turns in the middle.[55]

I have a number of queries about these observations. First, the withdrawal of hospitals from emergency care is not just an all-or-nothing phenomenon. To be sure, we have to worry about the closure of major trauma centers, but in addition we have to worry about the marginal adjustments made in those centers that do remain open. On this score, Brennan is, I think, wrong to assert that my view implies that hospitals with EDs will be more likely to close than to remain open. The more accurate statement is that hospitals will make their choices regarding the size, staffing, and configuration of EDs in a way that maximizes their utility as they see it. One element that goes into that equation is the gains obtained from keeping the ED open for customers whom the hospital wishes to serve, both paying and nonpaying. A second, and conflicting, element in the equation is the losses suffered from having to take patients into the ED that the hospital would rather not have to take, at least under the EMTALA rules. Before EMTALA, all the hospital had to do was to implement its own policy, which allowed it to treat each group of patients separately. It could expand size to help those patients whom it wanted to admit, without having to make commitments to those whom it did not choose to admit; and, more importantly, it could decide how much care to supply to each patient without thereby having to commit itself to like amounts of care to other patients who for whatever reason it thought were less deserving. Under these circumstances, a hospital has no incentive to constrain the size of its ED services to keep out unwanted business. It just has to exercise its right to say no—or no more—as the case may be.

But once EMTALA becomes law, the two elements are tied to each other. Now the hospital that wants to keep its ED available for some patients will have to find ways to make it relatively less accessible for others. The withdrawal of the University of Chicago hospitals from the ambulance network represented one way in which it tried to reduce its losses without cutting out the business that it wanted to keep. It, and other hospitals, could of course follow other strategies by manipulating other variables. First, advertising campaigns—where

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[53] *See id.*

[54] *Id.* at 354 n.10.

[55] For the complete data compiled by the American Hospital Association and the American College of Emergency Medicine, see Brennan, *supra* note 2, at 354 n.10.

and how one advertises has a good deal to do with the patients that one brings into a hospital. Second, the number of beds in the ED and the ICU—let those be closed and beds are no longer "available" under EMTALA. Third, the construction of new facilities at or off site—running an ED on a contract basis with a city or public department allows a private hospital to provide services without having to bear ultimate financial liability for losses. Fourth, staffing levels and affiliation agreements with other institutions—if these are structured well they allow private hospitals to fill up beds without having to rely on the ED. Doubtless an insider to this business knows more than I about how to fine-tune the mix in order to maximize the net profit from operating an ED subject to the EMTALA constraint. But the implication of my view is not that we should expect that surviving hospitals have closed EDs; rather it is that the hospitals that stay in business would alter their strategies in ways that are counterproductive in order to minimize the unfortunate impacts of EMTALA. As far as I can tell, just that is taking place.

C. Medicare

The last of the access programs that I shall discuss here is Medicare, which was defended by Professor Richard L. Kaplan in his article *Taking Medicare Seriously*.[56] I take his argument to be a tribute to invincible conviction. No matter how strong the evidence that something is seriously awry with a program, he has only one cure: to expand its coverage so as to eliminate current anomalies. He wants to allow for public payment of prescription drugs;[57] and to cover the costs of long-term nursing care at all levels.[58] In both cases his argument is that one effect of the broader coverage is to reduce the overall cost of the program. Having low-cost drugs could well reduce the need for hospitalization; and providing nursing home care could have the same effect. But that argument falsely assumes that these additionally covered items are only substitutes for what is now covered by Medicare—hospitalization and physician services. But these new items could also be complements as well as substitutes, such that the increase in the availability of prescription drugs and long-term nursing care will increase the willingness to see physicians or to undergo hospitalization (to make sure that the free or low-cost prescription drugs are properly administered).

In addition, Kaplan notes the difficulty of getting through any small reform that could well limit the scope of coverage, as for example by raising the age of Medicare eligibility by so little as a single year, or by means testing Medicare payments to reduce the public

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[56] Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777.

[57] *See id.* at 794.

[58] *See id.* at 795-98.

subsidy (but of course not the taxes) associated with the program.[59] Yet these reforms have gone nowhere because of the powerful opposition to them by Medicare recipients, at thirty-seven million strong.

Yet what is quite amazing about Kaplan's defense of the program is that he addresses only the needs of the Medicare recipients while ignoring the program's costs. The overconsumption of medical resources supplied at a zero price should pass for a self-evident proposition. But often it does not. Occasionally, it is argued that health-care expenditures are not subject to the standard moral hazard risks because individuals do not like going to the doctor, such that there is a nonprice constraint against the excessive consumption of Medicare services.[60] Yet the argument clearly misses at both a theoretical and a practical level. Theoretically, the cost to a patient contains two components, one price and the other nonprice. Even if the second component is high, it hardly follows that the level of consumption of services is unaffected by the price term. Unless the demand for services is completely inelastic, the usual conclusions hold, the larger the subsidy, the greater the levels of overconsumption. That conclusion holds true even if the nonprice term is substantial. The moral hazard issue remains serious and has to be faced, but Kaplan is silent as to how it should be addressed.

In his loyalty to Medicare beneficiaries, Kaplan is similarly insensitive to the real inequities generated by a Medicare system that imposes payroll taxes on families of limited income to generate extensive subsidies for older individuals. In response to the huge cost increases of the Medicare program, his only suggestion is that we rethink the current view of using the payroll tax as the exclusive source of funding for the program, and advocates, in effect, that taxes on investment income be directed toward Medicare expenditures. In one sense, I favor that position if only because large portions of the investment portfolio are held by elder individuals who benefit from the Medicare system. The expanded tax base would therefore supply a kind of rough justice. But the major objection to this proposal is decisive. The question here is not what method can be used to fund a subsidy program; but, rather, what social justification is there for generating the subsidy in the first place?

On this question, Kaplan makes one common error that replicates in small compass the error that Greely made about the funding of positive rights generally. He assumes that levels of Medicare expenditures are fixed and that the only movement in the system is how to satisfy its voracious appetite. That is surely true today given the thirty-three years that have locked us into Medicare. And I went to

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[59] *See id.* at 791-94.

[60] *See* Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1490-91 (1994).

great pains in *Mortal Peril* to explain how difficult the transition to any more sensible system would be.[61] It is not possible to ask individuals who are over eighty years of age to now fend for themselves on health care when they received strong assurances that they would be protected against this risk by public funds. But once again the right question to ask is how the situation would look if we had not adopted the Medicare program in 1965. And here the obvious point is that private individuals with knowledge of their longer life expectancies would make provisions in advance to provide themselves health-care insurance for their old age. One obvious advantage of this system is that small prepayments could fund relatively large benefits twenty or thirty years down the road given the miracles of compound interest. A second advantage of the private solution is that it will economize on the level of care provided and thus reduce the implicit subsidies that it will create. A third advantage of that system is that it would reduce the ongoing war between Congress and Medicare providers, which thus far has left us with the worst of both worlds: program recipients whose large appetites lead to ever larger program deficits, and institutions and hospitals who find themselves squeezed on reimbursement at every turn.

Clearly some portion of these difficulties should be attributable to the difficulty in organizing health-care markets in the best of all possible circumstances. The uncertainties in the demand for the services, and the difficulties in evaluating their quality do not just disappear because private contractual solutions are preferred to state-dominated ones. But the issue here is one of magnitudes. I find it difficult to defend a system in which "the elderly now spend a larger share of their income out-of-pocket on health-care than they did before [Medicare and Medicaid] existed."[62] Which system is likely to generate better information and better incentives to maximize net benefits? I am hard pressed to see how in the original position one could defend the Medicare program against its private alternatives. When Kaplan speaks of the need to keep the "promise of Medicare," he begs the one question above all that his essay should have addressed.

III. BIOETHICAL AND LIABILITY ISSUES

Let me turn now to the contributions that deal with questions of choice and access, the problems that I address in the second half of *Mortal Peril*. Here again I shall follow the organizational pattern from the book, and begin with a discussion of the paper by Laura

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[61] *See* EPSTEIN, *supra* note 5, at 174-81.

[62] JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 406 (1992). The differences were not trivial. The percentage was less than 8% in 1962 and 15% in 1992. *See id.*

Dooley and Robert Gaston on kidney transplantation, then turn to David Orentlicher's observations on physician-assisted suicide, and last make some comments about Gary Schwartz's observations about liability systems for medical injuries. The topics here are more focused than the free-ranging discussion of the broad issue of the right to health care, and so too will be my responses.

A. Organ Transplantation

My main objective in *Mortal Peril* was to advocate the emergence of a voluntary market for organ transplantation, which would alleviate the chronic shortage of available kidneys for transplantation. The price mechanism might induce an increase in supply. Market and charitable mechanisms on the demand side could remove the need for various government (or in the case of UNOS—the United Network for Organ Sharing—quasi government) mechanisms for organ allocation that rely on various formal criteria that are difficult both to articulate and to apply.

In their thoughtful comment on this section of *Mortal Peril*, Dooley and Gaston show partial sympathy for my willingness to use purchase methods to acquire organs.[63] But they are reluctant, to say the least, to allow a bid system to allocate the organs among recipients, fearing the spectacle of having the rich outbid the poor for organ transplants.[64] Although their position has carried the political day, I still continue to dissent. Other forms of medical care involve the side-by-side use of charitable and commercial ventures. A sharp egalitarian line on health care has been rejected in this country with the demise of the Clinton health-care plan, so I am hard pressed to see why that imperative should flourish for organ transplants or for any other specific subareas. The unwillingness to allow buyers to bid makes it far less likely that any system will emerge that allows the payment to organ donors: private bidders are far more likely to fuel the demand than government agencies strapped for cash and reluctant to participate in the venture. The upshot is a blockade on both sides of the market in the short run. And, in the long run, the refusal to allow bidding will, on balance, reduce the stock of wealth available in the next generation to care for the full range of charitable and commercial needs. The choice is often portrayed as one between 100 randomly chosen recipients and 100 wealthy ones. But that view ignores all dynamic elements that influence the long-term operation of the system. Are we so emphatic if a bidding system allows us to save 110 wealthy

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[63] *See* Laura G. Dooley & Robert S. Gaston, *Stumbling Toward Equity: The Role of Government in Kidney Transplantation*, 1998 U. ILL. L. REV. 703, 707 (quoting James F. Blumstein, *The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs*, *in* JUSTICE AND HEALTH CARE: COMPARATIVE PERSPECTIVES (Andrew Grubb & Maxwell J. Mehlman eds., 1995)).

[64] *See* Dooley & Gaston, *supra* note 63, at 708.

individuals instead of 100 randomly chosen, with greater gains in future generations?[65] Regrettably, the literature that condemns the injection of wealth into organ transplantation misdefines the problem and assumes that the choice of rule determines only *who* gets an organ transplant when it also determines in part *how many* people will get them as well. The desire to maximize the number of lives saved by transplantation thus is at war with the egalitarian ethic on access to transplantable organs regardless of the wealth of the recipient. The egalitarian ethic should come out in second place.

This concern with expected lives saved also arises with the main topic of the Dooley/Gaston paper, namely the relationship between equity and efficiency in kidney transplants, with special reference to the problem of race. Thus in *Mortal Peril*, I commented at some length on the studies that Dooley and Gaston, along with Ian Ayres, had written in defense of a UNOS allocation system that sought to increase the percentage of kidneys allocated to black recipients.[66] As these three authors so carefully documented, it has long been clear that black individuals with end-stage renal disease (ESRD) must on average wait far longer than white recipients to receive a kidney transplantation. This result is not, of course, the result of any conscious racial policy to place black recipients at the back of the queue. Rather it stems from two key factors. The first is the high incidence of kidney disorders among black recipients, traceable in large measure to their lower tolerance of salt in the standard diet.[67] As Dooley and Gaston write: "The incidence of ESRD in African-Americans from 1993 to 1995 (758 per million) was over four times that of Caucasians (180 per million)."[68] In and of itself, a fourfold difference in the rate of kidney disease need not influence the odds of receiving a kidney. If, for example, kidneys were allocated to recipients on a first-come, first-serve basis, then there would be no observable difference in the waiting time for black and white recipients: the larger percentage of blacks on the queue would advance at the same rate as whites.

It is just here that the second factor enters. Kidneys are not perfectly fungible among recipients. Rather, good "matches" result in a higher success rate than bad matches. The matches in question in turn depend on the correspondence in HLA-antigens between the kidney

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[65] *See* Epstein, *supra* note 5, at 112-15.

[66] *See, e.g.*, Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 Vand. L. Rev. 805 (1993); Robert S. Gaston et al., *HLA Matching in Renal Transplantation*, 332 New Eng. J. Med. 752 (1995); Robert S. Gaston et al., *Racial Equity in Renal Transplantation: The Disparate Impact of HLA-Based Allocation*, 270 JAMA 1352 (1993). For my earlier critique, see Epstein, *supra* note 5, 272-82.

[67] *See* Dooley & Gaston, *supra* note 63, at 714, noting as well that one selection factor could have been the deprivation during forced transfer to the United States as part of the slave trade.

[68] *See id.* at 713.

donor and the kidney recipient.[69] Everyone believes that the odds of survival improve with "perfect" six-antigen matches.[70] The controversy has intensified with disputes over what should be done with partial-antigen matches, where the matches could range from five down to one. Here, the traditional view adopted the position that the better the match, the higher the priority. It turns out, however, that matching is correlated with race: white recipients will on average do better with kidneys from white donors and black recipients will do better with kidneys from black donors. The older technical criteria pushed these differences to the limit in order to maximize the expected number of lives saved by kidney transplantations. The unavoidable side effect was to advance white recipients to the head of the queue and push black recipients to its rear. It was this manifest racial impact of race-neutral policies that led to the counterattack on the older rules resulting in the adoption by UNOS of a rule that awards additional points for "rare antigens." As Dooley and Gaston note, these extra points will often, but not exclusively, be awarded to African-American patients.[71]

Dooley and Gaston defend this position on two grounds. The first one is medical and claims that an exhaustive review of the evidence shows that for partial-antigen matches the differential success rates are so small that they are not worth worrying about.[72] Stated otherwise, the technical matches do not generate any increase in the number of lives saved once the perfect six-antigen matches are put to one side. I have no technical competence to dispute this claim and will accept it as true in all that follows.

The second part of their exposition, however, is subject to more direct criticism. It goes to the objectives of the overall system of allocation within the current UNOS framework. They state the goal of the system as follows: "[E]very patient who enters the queue for kidney transplant should have roughly the same chance of receiving one."[73] As stated, that test looks like an unexceptionable endorsement of the principle of equal access in a nonmarket setting, and Dooley and Gaston chastise me for thinking that it represents the spillage of political intrigue into a high-minded ethical and scientific inquiry.[74] But the philosophical inquiry is in fact more complex than this appealing formulation suggests. The alternative system of kidney allocation also rests on a neutral principle of some allure: let the kidneys be allocated to maximize the number of expected lives (weighed

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[69] "HLA antigens are proteins on the surface of tissues that enable the immune system to distinguish foreign tissues." *Id.* at 704 n.4.

[70] *See id.*

[71] *See id.* 705 n.9.

[72] *See id.* at 721.

[73] *Id.* at 706-07.

[74] *See id.* at 705.

by quality-adjusted years) saved. That goal could be further refined to take into account quality of life concerns, or the number of years that the lives are saved. But for these purposes these refinements are beside the point. The key questions are: (1) does the Dooley and Gaston proposal of equal chances differ to any material degree from the objective of saving the maximum expected lives, and (2) if they do differ, which criterion should be preferred?

From the outset, some tension is there. As Dooley and Gaston note, at present blacks constitute about one-eighth of the population yet have one-third of the cases of ESRD, and the rate of ESRD is over four to one black to white.[75] To make matters simple, assume that the six-antigen matches yield a success rate of 0.75 lives saved per kidney transplanted, while the less-than-six-antigen matches all generate a success rate of 0.50 lives saved. The realism of these numbers is not my concern: all that matters is the indisputable fact that recipients on the six-antigen matches outperform the less-than-six-antigen matches. Here no one, least of all Dooley and Gaston, argues that we should ignore this piece of information, and award all kidneys at random. Yet so long as white recipients receive more of those six-antigen matches, then for this class the only way to maximize the expected number of lives saved is to allocate the non-perfect-match kidneys to black recipients on an overtly preferential basis.

To see why, assume that there are sixty kidneys to go around in a pool of thirty black candidates and sixty white candidates, roughly the ratio of the recipient pool. For these individuals, assume that twenty-one whites give six-antigen matches with white recipients and three give six-antigen matches with black recipients (a ratio which reflects the difference in the donor pool). Once these are allocated to their preferred recipients, then twenty-seven black and thirty-nine white individuals remain in the pool, with only thirty-six kidneys left to allocate. The appropriate one-to-two black/white mix of kidneys requires ultimately that twenty be given to black recipients and forty be given to white recipients. Taking into account those allocated in the first round, nineteen of the remaining kidneys must go to white recipients and seventeen to black ones. A random draw in the second pool could not achieve the desired result, given that thirty-nine whites and twenty-seven blacks are left in the pool, which implies that just under forty-one percent of the second round will go to black recipients, instead of the needed allocation of just over forty-seven percent. In effect, therefore, the Dooley/Gaston program requires a race-conscious allocation in the bottom half of the draw to offset the necessary racial skew in the top-half. In this case, favoring black applicants in the second half of the draw leads to no increases or decreases in expected lives saved, so that the practice is neither required nor forbidden by a

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[75] *See id.* at 713.

criterion that seeks to maximize the number of expected lives. And the outcome appears to satisfy the Dooley/Gaston desire to equalize the waiting time of all individuals on the queue, and with no apparent efficiency loss.

Yet even here all might not be well. Suppose, for example, that the total number of kidneys was below thirty. Now if twenty of these are perfect matches with whites, the idea of equal access cannot be achieved unless some perfect matches are sacrificed, since more than two-thirds of the kidneys are allocated to whites given their six-antigen priority. In principle at least, the two goals come into conflict and some choice has to be made. It looks as though everyone, including Dooley and Gaston, would choose to stick with the perfect matches no matter what the consequences to recipients down on the queue.

More importantly perhaps, the trade-off between social efficiency and equity cannot be settled solely by looking at the life chances of recipients given transplantation. Equal attention has to be paid to the life chances of individuals who do *not* get kidney transplantation. Here, one alternative is dialysis, which by every account usually leads to a miserable existence.[76] But dialysis is usually not as bad as death: the government pays for it, and people with ESRD often accept it when no kidneys are available. The test of expected lives saved requires one to consider the fate of those who are left behind without donated kidneys. In particular, consider individuals with less than six-antigen matches who are now assumed to have equal prospects of success in transplantation. For these people, the criterion holds that the kidneys *always* should be given to those individuals who will do on average *least* well on dialysis.

The logic is as follows. Assume two groups of individuals. Everyone in group *A* has expected lives saved on dialysis of 0.2, and everyone in group *B* has expected lives saved on dialysis of 0.1. Both groups yield 0.5 lives saved through kidney transplants. Assume that the total pool of 100 individuals is divided equally into the two groups. If there are only fifty kidneys available, then *all* of them should go to the members of group *B*. Taking that course yields 50 (0.2) + 50 (0.5) = 35 lives saved, 10 from group *A* and 25 from group *B*. Reversing the priority yields 50 (0.5) + 50 (0.1) = 30, for a loss of 5 lives. Splitting between the two groups equally yields a difference of 2.5 lives. Indeed, every shift of a kidney from group *A* to group *B* costs on average 0.1 life.

Now the evidence suggests, as Dooley and Gaston acknowledge, that black individuals for whatever reason tolerate dialysis somewhat better than white individuals.[77] If so, then the expected lives principle equates them with group *A* and whites with group *B* and justifies on a

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[76] *See id.* at 718.

[77] *See id.* at 717.

color-blind criterion the traditional white preference on kidneys in imperfect matches *not* because of the superior results that whites get on transplantation, but because of the *inferior* results that whites get on dialysis. Certainly, if we were told that the two groups were divided by eye color or height, then there would be little counterweight to picking that group of individuals with the highest rate of return. The question is why race calls for a different result.

Dooley and Gaston seek to wiggle away from these implications by assuming that my analysis presupposes an "implicit equation" between dialysis and transplantation.[78] In support of that view they note that dialysis is a far inferior alternative to kidney transplantation. Acknowledged and agreed, for all persons. But this truth does not make the social problem disappear, for the above examples operate on their assumptions. All that they presuppose is that transplantation is better than dialysis; they do not deny that dialysis is better than death. It is this realistic assumption that forces us to choose between the Dooley/Gaston criterion of equal access and the alternative of maximum lives saved. I have little doubt that the latter is the better test, no matter which way the chips fall. Indeed for all I know this criterion may not lead to the stark dichotomy set out above, for some identifiable subgroups of black individuals might fare worse on dialysis than identifiable groups of white recipients, at which point any state system of kidney allocation should flip over to reflect that fact. But none of these complications saves the Dooley/Gaston *criterion* of equal waiting times for kidney allocation. To take the starkest case, suppose *for sure* that the Dooley/Gaston system led to kidney allocation that resulted in saving fifty black and forty-nine white recipients, while the alternative system resulted in the saving of sixty white and forty black recipients. Is there any moral reason to prefer the ninety-nine lives saved to the one-hundred lives saved? That is the ultimate question involved. Neutral rules can be used to achieve either of these two results. But it takes some doing to explain why less should be preferred to more, all else being held equal. Nothing since I wrote *Mortal Peril* leads me to think that so long as we operate within the UNOS framework, we should abandon the goal of using the number of available organs to maximize the number of lives saved, for both those who receive organs and those who do not. Within the present political context, the proper ideal remains the utilitarian credo, each person counts for one, and only for one.

B. *Physician-Assisted Suicide*

The next topic covered in *Mortal Peril* was physician-assisted suicide, a question on which I announced myself to be very much of two minds. As a matter of sound social policy, I believe that physician-

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[78] *See id.* at 718.

assisted suicide in cases of terminally ill patients should be legalized, but not as a matter of constitutional law. The basic argument proceeded as follows. Individual claims for autonomy should be understood as a matter of principle to cover the right to end one's own life if one so chooses. The effort to treat individual life as though it were a divine gift which has to be preserved at all costs makes for dramatic recitation, but not for sound philosophical treatment. So long as individuals are entitled to refuse medical treatment, or even nutrition and hydration, then there is no reason in principle to require that they be forced to linger, perhaps with unbearable pain, when they have it within their means to hasten their own death. And so long as people prefer that others assist them in their final act, they should be allowed their choice of means to fit the end. Not only should physician-assisted suicide be allowed, but active euthanasia should be allowed as well.

The question of physician-assisted suicide and active euthanasia has a second dimension that is more difficult to deal with: abuse and incompetence. People in the pink of health rarely contemplate physician-assisted suicide. Rather, that course of action is demanded when sick people are struggling to cope with circumstances beyond their control, often under the influence of family members who may have agendas of their own. It is always an open question whether the decision for physician-assisted suicide represents a fair estimation of one's own choices or whether it is obtained by dubious means. The level of disagreement on this question is quite substantial, and the choice of mechanisms that can be used to respond to it quite extensive. In the face of great debate over the operation of the practice, it seems the course of wisdom not to create constitutional rights on the installment plan. So long as issues of overinclusion and underinclusion are at stake, some degree of legislative experimentation seems appropriate. A Supreme Court, leery perhaps of entering into a reprise of the abortion struggles of the past generation, has now rightly decided to take a pass on physician-assisted suicide.[79]

In general, David Orentlicher's views on assisted suicide are sympathetic to my own,[80] so I shall concentrate my attention only on the issues that separate us. Both points of contention concern the much-belabored distinction between withdrawing treatment on the one hand, and active euthanasia and physician-assisted suicide on the other. As I read him, Orentlicher has a somewhat schizophrenic atti-

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[79] *See* Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

[80] *See* David Orentlicher, *The Alleged Distinction Between Euthanasia and the Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain*, 1998 U. ILL. L. REV. 837 [hereinafter Orentlicher, *Alleged Distinction*]. *See generally* David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663 (1996); David Orentlicher, *The Supreme Court and Physician-Assisted Suicide*, 337 NEW ENG. J. MED. 1236 (1997) [hereinafter Orentlicher, *Supreme Court*].

tude to this distinction, regarding it as incoherent at one point, but as a useful proxy on the issue of genuine consent at another. I think that he is wrong on both issues.

In dealing with the conceptual foundations of the distinction between killing and letting die, Orentlicher initially states that "a right to euthanasia was effectively granted when the Supreme Court recognized a right to refuse life-sustaining treatment in *Cruzan v. Director, Missouri Department of Health*."[81] I think that this point is wrong. *Cruzan* itself only involved a case that sought to withdraw life-support treatment. The question of physician-assisted suicide was expressly kept off the table.[82] It is one thing to argue that in the absence of any strong conceptual distinction between killing and withdrawing treatment, the decision in *Cruzan* should not stand. But it is quite another thing to argue that the Supreme Court has taken that position. For better or worse, it has accepted the traditional distinctions between these two states of affairs, and meant its ruling to apply only to the withdrawal of treatment, not to the active termination of life. Conceptually, the distinction is perfectly maintainable, in the sense that triers of fact can decide which practice has taken place. It is one thing to withdraw a feeding tube. It is another thing to strangle a patient. We might prefer to allow the second if we are prepared to allow the first, so long as both are done with the patient's consent. But that is a judgment that goes to the relevance of the distinction, not to our ability to put cases on one side of the line or the other.

Orentlicher seeks to escape this position by noting that in *Glucksberg*, Justice Breyer made explicit mention of the right of patients to receive terminal sedation, that is, pain-killing medicine that places the individual into a coma.[83] Orentlicher's argument is quite simply that, given this concession, the physician need not kill. He need only sedate his patient into a coma and then let her die for want of nutrition and hydration. That would indeed be a form of active euthanasia, hardly different in kind from knocking one over the head with a two-by-four and then inserting a syringe for blood to leak out. But the point does not generalize. In order for it to work, it must be established that terminal forms of sedation could be used on any and all patients. Orentlicher claims that "[w]hile in practice, terminal sedation seems to be limited to terminally ill patients, there is no reason in principle why it must be so limited."[84] But of course there is. The doctrine of double effect may countenance actual killing in some cases, namely, those where the alleviation of pain requires dosages of palliatives that block respiration. But the doctrine hardly allows lethal

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[81] Orentlicher, *Alleged Distinction*, *supra* note 80, at 839 (citing 497 U.S. 261 (1990)).

[82] *See Cruzan*, 497 U.S. at 268.

[83] *See* Orentlicher, *Alleged Distinction*, *supra* note 80, at 838; *see also* Orentlicher, *Supreme Court*, *supra* note 80, at 1236.

[84] Orentlicher, *Alleged Distinction*, *supra* note 80, at 855 n.103.

dosages of any drugs for persons who are not in pain. In short, there is every reason to limit the use of terminal sedation to terminally ill patients, for only in those cases can we find justification for ending life. Otherwise, the practice does have ominous implications for medical care and for the prohibition against suicide in the cases where it matters.

In an odd turn of events, Orentlicher later finds use for the distinction between withdrawal of treatment and physician-assisted suicide. He maintains that our basic social principle is that individuals have a right to end their life when life becomes intolerable. "We in fact respect decisions to refuse life-sustaining treatment out of the moral sense that people should be able to choose death when they are irreversibly ill and suffering intolerably."[85] It is, however, costly to make individual determinations as to when that state of affairs comes to pass. The distinction between physician-assisted suicide and euthanasia, on the one hand, and withdrawal of treatment, on the other, functions as a useful proxy for distinguishing genuine exercises of personal autonomy from those that are coerced or uninformed.

I have no doubt that Orentlicher is correct that we often have to use proxies when evidence on ultimate issues is hard to find. We do adopt minimum-age rules for drinking and driving precisely because we have to avoid the costly case-by-case determinations on individual fitness. But by the same token, our proxies have to fit the underlying data fairly well. No one would defend a minimum driving or drinking age of six or twenty-six, because neither comports well with our sense of when most individuals are fit to drink or to drive. The proxies work best when the variation about the median is likely to be small, and the costs of sorting individual cases high. Even when we resort to proxies, we need not rely on them conclusively. Just about anyone can drink at age twenty-one. But individuals are not allowed to drive just because they turn sixteen. Rather, they are eligible to take tests that will gain them a license. The risk of harming other individuals is too great to make age a both-ways test on driving. Too young may exclude; but old enough requires a second round of individual determinations.

These complexities with proxies arise in cases of physician-assisted suicide. The reason why we do not allow consent as a defense to murder is that we are quite convinced that most individuals wish to preserve their own lives.[86] In the basic case, the background presumption is so strong that we think that we will make far more mistakes if we allow (dubious) evidence of prior consent is to killings when the victim cannot protest the outcome. But how strong is that background presumption when individuals are terminally ill? It has to be far weaker. The impulse to end one's own life is likely to be far

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[85] *Id.* at 851.

[86] *See* EPSTEIN, *supra* note 5, at 300-05.

greater, so here it is defensible to create institutions that allow for physician-assisted suicide or active euthanasia. My disagreement with Orentlicher is not that the change in background condition should lead to a change in legal response. It is with his new-found conviction that the distinction between withdrawing treatment and physician-assisted suicide, or active euthanasia, is a serviceable proxy for any of the relevant issues.[87] It is not. The key variable is that of terminal illness, which is operative in both cases of withdrawing treatment and active euthanasia or physician-assisted suicide. But the choice of ending one's own life depends on all sorts of judgments about how long a person is likely to linger if life supports are removed, the emotional support from one's family, and religious beliefs about the relevance of the killing/letting die distinction. Likewise, a patient's wishes can be disregarded in withdrawal cases just as they are in cases of physician-assisted suicide and active euthanasia.[88] The key relevant background fact is terminal illness. For the rest we have to rely on individual determinations, and a set of social mechanisms that control against the prospect of abuse or overreaching. It is pursuing this program, and not any unnecessary diversions from it, that promises the greatest chance for social progress in a highly conflicted field.

C. Liability for Medical Accidents

My last comments are directed toward Gary Schwartz's observations on the final section of *Mortal Peril*, which deals with liability for medical accidents. In this section, I pursue a theme that I have advanced (without real practical success) for over twenty years, namely, that medical malpractice and hospital liability should be governed by private contracts, and not by state-imposed rules of liability.[89] The explanation is simplicity itself. The ordinary contract between two informed parties results in expected gains for both sides. Each party has an incentive to accept deals that leave it better off than before, so that any contract produces mutual gains for the parties which, absent any negative third-party effects, contribute to overall social gains. To be sure, contracting in medical areas raises matters of competence, but government intervention is not the only means to overcome these difficulties. Frequently, a parent or guardian can, and does, act on behalf of individuals who by virtue of age or illness are unable to contract for themselves. In many other contexts, individuals who are uneasy about

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[87] "With euthanasia or assisted suicides on the other hand, we have good reason to suspect that the person's choice is not a genuine expression of autonomy." Orentlicher, *Alleged Distinction*, *supra* note 80, at 851.

[88] *See generally* David Orentlicher, *The Limits of Legislation*, 53 MD. L. REV. 1255 (1994); The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments*, 274 JAMA 1591 (1995).

[89] *See generally* Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. BAR FOUND. RES. J. 87 (1976).

their own general knowledge can, and do, form groups which rely on third-party professionals to negotiate for them. Employers, unions, and churches often undertake the role of being, or finding, a trusted intermediary.

Although somewhat sympathetic to this contractual approach, Schwartz raises a number of concerns about its application. His initial sally is to puzzle why contract solutions are needed today when tort law has reigned in medical malpractice areas from, at the latest, the mid-nineteenth century.[90] The concern with medical malpractice was raised in the professional literature of both law and medicine during the nineteenth century. Why then depart from established practice today, especially when the negligence remains operative?

The answer comes in several parts. First, why assume that the older tort system was optimal even in the early days? It could easily be that the system was less than ideal but nonetheless was good enough so that no group thought it was worthwhile to refashion the rules through legislation. Second, in at least one particular instance, the rules did differ: the scope of charitable immunity was far greater in the nineteenth century than it is today, and to the extent that hospital liability was an issue, the rejection of charitable immunity toward the middle of this century did introduce a substantial change in liability rules. Third, the question of the desirability of tort liability is not simply a function of the doctrinal structure of the legal rules. What matters is the level of transfer payments that takes place under them. Negligence is a pliable system; proof is an uncertain exercise; damage awards can vary over the lot. A good deal of mischief has come from the preoccupation that negligence rules are efficient because they purport to use the cost/benefit formula associated with Learned Hand's famous B>PL formula in *United States v. Carroll Towing Co.*[91] But the formula at most concerns one corner of the overall system of negligence. The frequency and severity of claims under a fixed doctrinal test can vary enormously over time, as indeed has been the case with medical malpractice. And it can vary enormously by county within a single state. For example, in Illinois, tort damage awards in Cook County are higher than those twenty miles away in DuPage County, and the insurance rates reflect that difference.[92] Similar variations can be found between different regions in other states as well.

It is precisely because the locational rules differ so much that a contract approach is needed: in those locations where the liability problem is securely in check, contractual experimentation will be a rarity. In those areas in which the costs of medical malpractice pres-

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[90] *See* Gary T. Schwartz, *Medical Malpractice, Tort, Contract, and Managed Care*, 1998 U. ILL. L. REV. 885, 896-99.

[91] 159 F.2d 169, 173 (2d Cir. 1947). The chief mischief-maker in this regard is still Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29 (1972).

[92] *See* EPSTEIN, *supra* note 5, at 386.

ent some threat, some contractual response is appropriate. The solutions could vary by region, by facility, or by specialty—it hardly matters. The contractual approach is preferable because players in the field have greater awareness of the bumps in the malpractice road than any court or jury. They do not have to look at overall averages, but can respond to the variations that can separate business success from business failure. Competition among rival health-care providers will place an effective check on the enthusiasms of a single institution or firm. If everyone independently moves to some contractual restrictions on malpractice liability, chances are that some good structural reason lies behind the change. There is strength in redundancy.

The movement to a contractual regime does not, of course, leave the legal system with nothing to do. Contracts have to be interpreted and default provisions have to be announced in the case of silence. Schwartz fears that my analysis is mired in the fee-for-service tradition of the 1970s, and that I have not sufficiently addressed the important interactions that could develop between the novel forms of medical delivery through various managed-care organizations, which might not thrive under the existing tort rules.[93] Perhaps I should have spent more time in dealing with the issue, but the point only strengthens the case for some contractual solution. The greater variation in the form in which health-care services are delivered, the greater the expected variance in the set of optimal contract terms. It may well be that rural groups, poverty clinics, large research hospitals, and halfway houses with different staffing conditions work best under different legal arrangements. Then by all means let them copy from each other when appropriate, and strike out in novel ways when faced with distinctive problems of their own.

The greater density of the legal organization has clear implications for the value of even the best default term. Most critically, if this variation in the provision of medical services does increase, then any standard default term will fall in value. Accordingly, we should see a market develop in contractual terms where parties develop their own approach, imitate key terms used by other firms, or follow some combination of their own approach. One reason to support the contractual approach is because we have little knowledge at the center about the optimal set of terms for the many entities that emerge in the health-care market. If we could predict the terms well enough to draft ideal default provisions, then this problem would be less acute than it is. But since we cannot, we should avoid the effort to impose a false pattern on the marketplace, and let the interplay of voluntary forces determine the outcome. The rapid change of the current situation makes this approach more imperative than ever before.

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[93] *See* Schwartz, *supra* note 90, at 899-906.

The basic argument here holds true notwithstanding the important shift in the use of managed-care organizations to supply health-care services. As Schwartz rightly notes, the key innovation of a managed-care system is that it abandons the traditional view that based compensation on the level of the services physicians rendered to covered patients. The effort to price these individual services, and to determine which were necessary and which were not, were constantly overwhelmed. One new strategy shifted to basic capitation arrangements that supplied the health-care facility (and through it the individual physician) with a payment of so many dollars per covered life for any given period. Yet in the face of marketplace resistance, still more complex approaches have been tried.

The shift in system from one to the other did not and could not eliminate all conflicts of interest between the health-care organization on the one hand and the individual physician on the other. With cost-plus reimbursement, the tendency was for physicians to supply unneeded services from which they could recoup the gain. Under the capitation systems used for managed care, the temptation is surely the opposite: to economize on services in order to allow the physician to pocket as large a share of the fixed fee as possible. This tendency is, of course, not unknown to the institutional employer who is in a position to modify the arrangement so that, for example, some portion of the physician's compensation is fixed, or depends on the performance of his group, and not just his own work. And there is little doubt that managed-care organizations engage in ceaseless modification of the compensation arrangements to reduce the costs that this conflict generates (and the costs incurred to monitor any deviation from optimal care).

The question one has to ask is what effects, if any, the judicial control over the terms of medical-malpractice liability has on the operation of these various arrangements. Schwartz sees in them the possibility of serving as a corrective against the temptations to which individual physicians might succumb in their own right. And he thinks that the imposition of tort liability might be necessary in order to curb the short cuts that employers are prepared to take in negotiating these health-care plans on behalf of the present (and retired) employees.[94]

Starting with this last point, Schwartz is surely correct to note that some slippage is always in the system. But how much? The employees who are short changed by poor medical coverage do have options. They can quit and work for another firm that provides for better health benefits. Or they can complain to the employer and demand additional assistance outside the parameters of the standard health plan. Or their loss of time and productivity could so inconvenience

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[94] This conflict was also stressed by Patrick Atiyah, *Medical Malpractice and the Contract/ Tort Boundary*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 287, 296-97.

the employer that it is better off supplying more comprehensive coverage that hustles key employees back to work or obviates their need to take personal days to offset the poor medical care supplied to members of their immediate family. The key question is, what is the strength of these feedback mechanisms? Given the salience of health care to ordinary Americans, I would say that it is quite substantial. The immediate concern of employers may be the cost of coverage; but the scope of coverage surely plays into the overall calculations. And on this point, nothing is more destructive to the success of employer-purchased plans than state and federal mandates that require certain minimums in coverage. If the minimum is in the joint interest of the parties, why require it by law when people will adopt it anyhow? If it is not wanted by the parties, then why impose terms whose negative expected value reduce the overall efficacy of the health-care program? The real danger here is a double whammy that Schwartz nowhere discusses. Broad coverage is required by positive law, which also fixes the rules governing medical malpractice liability.

But what of the former claim that malpractice liability in tort is needed to counteract the evils of undertreatment brought on by the capitation system? In evaluating these claims, one concession is too obvious to require detailed explanation. The contractual provisions that limit access to service will not generate the optimal result in all cases. No set of contractual terms can eliminate all the conflicts of interest in any institutional setting. And when a single set of contractual arrangements must govern thousands, or indeed millions, of cases the law of large numbers suggests that at least some incident will generate horrible results no matter what liability rule governs. The great genius of the plaintiffs' bar is its ability to pick the most graphic cases to overcome whatever contractual defenses could be raised.

The litigation to which Schwartz refers demonstrates just that risk. The health-maintenance organization (HMO) denies a woman suffering from advanced breast cancer the bone-marrow transplant that holds out the only slim chance of recovery. After her death the jury slaps the defendant with $12 million in actual damages and $77 million in punitive damages.[95] Wow! The first impulse is to ask why the HMO should be castigated for denying an experimental treatment that holds out little chance of success in cases of advanced breast cancer. The second is to ask how likely it would be that this treatment would have made the difference even if administered. The third is to ask whether the appropriate institutional judgment is to bankrupt all HMOs by allowing verdicts of this sort to destroy their cost structure and eat away at their profits: after all, many of the major HMOs have

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[95] This litigation is discussed by Schwartz, *supra* note 90, at 903, and earlier in Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1362-69 (1994).

had major distresses with their profit pictures in the last few years.[96] Other horror stories provoke the same response. The real danger in these cases may not be that HMOs provide insufficient service, even if on balance their overall performance is no worse than other forms of health care. Indeed in the midst of the general denunciations of HMOs "the evidence shows that managed care has curbed medical inflation without compromising the quality of care."[97] Any systematic evidence of this sort would come out in a system of comprehensive review that looked at the outcomes over some broad class of cases. But that careful sampling is exactly what medical-malpractice litigation avoids. Today the real danger is that the bad cases generate huge adverse verdicts while the success stories go largely unreported and unrewarded.

That fundamental asymmetry in results could prove so strong that the use of tort liability against HMOs, far from having special needs, instead carries with it special perils. It is difficult perhaps to summon populist indignation before a jury against an individual physician who could never afford to pay the kinds of judgments that are lodged against HMOs. But make an impersonal and heartless cost-cutting corporate entity the defendant, then it is at the mercy of every person who has been frustrated with the medical services he has received. Schwartz has made the common mistake of identifying one incentive effect that might call for greater judicial scrutiny and concluding that it should dominate the analysis. But other unnoticed effects of greater magnitude could easily cut in the opposite direction. If they do, then sailing forth on the seas of tort law could easily bring the worst tendencies of coercive state power to bear in these malpractice actions.

In this environment it becomes clear why it is that large institutional defendants would seek to veer away from the jury system and seek arbitration for their claims, even if they are not allowed to vary by contract the substantive rules of liability. In this regard it is instructive to comment briefly on the experience with the Kaiser Permanente arbitration plan in California, which in 1976 received a qualified blessing from the California Supreme Court in *Madden v. Kaiser Foundation Hospitals*,[98] only to be subject to sharp criticism for an evidently woeful performance in *Engalla v. Permanente Medical Group, Inc.*[99] No one should be pleased by plans that take forever to appoint arbitrators and visit swift retaliation on arbitrators that award

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[96] *See e.g.,* Charles Stein, *HMO Profits Take Big Dive in 1995*, BOSTON GLOBE, May 22, 1996, at 34.

[97] *Patient or Profits?*, ECONOMIST, Mar. 7, 1998, at 15. For a longer account, see *Health Care in America: Your Money or Your Life*, ECONOMIST, Mar. 7, 1998, at 23-27. "Yet the evidence suggests that, overall, the HMO has not only saved a fortune (thus helping to keep America's health-care arrangements affordable) but has done so while maintaining and sometimes improving upon previous medical standards." *Id.* at 24.

[98] 552 P.2d 1178 (Cal. 1976).

[99] 938 P.2d 903 (Cal. 1997).

large verdicts against the health-care provider. But it is far less clear what the appropriate response should be. One avenue is for management to clean up its internal act, which the Kaiser plan seems to be doing in response to criticism from its major corporate clients who feel the heat whenever this portion of its benefit package underperforms. Another is to try to add some further guidance to the arbitrator, and it is here, ironically, that the refusal to allow contracting out on substantive terms may hurt the arbitration by making it impossible for the medical program to reduce the variation in awards below the level found in the judicial system.

In and of itself, it could be claimed that variance is of no consequence so long as the health plan knows the mean award: after all, the law of large numbers makes the insurance program a self-insurer in spite of itself. But that view is too optimistic. First, the larger the variation, the larger the amount of resources that both sides will use to win particular cases. Hence the administrative costs of the system increase relative to the amount of resources transferred, compounding the dead weight losses of the system. Second, the high variance may make it difficult for the firm to determine the mean award against it, for the cases coming over the horizon could differ in some dramatic way from those already seen. That uncertainty about the mean makes it more difficult to price liability and hence the overall cost of services. How ironic it would be if the reason arbitration is compromised is because it must use the doctrines inherited from the state-tort law system. Freedom of contract may well not thrive by half measures.

IV. CONCLUSION

The full range of observations and criticisms raised in these responses to *Mortal Peril* indicates that choosing the proper legal regime for health care is indeed a taxing task. In seeking to answer my critics, I have not disposed of all objections; nor have I tried to make the claim that the common-law regime of negative rights carried over to health care will handle all cases in an ideal way. But once again the key question that must be asked is, "compared to what?" The great danger of policy analysis in this area is to assume that strong counterexamples can overthrow a coherent system of rights. That is just not the case. The real question is whether the system that is substituted in its place suffers from greater flaws and perils than the system it seeks to overthrow. That requires a long and careful analysis of the various proposals, one which shuns the temptation to treat all errors of the common-law rules as subject to sensible correction by direct state intervention, and all errors from state intervention as correctable only by greater, or more intrusive, forms of state intervention. Heads-I-win, tails-you-lose is not an intelligent way to make social policy. Yet all too often errors in execution of any set of legal rules are found to justify more government intervention, but never less. As error is endemic to all institutions, market solutions are displaced by state solutions; and one for state intervention is displaced by one that is still more heavy-handed in its operation.

In *Mortal Peril*, I have argued that this approach is both dangerous and self-destructive. The central thesis of the book is that when direct and indirect effects are taken into account, the classical regimes of contract, property, and tort do a better job in organizing our social relationships than the torrent of regulations and judicial decisions that seek to create positive rights to health care on the one hand, or interfere with the contractual choices of autonomous individuals on the other. These fundamental principles have worked well in other contexts. If given their fair chance, they could go a long way to cure the malaise of the current health-care system.