POSTSCRIPT

DEFINING AN "ADEQUATE" PACKAGE OF HEALTH CARE BENEFITS

PAUL E. KALB†

America's health care system is in a state of crisis. We spend far more per capita on health care than any other nation, yet almost 15% of our population lacks health insurance, and an even larger percentage has coverage that is insufficient to protect them in the event of serious illness. Although in fundamental disagreement over how to resolve this crisis, academics, policy-makers, and the American public appear to agree on one central goal of health care reform: At a minimum, all members of our society should be provided with an "adequate" package of health care benefits.

Despite this common goal, little attention has been paid either to the meaning of "adequate" health care or to the content of an "adequate" package of health benefits, in large measure because of a prevailing sense that "adequate" care—and hence "adequate" coverage—cannot be defined. This prevailing sense is misguided. We most likely can develop an actual, ethically justifiable "adequate" minimum package of health benefits, and we should initiate serious efforts to do so. Developing such a package would provide us with both a clear objective for health care reform and a standard against which to measure the success of reform efforts.

I. THE HEALTH CARE CRISIS AND THE PROPOSED SOLUTIONS

In 1991, we spent $738 billion on health care, almost 14% of our Gross National Product,[1] and approximately 34% more per capita than any other country.[2] Despite this massive outlay, an estimated 31 to 36 million Americans have no health insurance,[3] and tens of

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† M.D. 1983, Boston University School of Medicine; J.D. 1990, Yale Law School.

[1] *See* Philip J. Hilts, *U.S. Health Bill Expected to Rise by 11% for '91*, N.Y. TIMES, Dec. 30, 1991, at A10 (reporting Commerce Department estimate).

[2] *See* Dale A. Rublee & Markus Schneider, *International Health Care Spending: Comparisons With the OECD*, HEALTH AFF., Fall 1991, at 187, 191.

[3] *See* Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991) (reporting results of National Medical Expenditure Survey, U.S. Bureau of the Census survey, Employee Benefit Research Institute survey, and National

millions of others are "inadequately protected against the possibility of large medical bills."[4]

Substantial evidence now supports the intuitively obvious links between inadequate health care coverage, poor health care, and poor health. Many uninsured are denied care altogether;[5] many others, concerned about cost, voluntarily delay seeking care.[6] Even when they gain access to the health care system, the uninsured frequently receive less intensive care than equally ill patients with insurance.[7] And several studies now demonstrate the correlation between inadequate care and poor health. Uninsured newborns, for example, have a higher incidence of adverse outcomes than insured newborns,[8] and those who have lost their Medicaid coverage as the result of state cutbacks have higher mortality rates than those who retained coverage.[9]

In the absence of systemic reform, the health care crisis will

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Health Care Expenditures Study).

[4] Pamela J. Farley, *Who Are the Underinsured?*, 63 MILBANK MEMORIAL FUND Q. 476, 499 (1985). The uninsured are disproportionately poor, Hispanic or black, and male. *See* Friedman, *supra* note 3, at 2491-92. Over half of the uninsured are full- or part-time workers, and more than one-fifth are children. *See* M. Eugene Moyer, *A Revised Look at the Number of Uninsured Americans*, HEALTH AFF., Summer 1989, at 102, 105-06.

[5] *See, e.g., Equal Access to Health Care: Patient Dumping, Hearing Before a Subcomm. of the House Comm. on Gov't Operations*, 100th Cong., 1st Sess. 4-5 (1987) (statement of Rep. Ted Weiss, Chairman, Human Resources and Intergovernmental Relations Subcommittee) (citing a study suggesting that an estimated 250,000 patients in need of emergency care are "dumped" every year from one facility to another for economic reasons); *see also* Fernando M. Trevino et al., *Health Insurance Coverage and Utilization of Health Services by Mexican Americans, Mainland Puerto Ricans, and Cuban Americans*, 265 JAMA 233, 237 (1991) (finding that uninsured Hispanics are less likely than Hispanics with private health insurance to have a regular source of health care, to have visited a physician in the past year, or to rate their health status as excellent or very good); Lisa Belkin, *Health Care on the Border, Poor Go to Mexico*, N.Y. TIMES, Oct. 17, 1988, at A1 (reporting that it is "common" for uninsured Americans "who have given up on the American health care system" to seek medical care in Mexico).

[6] *See* John Billings & Nina Teicholz, *Uninsured Patients in District of Columbia Hospitals*, HEALTH AFF., Winter 1990, at 158, 161-62.

[7] *See* Paula A. Braveman et al., *Differences in Hospital Resource Allocation Among Sick Newborns According to Insurance Coverage*, 266 JAMA 3300, 3303 (1991); Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome*, 265 JAMA 374, 378 (1991).

[8] *See* Paula A. Braveman et al., *Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982 to 1986*, 321 NEW ENG. J. MED. 508, 510-11 (1989).

[9] *See* Victor Cohn, *Rationing Medical Care; It's Here–and This Is Just the Beginning*, WASH. POST, July 31, 1990, at 10, 11 (reporting the results of a Rand Corporation study).

undoubtedly worsen. Health care costs, driven in large measure by technological development and an aging population,[10] will likely continue to rise as they have for the past several decades. In response, self-insured companies and private insurers will continue to seek ways to avoid insuring individuals who are likely to require intensive health care.[11] In addition, public funds will likely become increasingly scarce, particularly in the absence of significant economic growth. Neither the federal government, facing an unprecedented budget deficit, nor the states, facing unprecedented budgetary problems of their own, can increase significantly their outlays for health care without cutting their outlays for other critical services.[12]

To remedy the (apparent) shortage of health care resources in this country, we ration resources—i.e., we allocate resources among competing individuals—through an ad hoc combination of market mechanisms and bureaucratic rules. Individuals who can afford insurance, who work for employers who provide insurance as a benefit of employment, or who qualify under certain byzantine rules[13] for various governmental benefits programs have reasonable access to health care services. Others for the most part struggle for access to decent care—often in emergency rooms and understaffed public hospitals—and hope to avoid financial ruin.

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[10] *See* HENRY J. AARON & WILLIAM B. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE 117-18 (1984); Stuart H. Altman & Stanley S. Wallack, *Is Medical Technology the Culprit Behind Rising Health Costs? The Case For and Against, in* MEDICAL TECHNOLOGY: THE CULPRIT BEHIND HEALTH CARE COSTS? 24, 25 (Stuart H. Altman & Robert Blendon eds., 1979).

[11] *See, e.g.*, Milt Freudenheim, *Employers Winning Right to Cut Back Medical Insurance*, N.Y. TIMES, Mar. 29, 1992, at A1 (noting recent federal court rulings exempting self-insured employers from state insurance laws that mandate coverage for certain illnesses); Gina Kolata, *New Insurance Practice: Dividing Sick From Well*, N.Y. TIMES, Mar. 4, 1992, at A1 (reporting that the insurance industry is increasingly embracing "practices that weed out the sick").

[12] Most states currently face budget problems that are at least as severe as the more-publicized budgetary difficulties of the federal government. *See* David S. Broder, *Recession, Soaring Medicaid Costs Put the Squeeze on State Budgets*, WASH. POST, Apr. 18, 1991, at A3; Robert Pear, *A Double Dose of Pain for the Poor*, N.Y. TIMES, Apr. 7, 1991, § 4, at 1; Martin Tolchin, *States Take Up New Burdens To Pay for 'New Federalism,'* N.Y. TIMES, May 21, 1990, at A1; David Von Drehle, *In States Large and Small, Governors Greeted by Sea of Red Ink*, WASH. POST, Jan. 9, 1992, at A23.

[13] Eligibility for Medicaid, for example, depends on a number of factors, including the presence of children in a family, the ages of the children, whether a woman is pregnant, the presence of a major disability, and income. *See, e.g.*, HEALTH CARE FIN. ADMIN., MEDICAID: A BRIEF SUMMARY OF TITLE XIX OF THE SOCIAL SECURITY ACT 1-6 (1991) (describing Medicaid eligibility criteria).

Despite agreement that our health care delivery system is in many respects arbitrary and inequitable, there is, as this symposium demonstrates, substantial debate about how best to reform it. Some suggest that the key, at least in the short term, lies in eliminating waste. They argue that we already devote adequate (indeed, more than adequate) resources to health care, but that we use these resources inefficiently. They argue further that the savings generated by efficient use of these resources would easily cover the cost of providing insurance for all those who are currently uninsured.[14] In support of their argument, advocates of this view point most notably to exorbitant administrative costs[15] and the widespread use of technologies that are unsafe, ineffective, or non-cost-effective.[16] As Professors Blustein and Marmor point out in this symposium, however, both defining "waste" and identifying and eliminating "wasteful" practices are technically complex processes fraught with difficult ethical and policy judgments.[17] Thus, "wasteful" practices, although inviting targets in the abstract, cannot easily be eradicated.

Others, either in search of a more immediate solution or skeptical of attempts to eliminate waste, focus on the question of how to redirect some of our health care resources to those with inadequate coverage. At one end of the spectrum, Professor Blank advocates more aggressive centralized administrative planning.[18]

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[14] Among those presenting arguments of this sort are: John E. Wennberg, *Outcomes Research, Cost Containment, and the Fear of Health Care Rationing*, 323 NEW ENG. J. MED. 1202, 1203 (1990); Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1256 (1991); Theodore Marmor & Jerry Mashaw, *Checking the Nation's Pulse: America's Health Insurance Fever*, WASH. POST, Sept. 17, 1991, at C1.

[15] *See, e.g.*, Woolhandler & Himmelstein, *supra* note 14, at 1255 (estimating savings of $69.0 to $83.2 billion in 1987 if health care administration in the United States were as efficient as in Canada); Spencer Rich, *Study Finds R_x for U.S. in Canada Health Plan*, WASH. POST, Oct. 18, 1991, at A19 (reporting study by the Economic and Social Research Institute estimating that $4.2 trillion would be saved over the next decade if U.S. switched to Canadian-style health care system). *But see* Patricia M. Danzon, *Hidden Overhead Costs: Is Canada's System Really Less Expensive?*, HEALTH AFFAIRS, Spring 1992, at 21, 21 (arguing that current cost comparisons are misleading because they ignore several "hidden" costs).

[16] *See, e.g.*, Paul E. Kalb, Note, *Controlling Health Care Costs By Controlling Technology: A Private Contractual Approach*, 99 YALE L.J. 1109, 1112 (1990) (defining these terms).

[17] *See* Jan Blustein & Theodore R. Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1545 (1992).

[18] *See* Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Rationing*, 140 U. PA. L. REV. 1573, 1595-96 (1992).

Professors Havighurst and Anderson, among others, advocate greater reliance on individual choice, contractual solutions, and the free market.[19]

This spectrum of academic views is reflected in the array of practical proposals for health care reform placed on the public agenda during the past several years. Those who favor greater centralized planning and control, particularly over funding, advocate the adoption of a "Canadian" style health care system, in which the federal government would insure all Americans and take advantage of its monopsony power to control costs.[20] Market advocates look to create incentives to join managed care programs and favor tax breaks for individuals who purchase their own health insurance.[21] Centrists favor broader access to existing governmental health care programs (or to a new unified government health plan) and requirements that all employers with more than a minimal number of employees "play or pay," i.e., either provide their employees with health care coverage or pay a surtax to a fund earmarked for health care benefits.[22]

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[19] *See* Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1641-43 (1992); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1757 (1992).

[20] *See, e.g.*, Julie Rovner, *Congress Feels the Pressure of Health-Care Squeeze*, CONG. Q., Feb. 16, 1991, at 414, 419 (describing proposals by the National Association of Social Workers and Physicians for a National Health Program); *see also* Robert J. Blendon & Jennifer N. Edwards, *Caring for the Uninsured: Choices for Reform*, 265 JAMA 2563, 2564-65 (1991) (analyzing thirteen reform proposals).

[21] *See, e.g.*, Carl J. Schramm, *Health Care Financing for All Americans*, 265 JAMA 3296, 3299 (1991) (advocating a program of expanded health care allocating responsibility jointly between the public and private system); Robert Pear, *Bush to Propose Income Tax Credit for Health Costs*, N.Y. TIMES, Jan. 5, 1992, at A1 (outlining President Bush's proposal, which would provide tax credits to stimulate the purchase of health insurance); Spencer Rich, *Senate GOP Task Force Unveils Plan to Expand Coverage for Health Care*, WASH. POST, Nov. 8, 1991, at A4 (detailing a Republican plan to increase access to health care and contain spiraling health costs).

[22] *See, e.g.*, Rovner, *supra* note 20, at 419 (describing the plans offered by the Pepper Commission, the National Leadership Commission on Health Care, and the American Medical Association); Michael Abramowitz, *AMA's New Face*, WASH. POST, Oct. 8, 1991, at Z10 (describing the American Medical Association's proposal).

II. COMMON GROUND: "ADEQUATE" HEALTH CARE COVERAGE

Beyond their differences, the proposed solutions to the health care crisis appear to share a common, though often unstated goal: to provide all Americans with access to an "adequate" level of health care services, i.e., a package of health care benefits that is in some sense reasonable or sufficient. These plans for the most part do not define the content of "adequate" coverage. It is clear, however, what they do *not* envision. They do not envision coverage for an *identical* set of services for each member of our society. Even under the relatively egalitarian "Canadian" model, for example, individuals can purchase health care services not covered by national health insurance. Moreover, these plans do not envision coverage for all services that might benefit each individual. Indeed, only market-based approaches contemplate individualized health care coverage, and no market theorist advocates providing each individual with sufficient funds to purchase *all* potentially beneficial necessary health care.

The goal of providing all members of society with an "adequate" minimum of care for all has strong ethical underpinnings. Although most American ethicists and policy-makers believe that individuals should have the liberty to spend their resources on those health care services they prefer,[23] most recognize that a health care system that permits individuals to spend their resources as they choose can be ethically justified only if each member of society has access, at a minimum, to some "adequate" or "basic" package of health care services. As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated in the early 1980's, we cannot, and should not, attempt to "[p]rohibit[] people with higher incomes . . . from purchasing more care than everyone else gets [because such a policy] would not be feasible, and would probably result in a black market for health care."[24] Nonetheless, "the special nature of health care dictates that everyone have access to *some* level of health care."[25] The

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[23] This liberty can be justified on a number of grounds, including economic efficiency. *See* James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal and Policy Analysis*, 59 TEX. L. REV. 1345, 1350 (1981).

[24] *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE 18-19 (1983) [hereinafter 1 SECURING ACCESS].

[25] *Id.* at 20. The Commission considered health care "special" because it promotes "well-being," "opportunity," and information about health, and because a society's commitment to health care "reflects some of its most basic attitudes about

Commission defined that level as "'an adequate level of health care.'"[26]

Given the shared acceptance and obvious importance of the goal of providing universal access to some "adequate" minimum of coverage, surprisingly little attention has been paid to the nature of such coverage. With the notable exception of Norman Daniels and several others, few academics have paid serious attention to this issue.[27] Similarly, few empirical efforts have been made to define an "adequate" package.

Indeed, only two groups, the Health Policy Agenda Ad Hoc Committee on Medicaid and the State of Oregon, have undertaken serious efforts to define an actual "adequate" package of health benefits. According to the Ad Hoc Committee, the "adequate" package of care should include "physician services; inpatient and outpatient hospital services; laboratory and roentgenogram services; prescription drugs; institutional care for the elderly and the physically or mentally disabled; dental services; early and periodic screening, diagnosis, and treatment services; family planning services; home health and personal care services; and other medically necessary professional services."[28] Under Oregon's plan,

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what it is to be a member of the human community." *Id.* at 16-17. For a more specific justification of the "special" nature of health care, as well as a criticism of some of the Commission's justifications, see *infra* note 34 and accompanying text.

[26] *See* 1 SECURING ACCESS, *supra* note 24, at 20 (relying on, among other works: Allen Buchanan, *The Right to a Decent Minimum of Health Care, in* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 2 SECURING ACCESS TO HEALTH CARE 207 (1983) [hereinafter, 2 SECURING ACCESS]; Norman Daniels, *Equity of Access to Health Care: Some Conceptual Issues*, 60 MILBANK MEMORIAL FUND Q. 51 (1982), *reprinted in* 2 SECURING ACCESS, *supra*, at 23 app. B; David Gauthier, *Unequal Need: A Problem of Equity in Access to Health Care, in* 2 SECURING ACCESS, *supra*, at 179 app. H; Allan Gibbard, *The Prospective Pareto Principle and Equity of Access to Health Care*, 60 MILBANK MEMORIAL FUND Q. 399 (1982), *reprinted in* 2 SECURING ACCESS, *supra*, at 153 app. G; Harry Schwartz, *Access, Equity, and Equality in American Medical Care, in* 2 SECURING ACCESS, *supra*, at 67 app. D).

[27] *See* NORMAN DANIELS, JUST HEALTH CARE (1985); *see also* Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55 (1984) (discussing the philosophic basis of the right to a "decent" level of health care); Daniel Callahan, *Ethics and Priority Setting in Oregon*, HEALTH AFF., Summer 1991, at 78, 82-83 (discussing the failure of Oregon's plan to provide an objectively "adequate" package of benefits); David C. Hadorn & Robert H. Brook, *The Health Care Resource Allocation Debate: Defining Our Terms*, 266 JAMA 3328, 3330-31 (1991) (attempting to define a "basic benefit plan"); H. Gilbert Welch, *Health Care Tickets for the Uninsured: First Class, Coach, or Standby*, 321 NEW ENG. J. MED. 1261, 1263-64 (1989) (discussing "coach class" health care for the uninsured and what it will buy).

[28] James R. Tallon, Jr., *A Health Policy Agenda Proposal for Including the Poor*, 261 JAMA 1044, 1044 (1989).

the adequate minimum package of care is comprised of the greatest number of services on a prioritized list developed by the state that the state can afford annually.[29]

Both of these packages, as well as other packages that might be considered models of "adequate" coverage,[30] provide coverage, at a minimum, for a relatively similar core of services—including hospital care and basic preventive and diagnostic testing—that most would agree should be part of any basic package of benefits. But neither can conclusively be considered "adequate," because each was developed in a relatively ad hoc manner and not by reference to any independently justifiable principle of adequacy. The contents of the Health Policy Agenda's package reflect only the good-faith judgment of a committee of experts. And Oregon's package, while reflecting public priorities to some extent, ultimately reflects the state legislature's judgment about how much it can afford to spend on health care, rather than its judgment about how much care is objectively "adequate."[31]

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[29] *See* John Kitzhaber, *Uncompensated Care–The Threat and the Challenge*, 148 W. J. MED. 711, 714-15 (1988). To prioritize health care services, Oregon compiled a list of more than 1,500 health care "services"—combinations of medical conditions and their appropriate therapies—and estimated the outcomes of these services in terms of both function and longevity. Oregon gave highest priority to those services that provided the best outcomes—both in terms of quality and longevity—at the lowest cost, and lowest priority to those producing the worst outcomes at the highest cost. *See* Norman Daniels, *Is the Oregon Rationing Plan Fair?*, 265 JAMA 2232, 2234-35 (1991); Charles J. Dougherty, *Setting Health Care Priorities: Oregon's Next Steps*, HASTINGS CENTER REP., May-June 1991 Supp., at 1, 6; Timothy Egan, *New Health Test: The Oregon Plan*, N.Y. TIMES, May 6, 1990, at A31; Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF., Summer 1991, at 7, 20-22.

[30] There are at least two other benefits packages that might also be considered "adequate": (1) the package of benefits that the federal government requires the states to provide medical beneficiaries, which includes, among other items, inpatient and outpatient hospital services, rural health clinic services, laboratory and x-ray services, skilled nursing facilities for individuals twenty-one or older, early and periodic screening, diagnosis and treatment services for individuals under age twenty-one, physicians' services, home health services for some patients, and some nurse-midwife services, *see* CONGRESSIONAL RESEARCH SERV., HOUSE COMM. ON ENERGY AND COMMERCE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 92 (Comm. Print 1988), and (2) the package of benefits that the typical American worker now receives. Like the packages developed by the Ad Hoc Committee and by Oregon, these packages were not developed by reference to any independently justifiable standard of adequacy, and thus cannot be considered "adequate" in any meaningful sense.

[31] For a variety of reasons—including the fact that the uninsured are likely to be under-represented in the legislature—legislatures are likely to allocate less funds than are necessary to establish an objectively "adequate" package. *See* Daniels, *supra* note

The paucity of theoretical or empirical efforts to define the "adequate" minimum of health care likely reflects a sense that "adequate" coverage simply cannot be defined in the abstract—that determining whether health care is "adequate" requires a retrospective evaluation of whether the specific health care needs of individual patients have been satisfied. Under this view of the meaning of adequacy, the "adequate" minimum package of benefits can probably only be defined as "everything an individual needs" or "everything that would benefit an individual."

This prevailing sense of how "adequacy" must be defined is wrong. From a public policy perspective, the "adequate" minimum package of health care is the minimum package that society must provide to each of its members to be considered "just." As discussed below, a society need not provide each individual with all care that might benefit that individual to be considered "just." Indeed, it is far from clear that most societies, faced with limited resources, could provide such a level of care.

Our collective failure to define "adequate" health care coverage creates two related problems. First, it is extremely difficult to design a program or programs to provide such coverage to the uninsured. Thus, without defining "adequate" coverage, it is possible to design a monopsonistic health insurance program, a "play or pay" system, or a voucher system, but it is impossible to determine the details—what services should be covered or how large the vouchers should be. Second, without an independently justifiable standard of "adequacy" we cannot objectively determine whether coverage is "adequate." It is, in other words, impossible objectively to assess the success of programs designed to provide "adequate" coverage.

III. CAN WE DEVELOP AN ACTUAL, ETHICALLY JUSTIFIABLE "ADEQUATE" MINIMUM PACKAGE OF HEALTH CARE BENEFITS?

This discussion of the ill consequences of failing to develop an actual, ethically justifiable "adequate" package of benefits leads naturally to the question of whether such a package can in fact be developed. I believe that it is possible to develop such a package,

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29, at 2235 ("Because the Oregon plan explicitly involves rationing primarily for the poor and near-poor, funding decisions face constant political pressure from more powerful groups who want to put public resources to other uses.").

and despite various practical difficulties, we should make serious efforts to do so.

Developing an "adequate" package requires, of course, a definition of "adequate" health care; only a package of benefits assembled by reference to some principle of adequacy can justifiably be labeled "adequate." For the definition to be ethically justified, it must be grounded in a theory of distributive justice; that is, a theory that distinguishes on some principled basis between those health care services that all must receive for a society to be considered "just" and those services that can be distributed inequitably without causing any fundamental injustice.

Norman Daniels, in his book *Just Health Care*,[32] offers one such definition of "adequate" health care, and undoubtedly other equally well-supported definitions can be developed. Relying principally on traditional liberal theory,[33] Daniels argues that a "just" society is one in which, at a minimum, each individual can avail himself or herself of the "normal" range of lifetime opportunities in that society, and that individuals must have relatively normal health—in Daniels's words, "normal species-typical functioning"—to avail themselves of that normal range of opportunities. Accordingly, he contends that the "adequate" minimum of package of care that a "just" society must provide consists of those health care services that are "needed to maintain, restore, or compensate for the loss of normal species-typical functioning."[34]

Defining "adequate" care in the abstract is, of course, just a first step; we must also be able to develop an actual package of benefits based on the definition. In the case of Daniels' definition, it is not self-evident that we can do so. Moreover, there is no guarantee that

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[32] *See* DANIELS, *supra* note 27.

[33] *Id.* at 33, 39. While relying principally on liberal theory, Daniels contends that his argument does not depend on any particular theory of distributive justice, and that it is in fact compatible with a utilitarian theory of justice. *Id.* at 41-42.

[34] *Id.* at 79. Expanding on Daniels's ideas, the President's Commission on Biomedical Ethics argued that "adequate" care is not just care that maintains, restores, or compensates for the loss of "normal" functioning, but must also include "enough care to achieve sufficient welfare, . . . information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life." 1 SECURING ACCESS, *supra* note 24, at 20. While recognizing that health care may *also* serve these goals, Daniels criticizes these additional goals on the ground that they are not rooted in any theory of distributive justice. *See* DANIELS, *supra* note 27, at 80-82.

While neither Daniels nor the President's Commission discuss this point, the optimal "adequate" minimum package of benefits is the least expensive package that satisfies the definition of "adequate." Thus, if two packages advance this goal to the same extent, the optimal package is the one that is the most cost-effective.

we would be able to afford a package of benefits developed in accordance with Daniels' definition or any other ethically justifiable definition of "adequate" care. Nonetheless, even if the likelihood of successfully developing an actual package of benefits that satisfies such a definition is low, and even if it is not certain that we will be able to afford this package, we should make serious efforts to develop such a package because of the substantial benefits that it would provide. First, developing such a package would focus efforts to reform the health care system by providing reformers with a specific and detailed objective.[35] Second, it would provide us with a "gold" standard against which to measure the success of existing programs and policies. It would, in other words, provide us with a standard by which to evaluate any claim that existing coverage is adequate. In the event that such coverage is inadequate, it would create an incentive for us and our political representatives to analyze deficiencies in this coverage and to re-evaluate public spending on competing programs in light of these deficiencies. Finally, even if ultimately unsuccessful, the process of attempting to define "adequate" care would itself be beneficial. It would cause some individuals who otherwise might not do so to reflect on the costs and reasonable goals of health care, on public spending priorities, and on the way in which we establish spending priorities in our political system.[36]

CONCLUSION

In sum, our health care system is plagued by rising costs and declining access. To resolve these problems, we should seek to eliminate waste and to reallocate the resources that we currently devote to health care in a more equitable manner. We should not lose sight, however, of what should be the principal goal of health care reform—to provide an "adequate" package of health care benefits to all Americans. Accordingly, we should seek to define "adequate" care and to develop an actual, ethically justifiable

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[35] It may also serve to focus research and to channel the development of technology.

[36] Successfully defining the "adequate" minimum package of health care benefits would not, of course, be a panacea. Even assuming that we could afford to provide this package to all who are unable to afford health coverage, we would still need to address a number of difficult questions. We would, for example, still need to determine how best to guarantee and fund access to this set of services, and how to update the package periodically to reflect the introduction of new technologies.

"adequate" package of benefits. While this task may be difficult, I do not believe that it is impossible, and successfully developing such a package would considerably advance the current debate on how best to allocate health care resources.