DISTRIBUTIVE JUSTICE AND SOCIAL POLICY: A CASE STUDY

BY

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THESIS

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SUMMARY

This research focused on explicating the conceptions of just distribution of resources underlying one example of health policy. The policy used as a case study was federal funding of home health care under Medicare, during the period 1965-1984. The data consisted of the public records of debate on federal policy for home health care during this twenty-year period. Based on the analysis of the concept of distributive justice, eight different criteria used to define the concept were operationalized: Ascription, Equality, "Justice as Fairness," Choice, Financial Need, Merit, Need, and Utilitarianism. Content analysis was performed on the data using these criteria, as well as several other policy-relevant variables. These variables included problem statement addressed in the debate, strategies suggested to address the problem, outcomes of the debate, type of debate, actors involved, and time period.

Results indicated that the most frequently mentioned criteria for distributive justice used in the debate were Ascription, Need, and Merit. Ascription was used in large part because the policy under discussion here focused on one specific group, the elderly. The criteria of Need and Merit were often used in opposing arguments. Much of the debate focused on allocating resources to meet a wide variety of the needs of the elderly; however, opposing arguments were made stressing that individuals have a responsibility to meet their own needs at whatever level they can afford. Discussions of the criterion of Need
SUMMARY (continued)

decreased towards the end of the twenty year period studied and were replaced by concerns with cost containment via cost shifting for services to the elderly themselves.

Criteria of distributive justice used in the public debate varied only slightly by actor. Representatives of special interest groups, such as health care providers and consumers, were more likely to make statements about distributing resources to meet a wide variety of health and social needs of the elderly.

No clear patterns were discerned between problems addressed, strategies suggested, and criteria of distributive justice. This was largely because the distributive justice arguments made were often expressed in global terms, thus the same criterion of justice could be used to support opposing problem and strategy statements. These global arguments were common because of the difficulty of making specific justice statements in light of the reality of political processes, where such statements increase the likelihood of alienating segments of the voting population.

Two of the distributive justice criteria, "Justice as Fairness" and Utilitarianism, were rarely reflected in the public debate. One explanation for this is that these criteria are complex statements about justice, and actors were more likely to make broad, nonspecific justice arguments.

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SUMMARY (continued)

The methodology used in this study worked well to explicate distributive justice arguments in the public debate examined. Inquiry into the role of morals in health and social policy has rarely been conducted. Such inquiry serves to encourage dialogue on the value bases of social policy, and results in more informed and thoughtful policy debate.
I. INTRODUCTION

Every gun that is made, every warship launched, every rocket fired signifies in the final sense, a theft from those who hunger and are not fed, those who are cold and are not clothed (Dwight D. Eisenhower, 1953).

A. Introduction

The above quotation, taken from a speech during the Eisenhower administration, illustrates a concern with the distribution of resources. In essence, it is an argument for context, i.e., being aware that decisions to appropriate public funds for one area necessarily diminish public funds available for other areas. The same issue, i.e., limited funds and difficult choices, has become a popular topic for discussion in health care in recent years. Witness book titles such as Victor Fuch's *Who Shall Live?* (1973) and Joseph Califano's (past Secretary of the Department of Health and Human Services) recent book, *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (1986).

The above titles dramatize a national concern with the cost of health care and the social choices involved in allocating health care resources. There is consensus that not everyone can have all the health care services that they might desire. Within this consensus, there is disagreement as to the specific problems. Some contend that our society should spend more (or less) on health care. Others argue that the problem is that health care resources are distributed poorly. Still others point out that the health of the population is dependent on the distribution of other resources in addition to health care services. There is
general agreement, however, that there is a finite limit to the amount of health care resources available, and that amount is sufficiently limited to create a situation of scarcity of these resources. That is, the population cannot have access to an unlimited amount of health care resources and thus, a concern for method of distribution of these resources exists.

The resulting distribution of scarce goods/services involves moral principles, regardless of how the determination is made. Many factors can influence these distribution decisions, however, the resulting distribution has moral implications. i.e., who gets what says something about what society values. The goal of the research presented here is to explore the moral judgements implied in the method of allocation of health care resources. The specific problem addressed is how a specific moral concept, i.e., justice, is expressed by different actors throughout the debate on the legislative enactment of a policy.

B. Significance

Social policy is policy designed to affect social problems such as education, housing, unemployment or health. Rain (1970) suggested that the study of social policy includes the history, politics, philosophy, sociology, and economics of social problems and services. Moroney (1981) contended that social policy is formed from a combination of social relations and moral values. Policy researchers frequently work from the perspective of one of the disciplines mentioned above and use that approach to recommend or analyze social policies. However, some of these perspectives and some of the factors affecting social policy have
received less attention than others. The area of interest in this investigation is the morals/values implicit in social policy.

Although there is little empirical research to document the role of ethics/morals in social policy, the importance of this issue has been addressed by both ethicists and policy researchers alike. The key issue in social policy decisions is that of social choice. Social choices are reflected in the policies developed, which are a mixture of facts and values (Bice, 1980). Bice has suggested that this mixture of facts and values is often difficult to untangle, but that it is the responsibility of political institutions and individuals to analyze competing values and compromise among them. Rachels (1981) agreed with Bice in his argument for ethical analysis to provide answers to moral questions. Although Rachels focused on the role of ethics in forming social obligations, he also argued that at times moral principles conflicted and even ethicists could not determine which one took precedence. At such times, according to Rachels, we have politics as a method for mediating the dispute.

Fleishman and Payne (1980) addressed the issue of ethics and public policy for the Hastings Center. They concluded that dominant social values are espoused in policy; there is a need to identify ethical conflicts in policy; and policy analysts need to develop skills in ethical analysis. Lebacqz (1980) suggested that the role of an ethicist interested in policy is to explicate the values underlying the policy and assess the logic of the argument supporting these values.
In his well-known work on health care policy, Fuchs (1973) argued for the inevitability of social choice. He contended societies have limited resources and thus have to choose how to distribute these resources at individual and social levels. In Fuchs's argument the root of health problems are value choices and any change in policy needs to be based on an understanding of the social system, including the values, in which the policy is developed.

Titmuss (1974) declared that social policy has no meaning at all if it is to be considered as value neutral. Additionally, he argued that policy makers have a special responsibility to make the values underlying social policy clear.

Moroney (1981) has argued for what he terms "fact-value" appreciation in analyzing social policy. In this sense there is no such thing as value free policy analysis and policy formation is normative in nature. Because social policy is composed of moral values and social relations, the approach needed by policy analysts is a value analytic approach which exposes the values implicit in an array of policy alternatives. Such a value critical perspective does not assume discoverable causal relationships which are stable over time, but does seek patterns and general principles which integrate facts and values within a policy context (Moroney, 1981).

Goodin (1982) emphasized the normative implications of public policy and argued for combining empirical and ethical theory in policy making. He contended that usually the normative implications or ethical components of a policy are discussed by analysts only as a footnote to
their economic efficiency calculations, which contains a paragraph on the distributive impacts of the policy. Fein (1980) agreed that technical models cannot adequately account for the normative, value components of policy. Thus, the ethical components of a policy are usually ignored because they do not fit into a cost benefit analysis and the policy analysts claim they are irrational and thus useless in policy science (Fleishman and Payne, 1980).

In summary, there is agreement that ethics or the study of values and morals in social policy is an integral and vital part of any examination of social policy. However, there is no agreement on how best to incorporate ethics into the examination of social policy. Philosophers have conducted inquiry relating to social policy by applying specific philosophical positions to social problems (Daniels, 1985; Ignatieff, 1986; Maguire, 1980). That is the nature of much of medical ethics, i.e., applying a philosophical argument to a specific case or a set of issues.

However, little work has been done to explore the ethical concepts/morals as they are expressed in policy formation. If, as mentioned earlier, the distribution of scarce resources reflects a conception of justice, what can be said about the reflected concept? How was this conception of justice shaped, i.e., in the policy process, what arguments for distribution of resources were made and what conceptions of justice are illustrated in the final policy?
C. Significance for nursing

The problem explored here is a problem of special concern for nurses studying the social policy process. Social policy, especially health care policy, is an area of interest for nursing. Numerous textbooks and articles have been written recently on health policy for nursing; the American Nurses' Association (ANA) has developed a social policy statement for the profession; and a variety of policy conferences have been sponsored by and for nurses in the 1980s (Aiken, 1981; ANA, 1980; Aroskar, 1987; Kalisch and Kalisch, 1982; MacPherson, 1987; Milio, 1981; Williams, 1983).

ANA's social policy statement (1980) was an effort to delineate the nursing profession's social responsibilities and explain how these are demonstrated through nursing practice. As part of this statement the ANA stressed the importance of nursing involvement in the formation of health policy via the political process. The political process, according to the ANA, should be used by nurses to benefit the public good. Health policies derived through this process will reflect social and political priorities for action, and the ANA affirmed that these priorities will be based on social needs and values.

MacPherson's 1987 article on nursing, values and policy urged nurses to be more active in examining health policy in the context of society. Examining the values underlying health policy is vital to understanding the social context of the policy. She contended that the dominant values in American health policy were individualism, competition and inequality. Although she did not define or explain these values, she
urged nurses to critically analyze them as a first step towards social change. Nurses were encouraged to look beyond policy changes which benefit primarily the nursing profession in order to examine the effect of policies on the public's health.

Aroskar (1987) contended that nurses need to recognize the overlap between policy and ethics. She discussed the need to examine the ethical dimensions of policy to illustrate not only what can be done technically in health care but to initiate discussion on what we ought to do to develop more ethically adequate health care systems. She acknowledged that such dialogue might be uncomfortable, but she saw it as necessary in meeting nursing's social mandate.

One way for nurses to become involved in social change is for nurse researchers to examine health policy in its context, including the moral arguments presented in the public debate about a policy and the moral implications of policy outcomes. The study reported here is an attempt to do just that.

D. Research question

The issue addressed in this study is: How are different conceptions of justice expressed in the public debate on allocation of resources in health policy. Specifically, the research question to be addressed is: What criteria of distributive justice are used by different actors in the public debate about a particular health policy?

The key term here is distributive justice, which is defined as the distribution of scarce goods/services on the basis of some non-arbitrary criteria of relevant differences between individuals. These criteria,
which will be defined later, include: justice as fairness, utilitarianism, merit, ascription, need, and equality.

In addition to the above criteria representing the variable of distributive justice, other variables of interest include the definition of the problem addressed by the policy in question; the strategies suggested to address the problem; the actors involved in the policy debate; the time period in question; the setting for the debate; and the outcome. Some of these variables are found in Moroney's (1981) fact-value model, which incorporates the value basis of policy as one of the policy analytic variables. These variables will be discussed at greater length in later chapters.

Federal health care policies as expressed via the legislative process is the population of interest here. For the purposes of this inquiry, a case study approach was used. The case chosen was the federal policy concerning funding for home health services for the elderly.

Content analysis was performed on the data, drawn from the documents chronicling the public debate on federal legislation governing home health care from 1965 through 1984. The analysis used the variables listed above: criteria of distributive justice; statement of the problem which is addressed; alternative strategies; strategy chosen; time period; and actor.

E. Assumptions

The assumptions underlying this research include the idea that the moral criteria for distribution of resources will be discernible from
the actor's statements about who should receive what type of services and why.

In addition, this research assumes that developing an analytic framework for ethics in public policy will be useful for future policy formation and debate. Additionally, an understanding of the role of morals in the policy process is a necessary condition for understanding the policy process in health care, particularly the discussion of social policy as a reflection of social values.

F. Definition of terms

A few key concepts will be discussed often during the report of this study. The following definitions are those used for the purposes of this research.

Social policy: Policy designed to affect social problems such as housing, education, unemployment or health (Rein, 1970). Used in this way, social policy includes health policy. While policies which affect the public's health include legislation, regulations, and decisions made by private, professional and administrative bodies, the object of this study will be legislation at the federal level, i.e., federal health policy.

Policy process: This term refers to the actions through which policy is developed, i.e., the stages that policies go through over time (Brewer and deLeon, 1983).

Public debate: This term is used to refer to the recorded discussion over particular concepts or policies during the legislative process. Thus, public debate is limited to congressional floor debate,
congressional hearings, congressional reports, and public law. While there is certainly public debate over particular policies in the policy literature, the news media, and at the local level, the term here is restricted to the federal legislative process, and the public record about particular policies enacted through legislation.

**Ethics/morals/values:** In this research, these terms are used to denote traditions of belief about right and wrong human conduct, i.e., judgements on how humans *ought* to act. Morals express what society expects of us in terms of behavior or taking the interests of other people into account (Beauchamp and Walters, 1982).

**G. Overview**

The second chapter of this report is devoted to an examination of the literature on the concept of distributive justice and the policy models used for this study. Because very little empirical work similar to this study has been reported, there is little empirical research literature to review. However, some of the work cited on the concept of justice is philosophical research and provides a demonstration of the type of inquiry that has been conducted in this area, as well as background for the concepts used as analytic variables.

Chapter III develops the methodology used here, including elaboration of the strengths and weaknesses of this approach. Because no prior empirical research of this type could be found in the literature, this study also addresses the usefulness of the methodology employed for answering this question.
Chapters IV and V present an analysis of the data. In Chapter IV a description of the sample is provided, including a brief legislative history of federal funding for home health care, i.e., what problems were addressed by such legislation and what strategies to address these problems were offered and selected. Chapter V focuses on the research question, a description of the results, and an analysis of the relationships between the variables.

Chapter VI provides conclusions, the need for further study, and the overall patterns discovered in the analysis of the data. This last chapter addresses the utility of the methodology employed and suggests alternative strategies for such research. It also discusses the contribution of this inquiry to the nursing research literature.
II. LITERATURE REVIEW

If men were supplied with everything in the same abundance [as air and water], or if everyone had the same affection and tender regard for everyone as for himself, justice and injustice would be equally unknown among mankind. Here then is a proposition, which, I think, may be regarded as certain, that 'tis only from selfishness and confined generosity of men, along with the scanty provision nature has made for his wants, that justice derives its origin (Hume, 1978).

A. Conceptual framework

As mentioned earlier, Moroney (1981) has developed what he calls a value analytic framework for policy analysis. This framework originates with Moroney's premise that social policy is a search for, and articulation of, social objectives and the means to achieve them. He argued that this definition assumes that social policy presents a normative position indicating predetermined values in relation to social issues.

Moroney (1981) criticized the traditional approach to policy analysis for its treatment of the policy process as rational and linear and its view of policy analysts as technicians who apply neutral, value-free approaches to the examination of social policy. He argued that this type of policy analysis assumes a consensus on social goals and values which does not exist.

The work of several policy analysts are cited in support of Moroney's (1981) position that policy is a reflection of social values. For example, Titmuss (1968) agreed that social policy concerns are essentially moral rather than technical. He called on policy analysts
to expose these moral choices and explicate the value assumptions underlying the development of such policy. Rein (1970) observed that social policies reflect choices among multiple, conflicting values and goals and that there are no rules to use when making these choices. Thus, social policy is an articulation of the ideology which bridges means and ends.

However, Moroney (1981) also acknowledged the hazards in addressing morals and values in policy. Morals cannot be explored in the strict logical positivist framework often used in social science. In addition, two extreme positions on morals are difficult to avoid. On the one hand is the danger of taking a value arbitrary stance, where all values are treated as equally good. Such a stance of moral relativism depicts policies and laws as irrelevant, because any one value reflected in a policy would be as good as another. However, the standard of moral absolutes is equally problematic. Moral absolutism means that only one moral principle or stance would be judged appropriate in all cases, at the expense of any others. Moroney (1981) called for an explication of facts and values in social policies and the development of systematic research methods to express or develop policy as an articulation of favored values. Such research would not try to determine causal relationships which are stable over time, but would instead seek patterns and general principles which account for the context of the policy, including facts and values.

There are three general moral principles which Moroney (1981) stated as social policy goals: liberty, equality and fraternity. He
acknowledged that all three cannot be maximized at once, and that giving priority to one necessarily diminishes the others. However, there are other moral principles that can be justified as the goals of social policy. For the purposes of this study the moral principle of interest will be distributive justice.

The above discussion provides the context for the framework developed by Moroney (1981) for a value-analytic examination of social policy. His framework has three parts: policy analysis, program development, and evaluation. For the purposes of this research, the policy analysis component is explored. The reported literature is devoid of further development or testing of Moroney's (1981) framework. However, his framework is a rare attempt to examine the value components of policy, and as such it was useful for the study reported here.

The first component of Moroney's (1981) framework for policy analysis is the problem analysis. He defines the problem analysis as a description of the problem, who defines it as such, and its etiology. A second component in his framework is the value criteria. These criteria reflect the ends that the analyst wishes to achieve, and the analyst is expected to provide a rationale for the selection of these criteria.

The third component in Moroney's (1981) framework is the identification of alternative strategies to solve the problem. In the last component, one strategy is selected after applying the value criteria to the alternatives and estimating and comparing the potential results. By using these components in his framework, Moroney (1981) tries to depict the relationships between the identified problem, the values involved,
the alternatives and the eventual outcomes. However, he does not explain the nature of these relationships.

A limitation in the use of Moroney's (1981) framework is that it ignores other variables which affect the strategy chosen to address a given policy problem. Such variables include economic indicators; the actors involved and who they represent; the time period during which the policy is being formulated, including other related events happening simultaneously, etc. While one can argue that the moral criteria ought to take precedence, often the other variables affect the interpretation of moral choices or the selection between two competing moral claims. In Chapter III, I will discuss modifications of Moroney's (1981) framework for this research, and the advantages and disadvantages of using this approach. In addition, definitions of the variables or components used from this framework are provided in Chapter III. The next section in this chapter will explore the literature relative to distributive justice, the concept used as the value criterion for this study.

B. Distributive justice

1. General definition

Philosophers and health care professionals have long debated the issue of a right to health care. However, if health care is considered a right, what does that mean? Does having a right to health care mean that everyone receives all the health services they ever want? Is society then obligated to ensure that this right is fulfilled? Such a right could be very costly and certainly would have implications for distribution of other societal resources. Daniels (1979) suggested
that society can only claim a general right to health care if it is
derivable from a generally accepted theory of distributive justice.
That is, rights and the means of assuring them are inextricably linked.

Determining a right to something tangible and in limited supply,
such as health care, involves issues of justice. Justice has been
defined in different ways by different philosophers. Some philosophers
have referred to distributive justice as a subset or type of justice.
Justice is described as having three levels: commutative or justice
between individuals; legal or justice as in the individual's responsi­
bility to the community; and distributive justice or the community's
responsibility to the individual (Fletcher, 1976). Justice is also
defined with three areas of application: retributive, procedural and
distributive (Jameton, 1984). The concern addressed here is distribu­
tive justice, i.e., the community's responsibility to the individual.

The concept of distributive justice is often left undefined, as
though the authors assume a common definition. However, when the con­
cept is defined, its definition varies according to the discipline in
which it is being discussed. The discipline which has devoted the most
attention to the concept is philosophy. Aristotle defined distributive
justice by the criteria used to make distributive decisions (Golding,
1981). The Encyclopedia of Bioethics suggested that distributive jus­
tice is the form of justice concerned with distributing among the
people the benefits and burdens that are due them. Persons must be
treated equally in this distribution unless there are relevant differ­
ences among them. That is, unequal distributions must be justified by
explaining the relevant differences between individuals which warrant the inequality. The different treatment accorded on the basis of relevant differences between individuals should be in direct proportion to the importance of these differences. Conversely stated, arbitrary inequality is the essence of distributive injustice (Reich, 1978).

Shelp (1981) contended that distributive justice is a human invention and thus not an absolute concept. The criterion for determining distributive justice will vary over time and reflect basic social values. As such, these criteria are value laden and evolving. These criteria, as discussed above, would reflect relevant differences which justify distribution inequalities. Rawls (1971) argued further that the acid test of a society is justice. This test requires answers to two questions: how effectively are arbitrary differences removed as criteria for distribution of resources, and how effectively do the remaining criteria properly balance competing claims to social benefits?

The common point in all these definitions is the idea of distributing benefits and burdens according to some criterion reflecting relevant differences between individuals. Frequently, scholars mention several types of relevant difference criteria for determining a just distribution of resources, and much work has been done in philosophy and economics to compare the potential outcomes of different criteria of distributive justice. The concept is complex and there is no societal consensus as to criteria to be used in distributing scarce
resources, such as health care (Davis and Aroskar, 1983; Gordon, 1980; Nagel, 1972).

The choice of relevant difference criteria for distribution often reflects the concerns of the discipline which suggests them. Aristotle said that complete distributive justice existed when the ratio of reward received to merit warranting reward was the same for all recipients of rewards. He suggested that distribution be done according to merit, with merit defined in keeping with societal definitions (Spengler, 1980). Spengler, a modern day economist, agreed that what was just in distribution must be according to merit in some way, although little agreement exists on indices of merit. Various philosophers have suggested that merit is one possible criterion for a just distribution of resources (Miller, 1976; Outka, 1974; Veatch, 1976). DeJong and Rutten (1983) suggested a related criterion, libertarianism as another possible criterion for a just distribution of resources. That is, people are entitled to natural rights or things they have earned. Hochschild (1981) suggested results or ascription as possible criteria for determining distributive justice. The criterion of results would mean that people would be entitled to things based on what they produced or earned. Again, this is the merit approach found in free market economic theory. The criterion of ascription means that resource distribution would be done on the basis of ascribed attributes such as race, gender, or age.

Cassell (1981) suggested that distributive justice should consider an individual's needs in relationship to the needs of others and in
light of the resources available. Maguire (1980) agreed that justice is need based. He defined justice as being a concern for rendering to each his/her own based on the idea of the inherent worth of individuals and the importance of meeting their essential needs.

Nurses working in the area of philosophy and ethics have contended that distributive justice is concerned with equal or comparable treatment of individuals and an equal distribution of benefits and burdens throughout society. Again, if unequal treatment of individuals is warranted, it must be done in terms of relevant differences between individuals which justify such treatment (Davis and Aroskar, 1983).

Equal treatment of individuals was mentioned as a criterion of distributive justice by several economists and philosophers (DeJong and Rutten, 1983; Englehardt, 1981; Gordon, 1980). However, equality or egalitarianism can be used two ways. First, equality may mean that all resources are divided equally among members of a society. Equal access to health care is an example of this approach. The second term, egalitarianism, reflects concern with equality of outcomes. All resources are divided so as to make everyone as equal as possible. For example, health care resources would be divided to equalize the health status of all as much as possible (Daniels, 1981; Davis and Aroskar, 1983; DeJong and Rutten, 1983; Hochschild, 1981; Veatch, 1976). This is actually similar to the criterion of need and different from equal access, which would not guarantee the equal distribution of risks or outcomes (Daniels, 1981).
Hochschild (1981), a political scientist, has argued that ideally all members of society may make equal claims on social resources. However, situations exist where some members of society may legitimately make greater claims on social resources. Thus, she posited equality and differentiation as subsets at either end of a distributive justice continuum. The criteria for determining relevant differences for distribution lie between these two ends.

Another criterion is that of utilitarianism, i.e., the greatest good for the greatest number (Fletcher, 1976). Fletcher suggested that this concept needs to be quantified to make it easier to measure the best possible outcomes for the most people. Utilitarianism as a criterion for just distribution has also been discussed by many others (Daniels, 1979; DeJong and Rutten, 1983; Reich, 1978; Veatch, 1976).

Rescher (Reich, 1978) suggested five relevant factors for determining just distribution of health care resources. These factors are: 1) the relative likelihood of success; 2) the patient's life expectancy; 3) family dependence on the patient; 4) future societal contributions of the patient; and 5) past services rendered by the patient. These criteria can be weighted, scores calculated, and then the final distribution between equal scores made by lottery. These criteria are similar to the ones discussed earlier. Criteria two and three are need criteria and criteria four and five are merit criteria.

The criteria described above are used by various philosophers to describe the way goods/services should be distributed. Hochschild
(1981) suggested three guidelines for deciding on criteria for just distribution of goods and services: 1) define who is equal to whom; 2) define what goods/services are subject to allocative choice; and 3) define what is meant by equal treatment or identify the relevant differences criterion to be used in the distribution process. As mentioned earlier, she argued that distributive justice was best defined as a continuum with equality and differentiation being the subsets of the concept on each end. She then suggested criteria for relevant differences between individuals which were arranged along the continuum between equality and differentiation. She contended that procedures for meeting the criteria on the equality end of the continuum are such things as majority rule or random rules, i.e., where everyone has an equal chance of participation in deciding the outcome. The criteria on the differentiation end are approached with such procedures as free consent and social Darwinism, i.e., where people with resources can choose to keep them and benefit from them, and not be forced to redistribute. Her examples of policies which exemplify the equality end of the continuum are: equal protection for all under the law, military draft by lottery, and majority elections for public office. Allocative decisions on the differentiation end of the continuum are: wages by output, legal contracts, and higher pay for higher education (Hochschild, 1981). She also argued that there are three domains to life and that our society tends more towards equality in the domains of socializing and politics and more towards differentiation in the economic domain. Figure 1 depicts Hochschild's continuum of distributive justice, including where the criteria fall on the
Criteria

DISTRIBUTIVE JUSTICE

Equality Criteria
1. strict equality
2. need
3. investment
procedures: random rules, majority rule

Differentiation Criteria
3. investment
4. results
5. ascription
procedures: free consent, social Darwinism

Continuum

strict equality investment ascription

EQUALITY DIFFERENTIATION

need results

Figure 1. Hochschild's (1981) continuum of distributive justice.
continuum, and the procedures which are used to attain the concept. This figure is useful as an overview of several criteria for a just distribution of resources in relation to one another.

Essentially, Hochschild (1981) summarized several of the main conditions for defining a situation of distributive justice, as discussed earlier. The first condition is that a situation of scarcity must exist. If the good/service in question was plentiful, there would be no concern with its distribution. The second is that the good/service must be a primary good. Although none of the authors cited earlier stated this explicitly, their implication was that society is only concerned with the distribution of those goods/services which are necessary for human life under our social customs. This includes such things as food, health care and basic civil liberties.

The third condition for determining whether a situation of distributive justice exists is whether the allocation is made by some non-arbitrary criterion. As noted earlier, these nonarbitrary criteria or relevant differences between individuals which justify unequal distribution of resources could be such things as: need, equality, utilitarianism, merit, ascription, or "justice as fairness". The relevant difference criteria used in social policy warrant further study to determine how closely they approximate social values and which criteria are operating at what time and for which goods/services. Figure 2 is a diagram which lays out the conditions essential for a situation of distributive justice. These conditions are common to the definitions of distributive justice most often found in the literature. The criteria are those most
1. Goods/Services—Is there a scarcity?
   Yes  \[\Rightarrow\]  No
   \[\Rightarrow\] No issue of distributive justice exists.

2. Are the goods/services primary?
   Yes  \[\Rightarrow\]  No
   \[\Rightarrow\] No issue of distributive justice exists.

3. Is allocation made on the basis of the criterion of relevant differences defined as:
   - equality (equal access)?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - justice as fairness?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - utilitarianism?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - merit?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - need?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - ascription?
     Yes  \[\Rightarrow\]  See #4
     \[\Rightarrow\] No
   - other
     Arbitrary  \[\Rightarrow\]  No issue of distributive justice exists.
     Non-arbitrary  \[\Rightarrow\]  See #4

4. Conditions for situation of distributive justice have been met.

Figure 2. Conditions for situations of distributive justice.
often found in the literature, as well. Some philosophers have argued for one of these criteria as the ultimate determinant of distributive justice. Others contend that several of these criteria may be relevant to a just distribution of resources, and that the choice is situation dependent. These criteria are discussed in greater detail in the following section.

2. Criteria of distributive justice

Now that the discussion of the general concept of distributive justice has been outlined, it is important to focus on the criteria most often cited as possible determinants of distributive justice. Some political philosophers have argued that these criteria differ in their scope. For example, utilitarianism and Rawls's "justice as fairness" are seen as outcome criteria, less concerned with procedures of distribution than with results. The remaining criteria focus more on procedures of distribution, that is what is the rule for distributing resources in a just manner (DeJong and Rutten, 1983; Miller, 1976). This will be illustrated in the following discussion of arguments for different distributive justice criteria.

a. Need

Need is one of the most often discussed criteria for just distribution of resources. In developing his theory of justice Maguire (1980) cited need as the essential concept. He contended that justice was based on the inherent worth of the person and that denying goods to those in need of them would effectively deny their human worth. Distributing resources to persons based on their essential needs was in the
interests of the common good, and essential needs granted rights to the needy. Maguire (1980) argued further that the common good was important to uphold as the only opposing force to rampant individualism. For him, individual rights might be sacrificed to the common good in order to correct an injustice. Consistent with the earlier discussion, Maguire (1980) only focused on essential needs, that is needs for resources such as food, health care, and shelter.

Gordon (1980) agreed that no one should lack the basic requisites for human life, such as food and shelter. He said that in our current system these needs were often addressed by private charity, but that this was inefficient. Daniels, in his 1985 work on justice and health care, claimed that distribution of resources based on needs was problematic because needs were difficult to define. For example, what were essential needs, and did they include health care? He further argued that among essential needs it was difficult to determine which needs should receive priority and what amount of the total social resources should go towards fulfilling those needs.

Although Miller (1976) used the term equal outcomes as a criterion for distributive justice, this term is interpretable as needs. Equal outcomes means distributing resources so that everyone reaches some desirable state. In the case of distributing health care resources, this state would be some agreed upon level of health. This is akin to need because those who are in poorest health would need the most resources to reach the desired state. One problem with this, as pointed out by Englehardt (1981), is that it does not account for the natural
lottery. The natural lottery is Englehardt's term for fate or circumstances which occur outside a person's control, such as birth defects and accidents. For people who are victims of events in the natural lottery, no amount of resources may be enough to bring them to a desired state of health. Englehardt (1981) asked whether the natural lottery is unjust or merely unfortunate, and if the latter is true, how much of society's resources should be used to correct this state of affairs in the name of justice?

b. Justice as fairness

A criterion which is somewhat similar to need is Rawls's (1971) theory of "justice as fairness." However, this criterion is more closely tied to outcome than to procedure of distribution. This criterion has received a great deal of attention in the past fifteen years because Rawls is a contemporary philosopher who has developed a method for defining justice. Much of the other work about the concept of justice is built on themes that have been debated throughout the history of philosophy.

Rawls (1971) articulated an important theory of justice in which he defined justice as what people would choose to do in the original position. The original position is a hypothetical situation where all people are equal and all are ignorant of relevant differences between individuals, i.e., no one knows the social value of differences between individuals and no one knows where they stand in terms of social worth. In this position, Rawls (1971) asserted that all would agree to act in such a way as to be fair to whomever is the least well off among them.
because each individual, for reasons of self-interest, would want to protect themselves in case they were the least well off. Two principles are important in Rawls's (1971) concept of "justice as fairness": 1) Each person should have an equal right to the most extensive basic liberty compatible with a similar liberty for others, and 2) social and economic inequalities should be arranged so that they are both a) reasonably expected to be to the advantage of all, and b) attached to positions and offices open to all (Rawls, 1971).

Daniels (1985) applied Rawls's theory of justice to the special case of health care. However, whereas Rawls (1971) was concerned with equal opportunities, Daniels (1985) discussed the normal opportunity range. This range was defined as an array of life plans which reasonable persons are likely to construct for themselves, given their personal characteristics and the society within which they live. Daniels (1985) argued that disease and ill health restricted one's opportunity relative to the normal range of opportunity given one's skills and talents and good health. Daniels (1985) posited that a just system of distribution of health care resources would enable individuals to maintain their normal opportunity range, i.e., resources would be distributed so as to guarantee equality of opportunity.

Daniels's argument is very similar to a needs based argument, with the difference being in how the needs are defined. Rawls (and thus Daniels) argued for an idealized system of determining resource distribution so that the least well off would be cared for in a situation where those making distributive decisions were figuratively blindfolded.
This would theoretically correct for individual motives such as envy or greed which affect distribution decisions.

Daniels's theory also attends to some of Englehardt's concern about the natural lottery. Daniels's normal opportunity range is defined as what people might expect given their talents, abilities and culture. Thus, the normal opportunity range is what one might expect given one's position in the natural lottery. For example, someone born blind cannot expect to be a photographer as a part of their normal opportunity range. However, this does not apply to natural lottery events which happen to one after birth, such as accidents. Daniels does not indicate whether an individual should get the necessary resources to regain their original normal opportunity range following an accident, or whether their normal opportunity range is altered by natural lottery events occurring after birth.

Clearly, however, one obvious criticism of Rawls is the impossibility of creating an ideal situation of resource distribution. Englehardt (1981) criticized Rawls's theory for not allowing for human nature. Those in the original position are demi-gods, according to Englehardt, and thus, such an ideal situation of distribution would be impossible to implement. Englehardt (1981) also criticized Rawls for not allowing for individual rights in terms of ownership or entitlement to resources. Miller (1976) concurred that the problem with Rawlsian justice is its neglect of the rights of the individual.
c. **Utilitarianism**

Utilitarianism is a teleological theory of justice. This means that rights are defined in terms of maximizing the good, i.e., the ends justify the means (Buchanan, 1981). Utilitarianism is the theory which calls for a just distribution of resources being that which provides the greatest aggregate good for the greatest number of people. This is intuitively a very appealing argument because it is similar to the theory of majority rule in a democracy. However, majority rule is a mechanism for making political decisions which may or may not be "right" in a moral sense. Utilitarianism deals with the morality of distribution systems, the good and the ought.

In light of the earlier discussion of Rawls, it is easy to determine the major criticisms of the utilitarian theory. Miller (1976) argued that utilitarianism is concerned with the good of the group as a whole and not of the individual members themselves. Maguire (1980) agreed with the premise that individual rights were sacrificed to the aggregate in utilitarianism, not to correct an injustice as in his theory of justice, but in principle. Maguire (1980) argued that utilitarianism would lead to a tyranny of the majority with no opposing social force. In defense of utilitarianism, however, DeJong and Rutten (1983) pointed out that it is an efficient, economical method to distribute scarce resources. Certainly in American business this principle operates frequently, such as in decisions to close one factory for the good of the rest of the corporation.
d. Merit/desert

The idea of distributing resources based on the merit or deserts of individuals has been argued since Aristotle's time. Aristotle acknowledged, however, that judgements of merit/desert differed by culture or social standards (Gordon, 1980). Gordon (1980) discussed the difficulties in using the merit criterion because of the problem of assessing the true value of any one person's production or worth in complex, Western societies. In addition, there remains the difficulty of how to judge the merit/deserts of those who are incapable of producing standard amounts of worth in an economic sense, e.g., children and the physically handicapped.

Miller (1976) agreed with this assessment of the difficulties of ascribing merit to individuals. He questioned the role of natural talents, efforts, circumstances and results in the judgement of an individual's merit. How are these factors weighted or considered in merit determinations? Although merit certainly could be used in ways other than resource/economic merit, other rewards for worth are not costly in social resources, so in general it is used in an economic sense.

The merit argument is often used in conjunction with arguments for personal freedom or libertarianism, i.e., that people have natural rights to keep their entitlements, either by inheritance or earnings. This argument is used frequently by those defending a free market distribution of health care resources, whereby individuals are free to purchase whatever health care services they want and can afford (DeJong and Rutten, 1983).
Englehardt (1981) used the merit criterion to argue for a free market distribution of health care resources. He argued that a concern with distribution of resources in a moral community rejected distribution by use of force. This, he said, indicated a basic adherence to the primacy of personal freedoms for individuals. Such freedoms could be extended to include freedom from coercion to share the resources to which one is entitled (or owns) by merit. Such a distribution system allows individuals to choose what resources are important to them. And, people are free to work harder to attain important resources. For those who have a lesser ability to contract for resources (the needy), he suggested that systems of charity work. However, he cautioned, charity does not entitle recipients to these resources as a right.

Buchanan (1981) agreed with the idea that libertarianism called for individual freedom, a minimal state and no coercion to redistribute resources. He too stated that, for cases of need, charity requires helping those who have no right to such help.

Ozar (1981) developed his theory of distributive justice on a model similar to the market system of health care. Ozar (1981) labeled his model the theory of the just exchange. In a two-person fair exchange of goods or services, certain conditions must be met. Both parties must find the exchange mutually agreeable and both parties must think that they will have received something of value from the exchange. In the case in which one of the parties lacks some primary good necessary for survival and the other party has an overabundance of such a good, whoever is responsible for this maldistribution is responsible to correct
the situation so that both parties can make a moral, just exchange. Ozar (1981) contended that this just exchange theory can be expanded to a societal level, and then society has the responsibility to correct the distribution so that just exchanges can be made.

Unfortunately, Ozar's (1981) theory omits consideration of some important points. If some individuals have to give up some of their resources to correct society's maldistribution, is that a just exchange? How is responsibility for maldistribution of essential goods decided on a societal level? This would be similar to Maguire's (1980) position that individuals' rights can be sacrificed to the common good to correct an injustice. Or is Ozar's (1981) theory just a restatement of a free market theory which will promote individual choices and call for charity for the needy?

One of the few pieces of empirical research in the area of health policy and values is Lockhart's (1981) examination of the values which health policy elites thought operated in health policy. The study was conducted with elites in three countries, the United States, Great Britain, and West Germany. Health policy elites were defined as those who influenced national health policy, i.e. health policy makers. Interviews were conducted with about fifteen people in each country to determine their perceptions of the operating values in their countries' health policies. The subjects in the United States included special interest group members, staff members for congressional committees on health, and federal health agency bureaucrats. The results indicated that in the United States those interviewed supported a health system

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based on libertarianism, merit and free market ideals, i.e., individuals received whatever health services they chose and that they could afford. These health policy makers thought that this system, based on private financing, guaranteed economic efficiency. This contrasted with the results in Britain where the subjects supported a need based, social distribution system for health services. The subjects in West Germany supported a combination of the two approaches.

e. Ascription

As mentioned earlier, Hochschild (1981) discussed distributing resources based on ascription, that is based on selected, relevant characteristics of individuals. Certainly these characteristics could be such things as need or merit, discussed earlier, but they could also be such things as age, sex, or race. This is somewhat akin to libertarianism in the sense of distribution based on natural rights. A prime example of this in Great Britain is the resources and privileges accorded to the royal family based on their family heritage.

f. Equality

The last criterion appearing in the literature on distributive justice is that of equality. This criterion is used to mean distributing resources based on equal inputs—that is equal amounts of some resource to all. The earlier discussion of need mentioned the idea of equality of outcomes, a state close to the criterion of need, because people who were more needy would receive more resources to bring them up to some predetermined level of outcome.
Equality is usually discussed in relation to equal access to services. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983), in their recommendations on distribution of resources, called for equal access for all to an adequate level of health care without excessive burdens. They stated that such a level of health care should be a minimum which no one should fall below but which those who had the available resources could rise above. Thus, their criterion of equality was combined with merit or free market criterion.

There are many problems with such a criterion. Englehardt (1981) pointed out that one needs to define what services will be included in the equal access formula and decide if the choice of these services will be based on social needs or desires. Gordon (1980) argued that providing a basic floor of services to all will diminish the incentive to work because basic needs would be cared for already. This reduced work output would decrease the economic efficiency of the society as a whole. DeJong and Rutten (1983) agreed that a distribution criterion which provides a basic level of services for all would be arbitrary and difficult to determine.

C. Conclusions

Several common elements link the discussions of justice criteria outlined above. First, all the economists and philosophers implicitly or explicitly referred to the need for debate in the development of theories of distributive justice to be used as guides to social policy. Many of these authors acknowledged that each criterion had its strengths...
and weaknesses and that it was difficult to determine which would be most cost effective or even what the most desirable outcome would be.

There was some debate about whether it was more important for the procedure of distribution to be just or for the outcome of the process to be just. Several of the criteria were discussed as being useful for determining social obligations and outcomes, whereas others were more concerned with distribution and responsibilities for, and of, individuals.

An interesting point was Englehardt's (1981) idea about the natural lottery. It is worth discussing whether this lottery is unjust or merely unfortunate. How much responsibility does society need to assume for distribution of resources to individuals who were victims of "bad luck" versus those who were more involved in the development of their health problems? For example, should social responsibility differ for the costs of care for someone who is severely injured in an auto accident versus someone who is comatose due to substance abuse?

Much of the discussion presented here focused on the tension existing between individual rights and a social ethic. The concept of distributive justice exemplifies this tension. As Englehardt (1981) pointed out, discussing distributive justice assumes the importance of individual rights, because otherwise any distribution scheme could be forced on individuals. However, such discussions also assume a social ethic or sense of the common good. If they did not, there would be no need to discuss distributive justice because individual rights would run rampant and the person who could demand the most resources (by talent or
force) would have them. The concept of distributive justice embodies implicit assumptions about social ethics including the importance of collaboration, the community's common resources, and a sense of the common good. But the concept also encompasses assumptions about the rights of the individual within a collective. Thus, many of the arguments for differing criterion of distributive justice exhibit this tension between individual and social rights.

A related concern in the discussion presented here is the difference between economic efficiency in the distribution of resources and justice in the distribution of resources. Several of the scholars cited dealt with primarily economic concerns. For example, the economic argument is that equal distribution of resources decreased the incentive of people to work and resulted in decreased economic efficiency for society as a whole. There is no mention made of whether such a distribution would be just. Arguments could be made that: the decreased economic efficiency of society would lead to greater injustice for all due to less economic resources; or that economic efficiency is not as important as a just distribution of societal resources. The point is that there exists a tension in much of the work presented here between what is economically efficient and what is just. Again, the definition of just is a moral one, involving what is right, what ought to be done in a moral sense.

The preceding discussion captures important questions for political philosophers and social policy makers to consider when making decisions about how to distribute resources. It is difficult to balance the
criteria discussed here as maximizing any one criterion often leads to problems with the others. Miller (1976) argued that choosing a criterion for distributive justice is an endeavor which is culture bound. He contended that there are no conclusive justice rules. What is needed is a logical argument for one criterion presented with empirical evidence of its effects. The strength of this case is determined by the weight of the evidence and the internal consistency of the argument presented.

This chapter presented the conditions necessary for the concept of distributive justice to be meaningful. In addition, arguments for various criteria for determining a just distribution of resources were discussed. Chapter Three will illustrate one method for translating the concepts discussed here into analytic variables, which can then be applied to a data set. The remaining chapters will present the analysis, that is an examination of some arguments presented by federal policy makers in regard to a particular policy. This analysis will look at relationships between variables representing criteria of distributive justice and other policy variables in a particular case study.
III. METHODOLOGY

A. Research design

The design used for this study is a qualitative, retrospective, longitudinal case study. The design actually combines two methodologies: the constant comparative method and content analysis. Moroney, in his 1981 discussion of policy analysis, discussed the need for social policy researchers to synthesize a variety of methodologies into a meaningful approach to examine a particular policy question. He argued that there is little agreement on the most useful methodology for policy analysis, so a multiple methodology approach is favored.

One of the uses of qualitative research is to describe concepts relevant to an area of interest (Knafl and Howard, 1984). It is especially helpful for understanding the context in which the concepts of interest are found. In the area of social policy, which is concerned with a search for, and articulation of, social objectives and the means to achieve them, it is vital to understand the context for the data. The policy process must be analyzed within the context of the society. Also, qualitative research is useful for exploratory studies, such as the one reported here, where little research has been documented. As mentioned earlier, there are few reports of empirical research in the area of morals and social policy.

Moroney (1981) argued that too often research in social policy focuses solely on services, e.g., how they will be organized, financed and managed. Rarely do such studies focus on the aims, nature and
values behind the services discussed. The organizational aspects of policy are important, but they need to be developed based on the purpose of the policy. If the purpose is not articulated, then analysis focuses on efficiency as a goal. In order to explicate or determine the purpose, goals or aims of policy, some attempt must be made to see the policy in light of social values. This is a very complex task requiring attention to such things as who is involved in policy formation, what their motives are, when they express them, and to what audience.

The purpose of this study, as mentioned earlier, is to explore the morals/values implied in discussion on the method of allocation of resources. The specific problem addressed is how a specific moral concept, i.e., distributive justice, is expressed by different actors throughout the legislative enactment of a policy. As mentioned earlier, there is little empirical research addressing this problem, although many scholars have spoken to the importance of study in this area. Overall, a qualitative design, with attention to the context for the data, serves to stimulate discussion of this problem, including suggestions on different ways to address the problem, thus sensitizing policy researchers to the issues involved.

The multiple methodologies employed in this study sought to explicate the values involved, in relationship to other variables, in one example of social policy. A case study approach was used for the inquiry to allow for in-depth investigation/clarification of concepts and ways to measure or examine them (Polit and Hungler, 1978). The policy of interest here was federal funding for home health care for the
elderly. Federal funding for general health care would have been far too broad a topic and encompassed massive amounts of data. Even limiting the area to federal funding of health care for the elderly would have encompassed a large amount of data, especially over the past twenty-five years. Selecting a specific issue, which reflects arguments of federal responsibility for health services within a well-defined time period and subject area allowed use of the methodology to assess the feasibility of asking questions about the values underlying such policy.

Content analysis is one type of qualitative methodology. It is generally defined as a way of categorizing qualitative or narrative data and quantifying the result (Holsti, 1968; Kerlinger, 1973; Polit and Hungler, 1978). However, more recently there has been diminished attention to the quantification of results. Krippendorf (1980) defines content analysis as a technique for making inferences about the context in which the data are found. Content analysis has been discussed as a useful method for answering questions about communications, e.g., who says what to whom, with what effect and why. This analytic method was used in this study to answer the why question, that is, communication data were analyzed to determine the values and motives behind a particular policy. This method of examining written communication to determine the motives for what has been said is similar to linguistic analysis, although linguistic analysis involves more careful attention to word usage and language patterns (Miller, 1976).

Content analysis is also a useful method to examine communication as a reflection of attitudes, interests and values of population groups.
(Krippendorf, 1980). For the problem addressed in this study, the literature reported philosophical research which examined the values involved in the policy process. Results from this philosophical inquiry were used in this study to develop categories corresponding to criteria for a just distribution of resources. These categories were then applied to the data to determine whether they were useful in reflecting the values of the policy makers involved in the process.

The other relevant policy variables, as described earlier, were those used in Moroney's (1981) value-analytic framework. These included: the problem addressed, alternative solutions suggested, and strategy selected. In addition, a few more variables were included to account for the actors involved, the time period, the type of debate, and the type of outcome. The variables for actor, time period, type of debate and type of outcome were categorized using specific variable definitions.

The variables of problem analysis, alternative solutions and strategy selected are dependent on the situation in which they are being examined. These variables, taken from Moroney's framework, were broadly defined. An analytic technique similar to the constant comparative method was used to determine themes and patterns in the data reflecting these variables (Glaser, 1969). The data were analyzed for statements of problems and strategies suggested and these were grouped by themes expressed for each one. As analysis continued, new data statements were compared against the evolving definitions for each theme. Then these themes were compared to each other and combined into concepts.
representing different types of problem statements, alternative strategies and solutions. This method differed from constant comparative analysis in that the end results were to be descriptions of relationships for this particular case, and not general theory.

The categories for the criteria of distributive justice were allowed to evolve as well. This means that the data were categorized using the definitions found in the philosophical literature. However, data which did not fit into defined categories were still relevant to ideas about distributive justice, and new categories were created from the themes found in this data.

B. Sample

A case study approach was used for this research. The population of interest was federal health care policies. A case study approach was used to keep the data set to a workable size, examine the problem in depth, and apply a combination of methodologies. The case chosen was federal funding for home health care services for the elderly. To further limit this case, the time period 1965-1984 was selected. Because federal funding for home care for the elderly began under Medicare, this time period covered almost the entire period of activity for this policy.

The data used for this study were federal government documents reflecting the public debate about this policy. Because the research problem involved expressions of social values, public debate was judged reflective of these expressions. In addition, because of the public nature of this debate, it was assumed that this debate would reflect
what policy makers thought the public would accept in terms of social values, i.e., this debate was the public record of policy makers views on this issue.

Further, the government documents were chosen as reflective of the public debate because the debaters were mostly elected officials, who were assumed to represent the values of the society. These were the debates that were most directly translated into social action. Certainly there was policy relevant debate in the newspapers and journals, expressed by scholars, policy analysts and researchers. However, the legislative debate reflected much of the outside discussions and was presented to the country as justification for the action taken at the federal level.

C. Data collection

The documents serving as data were chosen by using several indexes to government documents. These were: The Monthly Catalog of U.S. Government Publications; The Congressional Information Service; and The Government Reports Announcements and Index. These listings have subject indexes and provide a comprehensive list of government documents. All documents relating to home health care for the elderly were listed for the years 1965 through 1984. This list of ninety documents was then examined for the types of documents included and the data list was refined. The documents deleted from the list were: instruction manuals; regulations; documents pertaining to home care for groups other than the elderly; references to home care supported by the Veterans Administration; and discussions about fraud and abuse. The remaining list
consisted of fifty-five documents including congressional floor debate, congressional hearings, committee reports, and public laws (Appendix A). These documents by type are arrayed in Table I.

Policy consists of more than legislation. Moroney (1981) discussed three expressions of policy: legislation, regulations, and judicial decisions. In addition, other policy analysts refer to implementation of policy as being part of the process (Brewer and deLeon, 1983). However, for the purposes of this study, legislation was the focus of the analysis. It would be very difficult to discern values from regulations because the rationale for regulations is not given, and a sound argument could be made that the distribution of resources embodied in regulations does not always match the legislative intent of Congress. Studying the values inherent in policy implementation would be interesting, and similar work was done by Mundinger in her 1983 examination of how nurses worked with home care regulations. However, a focus on implementation would relate more to the values and interpretations of the health care providers and the need for clear and unambiguous regulations than it would relate to social values. Thus, documents which reflected policy regulations, implementation, or recipients other than the elderly were eliminated to clarify the focus of the study. The nature of a case study is to minimize extraneous issues and investigate the problem of study in depth.

D. Data analysis

As discussed earlier, data analysis consisted of a combination of the techniques of content analysis and constant comparative analysis.
<table>
<thead>
<tr>
<th>Year</th>
<th>Floor debate</th>
<th>Hearings</th>
<th>Committee Reports</th>
<th>Public Laws</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>8</td>
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</tr>
<tr>
<td>1972</td>
<td>4</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>8</td>
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<tr>
<td>1973</td>
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<td>-</td>
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<td>1</td>
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<td>1974</td>
<td>-</td>
<td>1</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1975</td>
<td>-</td>
<td>1</td>
<td>-</td>
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<td>2</td>
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<td>5</td>
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<tr>
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<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>TOTALS</td>
<td>17</td>
<td>25</td>
<td>8</td>
<td>5</td>
<td>55</td>
</tr>
</tbody>
</table>
Exploratory studies require less instrumentation at the beginning of the inquiry which allows for themes and concepts to emerge from the data (Miles and Huberman, 1984). The analytic unit of interest here was thematic, which could be sentences, phrases or statements defined on conceptual grounds. In the approach used here, some variables have very specific categorization schemes and some have general definitions used to determine categorization schemes for the data. Categories for the criteria of distributive justice were derived from the literature and were discussed in detail in Chapter II. The operational definitions of these criteria for the variable of distributive justice follow.

**Utilitarianism.** Distribution of resources decided on the basis of an estimation of the greatest good/benefit for the greatest number.

**Need/equal outcomes.** Distribution of resources decided on the basis of trying to attain equal outcomes for all, i.e., those with the greatest need for a particular resource receive the greatest amount of it.

**Merit.** Distribution of resources decided on the basis of what one has earned, i.e., those who have contributed the most to society, receive the most, in socially acceptable terms.

**Ascription.** Distribution of resources decided on the basis of ascribed characteristics, which must be stated, e.g., gender, race, age.

**Justice as fairness.** Distribution of resources decided so that the least favored in society would get the resources that an unbiased person would deem fair.
Equality/equal inputs. Distribution of resources decided on the basis of strict equality, all of the resource in question is distributed in the same amounts to everyone.

In addition to the above categories for the variable of distributive justice, several of the other variables had categorical definitions.

Time period. This was defined in years.

Actors. These were broken down into three general groupings: government appointed officials; government elected officials; and representatives of interest groups. Government appointed officials included members of the administrative branch of local, state or the federal government. Government elected officials included any elected representatives of the people at the local, state, or federal level. The last group, members of interest groups, included health care providers and administrators, researchers, lobbyists, and consumers.

Type of debate. This was defined as type of document or the setting for the public debate. As mentioned earlier, this included hearings, floor debate, committee reports, and public laws.

Type of outcome. The types of outcome were either recommendations, the passage of a bill, or a public law.

The remaining variables were not analyzed with preexisting categories. These variables included: the problem analysis, alternative strategies suggested, and the strategy chosen. These variables were analyzed using the definitions from Moroney's (1981) framework and themes were determined from the data. These themes were later combined into categories. The definitions follow.
Problem analysis. A description of the dilemma being addressed by each actor, its etiology, and its history.

Alternative strategies. The actor's proposed solution to the problem.

Strategy chosen. The action chosen after the debate to resolve the problem.

As mentioned earlier, the data were coded for these variables. This was done by having copies of all the data documents and using colored markers to represent different variables. The coding was rechecked several times, and categorizations were checked against other entries in the categories. "Field notes" were kept to aid in decisions to categorize, and several categories were modified or added to reflect themes found in the data.

The data were entered into a microcomputer and coded again using the Ethnograph program (Seidel et al., 1985), to assist with the mechanical aspects of data analysis. This program is designed for narrative or text data and allows the researcher to code, recode, sort and print the data in files to facilitate the interpretation and analysis (Appendix B). The variables were then analyzed in terms of relationships with each other.

E. Discussion of approach

1. Reliability and validity

Reliability and validity are always problematic with qualitative studies such as the one described here. Three forms of reliability for content analysis are discussed by Krippendorf (1980). These are
stability, reproducibility and accuracy. Stability has to do with agreement with one rater coding the data at two different times. The data described here went through three separate coding processes by the investigator. Because the categories were being refined during the data collection and analytic process—via a constant comparative technique—the data were recoded at different stages of the process and as they were being entered into the computer. During each coding session "field notes," actually notes made during the collection and coding of the data, were kept to record problems in the coding process or with the categories. These notes were then compiled and used to compare data segments against the evolving coding categories and the segments were recoded accordingly. Although this enhanced the stability of the coding and analysis, stability is the weakest form of reliability.

Reproducibility would have involved having another person code the data using the definitions developed in this research. This was not attempted because the nature of a case study is that a well defined data set is examined in depth, and the coding categories were evolving and were not established until the end of the study. Future research in this area is warranted to use the categories and method developed here on other examples of policy and to develop indices of reliability. Given the lack of an attempt to judge reproducibility, it is important in the report of this study to be as explicit as possible about the methods used so that others could attempt to replicate this study and compare their results with those reported here (Miles and Huberman, 1984).
The last and strongest index of reliability is accuracy, that is, judging the coding by an independent standard. This is difficult to do in a study such as this where no independent standards exist. This measure of reliability is akin to the concept of validity.

The validity of an exploratory study such as this is also difficult to assess. The intent of this study was to determine whether valid statements about the values involved in policy could be made by analyzing documents. Content validity was achieved for the preestablished categories or criteria for the variable of distributive justice. This is because these categories were derived from experts in the field and their work as reported in the literature, and thus represented their judgments about definitions of distributive justice.

2. Strengths and weaknesses

The advantages to this methodology are found in the explorative nature of the work. The methodology used allowed for a description of concepts heretofore not examined empirically. In addition, these concepts are examined in relation to other variables which are drawn from the data, so that the results of this study will be grounded in the data. When results are distanced from the data in terms of instrumentation and other representations of concepts, there is more room for the introduction of bias and measurement errors.

In addition, the case study approach used here facilitated an in-depth treatment of the problem and an examination of the context in which statements reflecting the variables of interest were made. In the case of the documents representing public debate, the nature of the
debate was illustrated by arguments favoring one solution or set of values over another. Thus, examining those arguments in their entirety was useful to determine the values reflected. Statements taken out of the context of such an argument could be mislabeled.

This method of study has the advantages of using documents as the data source. Documents as data are non-reactive, that is they are not affected by being studied. In addition, they provide access to otherwise inaccessible subjects. In this study it would have been virtually impossible to interview as many policy makers as are represented, and the cost would have been astronomical. In addition, using documents as representative of the public debate on an example of social policy permitted longitudinal analysis of the data. If interviews were performed, the comparison of changes in the debate over time would have been lost. Lastly, the documents used were of high quality. Because of the nature of the federal policy process, the public debate is documented scrupulously for government records, and thus is of better quality than if an observer had attended these meetings (Bailey, 1982).

Likewise, there are several disadvantages to the type of study reported here. Qualitative research is subject to concerns about the lack of objectivity of the results. The best defense against this limitation is to document the process explicitly so that others can replicate it and compare their findings. Replications of this study would enhance its reliability.

The lack of good reliability indices and the narrowness of the case study approach results in findings which are not generalizable to other
policies. However, if the method is judged worthwhile, it would be appropriate to try it with other policies and compare results for different policy situations. As mentioned in the earlier discussion of the concept of distributive justice, some philosophers argue that criteria for just distribution are situation specific. Given that philosophical stance, the fit between the problem and the method of study is ideal.

The limitations in using documents as data include potential sampling biases, selective survival of the documents, and the limits of judging behavior based on verbal accounts. Here, however, a case study approach was used so there were no sampling issues, i.e., all relevant documents were used. Also, because of the nature of the documents, selective survival was not a concern because of the availability of government documents. However, the nature of the data in these documents remains a problem. These are largely political and public documents, and an argument can be made as to whether the statements accurately represent the values of the actors or what they thought the public wanted to hear. In addition, many policy decisions are made behind closed doors and for reasons other than those acknowledged in public debate. However, it is unlikely that such information could be obtained by interview. The only way to circumvent this problem would be by methods of participant observation over a long period of time.

Methodological issues will be discussed again in the chapter containing the conclusions and recommendations drawn from this study. The methodology discussed here presented a way to conduct systematic inquiry into the research question. The process is described to stimulate
future research and debate on approaches to such questions and the results engendered.
IV. DATA ANALYSIS I: LEGISLATIVE HISTORY

A. Introduction

This chapter presents a description of the case study problem and its formation and development over time. The case studied was federal funding under Medicare for home health care for the elderly during the period 1965-1984. This includes the debate over the enactment of Medicare, the first piece of legislation specifically funding home health care for the elderly. In addition, the debate presented reflects changes in and discussions of the policy pertaining to federal funding of home health care.

B. Analysis of problems and strategies

The data analysis performed for the variables of problem, alternative strategies and solution was described in Chapter III. The list of categories for each variable are presented below. Then a brief description is presented of each document representing public debate over that time period, focusing on the problems addressed, strategies suggested and outcomes.

The analysis of the problem statements was conducted in three phases. First, content analysis was performed to identify themes in problem statements. Concurrent with this process, the constant comparative technique was used to compare each succeeding data statement with the existing theme categories and to recategorize as necessary. Lastly, the categories were grouped into four general theme areas (Table II).

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<table>
<thead>
<tr>
<th>Need Based Problems</th>
<th>Program Problems</th>
<th>Justice Problems</th>
<th>Procedural Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical needs</td>
<td>Cost of care</td>
<td>Unequal treatment</td>
<td>Regulations</td>
</tr>
<tr>
<td>Catastrophic illness needs</td>
<td>Financial needs</td>
<td>Lack of choices</td>
<td>Quality assurance</td>
</tr>
<tr>
<td>Social needs</td>
<td>Socialized medicine</td>
<td>Fairness of financing</td>
<td>Control of services</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Funding problems</td>
<td></td>
<td>Further study</td>
</tr>
<tr>
<td>Family support</td>
<td>Social security financing</td>
<td></td>
<td>Fraud and abuse</td>
</tr>
<tr>
<td>Coordination of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growing numbers of elderly</td>
<td>Private insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependency needs</td>
<td>Harms the current medical system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits of care system</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Appropriateness of care</td>
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</table>
The most common type of problem statement was a need based problem. This included statements identifying the problem being addressed as the medical needs of the elderly; catastrophic illness needs of the elderly; custodial care needs; social needs, including needs for homemaker/chore services, transportation and day care; preventive care needs; the need for support for families caring for elderly family members; lack of coordination of health care services provided to the elderly; the increasing proportion of elderly in the general population; limitations of existing services; appropriateness of care funded or provided for the needs of the elderly; and problems with dependency of the elderly on outside assistance. These problem statements were often used in combination to describe needs of the elderly which the debate in question was designed to address. However, each category presented here was presented in a unique fashion from the others, expressing a slightly different aspect of needs of the elderly. Many of the categories seem similar. However, each was expressed in the data with unique terms which could not be reconciled with any other category and still retain the integrity of the statement.

The next broad type of problem statement was program financing statements. This included statements of concern about the cost of programs and legislative changes being discussed; statements about financial needs of the elderly; problems with private insurance coverage for health care for the elderly; concern about tampering with the current well functioning medical care system; concerns about moving towards a system of socialized medicine; problems with funding of the programs
under discussion; and specific concerns about financing the programs discussed under the social security system. Again, although all the problems represented in this broad category involved concerns with how to finance the health care initiatives under discussion, each subcategory represented a unique argument. An example is the category of concerns in funding the programs discussed. The category of concern in funding programs through the social security system is closely related, however, very specific concerns were expressed about social security funding versus concerns about other types of funding mechanisms.

The third broad category drawn from the data related to justice concerns. This category included statements about problems with unequal treatment of individuals; the problem of not allowing service recipients a choice of health care providers or the choice of whether or not to participate in a program; and problems with the fairness of a program which involved those less well off paying for services for those who could afford to pay for care for themselves. These were not arguments about how to distribute resources in a just manner; rather, they were statements of problems about things that were thought to be unjust and needed to be addressed.

The last broad category of problem statements in the data was identified as procedural problems. These included statements of problems with regulations or the procedures by which a policy or program was implemented. Such things as statements about lack of standards and quality assurance mechanisms, control of health service delivery, the need for further study into a problem, and fraud and abuse, were
included in this category. In general, these were problems of implementation or problems with the means chosen to achieve the policy goals.

The strategies suggested to resolve the problem under discussion and the solution chosen were analyzed in a manner similar to the treatment of the problem statement data (Table III). These data were divided into the same four broad categories discussed earlier. Need based strategies included programs to address the medical, social, custodial care, catastrophic illness or preventive care needs of the elderly; strategies to improve health for the elderly or achieve the goal of dignity and independence for the elderly; strategies for community based services, long-term care or specifically home health care; family support measures; nursing home care needs; strategies to coordinate an array of services or provide for assessment of the needs of elderly individuals; or strategies exemplified by programs already in existence and discussed as examples of model programs/policies.

The next broad category was financing strategies. These strategies included providing services to the elderly based on financial need, financing services out of general revenues, financing programs through private sector mechanisms, requiring contributions from recipients to finance services, strategies to maximize economic efficiency, and other general program financing mechanisms.

The third category was justice strategies. These strategies overlap with the categories for the criteria for distributive justice to be discussed in the next chapter and include allowing for choice of
<table>
<thead>
<tr>
<th>Need Strategies</th>
<th>Financing Strategies</th>
<th>Justice Strategies</th>
<th>Procedural Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical needs</td>
<td>Financial need</td>
<td>Participants' choices</td>
<td>Control of services</td>
</tr>
<tr>
<td>Social needs</td>
<td>General revenue financing</td>
<td>Equal treatment</td>
<td>Quality control</td>
</tr>
<tr>
<td>Custodial care</td>
<td>Private sector financing</td>
<td></td>
<td>Further study</td>
</tr>
<tr>
<td>Catastrophic illness</td>
<td>Recipient contributions</td>
<td></td>
<td>Local control of services</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Economic efficiency</td>
<td></td>
<td>Demonstration projects</td>
</tr>
<tr>
<td>Health promotion</td>
<td>General financing mechanisms</td>
<td></td>
<td>Support or opposition of policies</td>
</tr>
<tr>
<td>Dignity and independence</td>
<td></td>
<td></td>
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<tr>
<td>Community care</td>
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<tr>
<td>Long-term care</td>
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<tr>
<td>Home health care</td>
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<td></td>
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<tr>
<td>Family support</td>
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<td></td>
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<tr>
<td>Nursing home care</td>
<td></td>
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<tr>
<td>Coordination of care</td>
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<td></td>
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<tr>
<td>Assessment of needs</td>
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<td></td>
<td></td>
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<tr>
<td>Demonstration programs</td>
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</tbody>
</table>
participation and providers by recipients and mandating equal treatment among recipients.

The last category of alternative strategies was procedural strategies. This included strategies for who would control services, quality assurance standards, plans for further study of a problem, plans for state/local control of services, reports of demonstration projects, and strategies expressing support or opposition to other measures. These strategies were not issue based and frequently emphasized the process of program implementation to address a policy goal.

The analysis of the problems and strategies focused on the main themes of the arguments made by different actors. Some of the problems they defined and the strategies they suggested might have been grouped by specific types or by program description. However, most frequently, actors argued several points that they believed important and did not give specific plans for action. Overall, the analysis reflects the main arguments which were made, singly or in combination.

C. Legislative history of policy

Home health care as performed by visiting nurses has a history dating back to the beginning of nursing in this country. Nursing care was originally given in the home and only moved to a hospital base in the early to mid twentieth century. However, this care was largely funded by private funds or charitable donations. With the enactment of Medicare in 1965, home health care became an option for the elderly with the cost covered by the federal government. What follows is a brief history of the public debate over federal funding for home health care over a
twenty year period, using the analytic categories just presented to describe the conflicts and changes in policy. The original Medicare legislation authorized federally funded home health care for the elderly, and the public debate after 1965 reflects discussions of incremental changes in this policy. Thus the majority of the debate over the decision to allocate resources to such care is found in the initial debate about the authorizing legislation, the Social Security Amendments of 1965.

Medicare was a program developed over a number of years. The twentieth century demonstrates a history of increasing federal government involvement in health care, and in many ways, Medicare was the culmination of that movement. Much of the early Medicare debate focused on the wisdom of government involvement in health care financing in general, of which home health care was only a small part. However, the debate studied focused on the whole of the Medicare program, including home health care, so the data presented here reflect that debate. Only after the enactment of Medicare are the data specific to public debate on home health care.

1. 1965

The 1965 debate on the enactment of Medicare had a long history. There had been discussions of federal support for health care for the elderly for a long time and a state-federal joint program for care of the indigent elderly, the Kerr-Mills Act, had been in place since 1960. The debate reflected here, from 1965 on, does not include the earlier hearings on federal funding for care of the elderly.
In the House and Senate floor debate on enactment of the Medicare program, there was much agreement as to the problems being addressed. The main problem was a need based problem, specifically that of the medical needs of the elderly, who were an increasing proportion of the general population and needed financial assistance to meet their medical care costs. The disagreements centered largely on financing problems, that is, how to best finance such a program. In addition, there was some discussion of what medical needs should be covered and to what extent.

The House Ways and Means Committee reported out a bill which was debated on the House floor. Because of the rules of the House, the initial step in the debate was to vote on the rule by which the bill would be considered on the floor (Clark, 1984). The rule chosen allowed a specified time limit on debate and only one amendment, in the form of a substitute bill. Thus, the debate centered on comparisons between the Medicare bill and the Republican substitute. The Medicare bill defined a medical care program in two parts: one which covered hospitalization for the elderly who were eligible for social security benefits (Part A); and another which covered medical expenses for all elderly who were social security eligible and opted to participate (Part B). Both Parts A and B provided coverage for home health care within rigid eligibility limits. Home health care was defined as skilled nursing care for home-bound patients recovering from acute illness.

Part A was to be financed from a new social security tax collected from employees and employers, which created a special trust fund earmarked for Medicare benefits. Part B would be covered partly by a
deductible from participants and partly from general revenues. This strategy was defended by its proponents as a way for the elderly to contribute during their working years to health care benefits for their retirement. In addition, this plan was defended as being well financed and treating all elderly equally.

Opponents of the Medicare plan argued that the financing mechanism was inadequate because social security or payroll taxes were regressive and unfair to low wage earners. In addition, providing a service benefit under social security was thought a threat to the solvency of the retirement program. Opponents judged it unfair to have low wage earners contribute to the medical expenses of some of the elderly who could afford to pay for their own care. Their solution, the Republican substitute bill, was financed via general revenues from a progressive income tax, i.e., a tax which varies with one's income level. Also, the substitute bill contained mechanisms to evaluate the financial status of the elderly and require those above a certain income level to pay some or all of the premium for their participation in the medical insurance plan. Other arguments were made about some of the procedures for implementation of Medicare and the lack of coverage for catastrophic care needs. In addition, some of the debate centered around government interference in the medical system and the fear of creating a socialized medical system. However, the major issue was the different mechanisms for financing the two plans, and who was eligible for federally subsidized care. The outcome of this debate was that the Medicare plan passed in the House.
The Senate floor debate was less restricted than the House due to different rules for the conduct of business in the Senate (Clark, 1984). In the Senate, debate was generally unlimited and any Senator could offer an amendment relevant to the bill. Once again, the definition of the problem addressed was not argued. Senators agreed that the elderly needed assistance with the cost of medical care. The same arguments which were made on the House floor were discussed in the Senate, i.e., the problems of financing the medical care package and of deciding whether the benefits would be based on medical need or the financial status of the recipients.

In addition to the basic arguments, Senators offered their own amendments as alternative strategies to improve the Medicare bill. Amendments offered included coverage for the cost of prescription drugs, coverage for catastrophic illness, higher deductibles for those who were financially well off, and substitute plans which allowed private insurance plans for the elderly with financial assistance from the government in place of Medicare. The amendments were either aimed at expanding definitions of medical need covered under Medicare or adjusting the financing of the program according to the financial status of the recipients. The outcome of this debate was that the basic Medicare bill was passed by the Senate with amendments which allowed for coverage of the costs of prescription drugs, and eliminated a 3-day prior hospitalization requirement for recipients to be eligible for home health coverage under Medicare. This last amendment was presented as a way to make the
program more cost efficient by eliminating incentives for unnecessary hospitalization.

The House and Senate had passed two different versions of the Medicare plan. The next step was to appoint a conference committee to discuss the differences and develop a compromise version (Clark, 1984). The conference committee reported out a Medicare bill, financed in part by payroll taxes and in part by general revenues and recipient deductibles. It did not include coverage for catastrophic illness. Home care was included under Part A with a 100 visit limit in one episode of illness and a 3-day prior hospitalization requirement, to ensure that home care would be used appropriately following acute episodes of illness.

The conference committee bill next was taken to the House and Senate floors for debate on final passage. On the Senate floor, the general tone of debate was that this bill was acceptable, with some discussion that the purpose of this legislation was to cover acute episodes of illness, i.e., medical needs, and not custodial care. In addition, many Senators lamented the lack of coverage for catastrophic care, which had been eliminated in conference. The House floor debate still reflected concerns with the financing mechanisms of using the payroll tax for funding and with government interference in the private medical system. However, the House passed the bill as well, and the President signed Medicare into P.L.89-97, in 1965.
2. **1971/72**

Following the enactment of Medicare, no major changes were made in the home health care benefits for several years. The next period of public debate took place in 1971. Several hearings on medical coverage under Medicare were conducted by the Senate Special Committee on Aging. This committee was not one of the permanent authorizing Senate committees. That means it was established to function for a specific period of time, usually in an advisory role (Clark, 1984). Such committees often provide much information on specific topics and bring certain important topics to the attention of Congress and the public, but they do not consider or report legislation back to Congress the way an authorizing committee does.

The 1971 hearings on Medicare focused on financing problems, primarily the high costs of medical care provided to Medicare beneficiaries, and suggested changes to make the program more comprehensive and efficient. Again, the problem statements were need based and concerned with financing, i.e., those testifying at the hearings were concerned with the limits to the coverage provided the elderly under Medicare and the rising costs of the program.

The strategies suggested in these hearings focused on the need to expand the Medicare benefit package, especially home health care benefits, to better meet the needs of the elderly. In addition, home health care was discussed as more cost effective than hospital care. Suggestions included restructuring Medicare into a national health insurance plan; expanding covered home health care services to include coverage
for appliances such as eyeglasses and hearing aids; including coverage for nutrition and homemaker services; and covering the cost of prescription medications. Another strategy suggested was to provide incentives for use of less expensive home health care by removing the 100 visit limit under Part A, eliminating the 3-day prior hospitalization requirement for eligibility for home health care under Part A, and eliminating the 5% coinsurance required for each home health care visit under Part B.

The debate involved discussion of health care as a right, which was jeopardized by talk about cuts in Medicare coverage in the face of rising costs. Home health care was presented as a way of meeting recipients needs to stay at home, and a method of controlling costs by substituting less costly care in the home for more expensive institutional care. There were no specific outcomes to these hearings, but the discussion of the problems and alternative strategies provided an addition to the public debate. The problems and strategies addressed were need and financing issues.

In late 1971, the House Ways and Means Committee considered and reported out a bill to amend the Social Security Act after review of five years of experience with Medicare. In general the problem addressed in the bill was the need to correct deficiencies in the Medicare program which limited the access of the elderly to covered services. The strategies contained in the House bill included expanding Medicare benefits to the disabled, controlling the rise in costs of the Part B premiums paid by recipients, and procedural changes to decrease
the incidence of retroactive denial of reimbursement to home health care agencies for services rendered. The outcome of this debate on the House floor was to pass the bill.

The Senate Finance Committee considered a similar bill and reported it favorably to the Senate. The debate on the Senate floor, however, added several amendments to the bill, including coverage of occupational therapy as a primary home health care service. In the original Medicare legislation, occupational therapy was covered only if the patient was receiving some primary service, e.g., skilled nursing, physical therapy or speech therapy. The argument for this amendment was need based, i.e., recipients who needed occupational therapy services and nothing else should be able to receive them as a primary covered service under Medicare. In addition, in response to the argument that home care was more economical than institutional care and thus needed to be encouraged, the Senate added an amendment to eliminate the 5% co-insurance fee for home health care under Part B. Senators claimed that home health care was not being properly used because the co-insurance caused financial hardship for the elderly recipients.

The conference committee accepted the co-insurance elimination under Part B, but did not accept the inclusion of occupational therapy as a primary home health care service. It was believed that this would lead to abuse of the home health care benefit and that anyone who needed occupational therapy would need one of the other primary services. The House and Senate agreed to the conference report and the final outcome was P.L. 92-603, signed in 1972.
3. 1973

In 1973, the Senate Committee on Aging presented a workpaper on home health care under Medicare. The workpaper did not have a direct outcome, but contributed to the debate on home health care under Medicare. The major problems addressed in the paper were the underuse of home health care, the decline in the number of home health care agencies, and the rising costs of institutional care. The strategies suggested in this workpaper included expanding the services covered, removing the three day prior hospitalization requirement for home health care services, eliminating the 100 visit limit on home health care services, and decreasing access barriers to home health care services. Home health care was considered an economical way to meet patients' needs and keep them out of institutions, while guaranteeing the elderly the right to a full life with health care needs met. Again, the issues discussed were need and program financing problems.

4. 1975

In 1975, the House Committee on Aging held a hearing to address the problem of alternatives to institutionalization for the elderly. The focus of the hearing was the elderly's need for long term care services other than those provided in nursing homes. This discussion focused on the elderly's need for a wide variety of services in the home, including home health care, homemakers, day care, mental health services, and nutrition services. Testimony was given documenting home health care under Medicare as aimed at acute medical care needs, whereas
the most pressing needs of the elderly were for long term care to support them at home.

Strategies suggested to resolve these long-term care needs were mechanisms for expanding the types of care in the home which could be financed by Medicare. These strategies included: homemaker services, transportation and shopping services under Medicare; different models for coordinating home health care services; eliminating the 3-day prior hospitalization requirement for home health care; eliminating the 100 visit limit for home health care; expanding the definition of skilled care covered in the home; encouraging the growth of home health agencies; and procedural concerns for implementing home health care services.

5. **1976**

In 1976 the House Ways and Means Committee held a hearing which focused on issues of fraud and abuse in home health care. The committee recommended that home health care services be expanded, but only with the appropriate controls and standards to limit fraud and abuse.

6. **1977**

In 1977, the Senate Special Committee on Aging conducted a series of hearings on alternatives to institutional care for older Americans. These hearings were held throughout the country and attracted testimony from a variety of people interested in the health care of the elderly. In general, those testifying agreed that problems with home health care included: underutilization, varying eligibility requirements, fragmented funding, and lack of impact on the major needs of the
elderly. In addition, participants testified to the institutional bias inherent in Medicare which led to unnecessary placement of many elderly in poor quality nursing homes. However, some providers of nursing home services objected to this characterization of nursing home care. They argued that the appropriate strategy for proper care for the elderly was the concept of a continuum of care. Such a continuum included home care for those who could be maintained in their homes, and nursing homes and residential care facilities when necessary. They argued that care in an institution was not always more expensive than care at home, depending on what needs a patient had and the availability of support from family.

Many participants at the hearings testified to the necessity of expanding home health care services to better meet the needs of recipients. Expansion ideas included services to meet custodial care and social needs of the elderly, i.e., transportation services, homemaker services, nutrition services, home delivered meals, and respiratory therapy. A few participants argued, however, that the intent of Medicare coverage for care in the home was to provide care for acute illness and not long-term, custodial care.

Much of the public debate centered around the problem of fragmented funding for services to the elderly in their homes. Medicaid and the Older Americans Act funded social and custodial care services for a small proportion of the elderly. Medicare funded home health care services to meet acute, medical care needs. The multiple funding sources for individuals led to duplication of care, improper assessments of the
patients, and lack of coordination of care and communication between providers.

Other strategies suggested to encourage home health care included the oft discussed elimination of the 3-day prior hospitalization requirement for home care, inclusion of occupational therapy as a primary service, coverage of services provided by dietitians in the home, and expansion of the definition of skilled nursing under home care to allow for custodial care, and deletion of the 100 visit limit for home care.

There was some discussion, in 1977, of procedural problems and strategies to regulate care and develop better standards for care. In addition, many programs were discussed either as model programs for comprehensive, community based care or as demonstration projects with federal funding which examined the costs and benefits of different arrangements of community based care.

However, in large part, the hearings focused on expanding home health care services to meet the needs of the elderly, defined from a broader perspective than that of acute, medical care. The predominant discussion centered on financing mechanisms to coordinate funding of these programs. Little discussion of limits to what should be covered under Medicare was undertaken, and very little concern was expressed about cost containment. It was assumed by most of the debate participants that the needs of the elderly should be met, and that meeting them with community based care and home health care was both desirable for the elderly and economical for society.
Two laws were passed in 1977 which affected home health care under Medicare. P.L. 95-142 dealt with limiting fraud and abuse in home health care and was partially an outcome of the Ways and Means hearings conducted in 1976. P.L. 95-210, the Rural Health Clinic Services Act, allowed rural health clinics to be reimbursed for providing home health care in areas where there was a lack of home health agencies. Usually, home health agencies were required to provide at least one service in addition to skilled nursing care in order to be eligible for reimbursement under Medicare. However, this concession was made to improve access to care in rural areas where access was problematic. In large part, these two laws were procedural in nature, i.e., they affected the implementation of the home health care benefit, without expanding the program or benefits.

7. 1978

The Senate Committee on Aging conducted an additional hearing on alternatives to institutional care in 1978. The problems discussed and the strategies suggested were consistent with those discussed in the 1977 hearings. Again, the outcome was the discussion of issues which added to the public debate.

The House Ways and Means Committee conducted hearings on expansion of the Medicare home health benefit also. Again, the same strategies were suggested: elimination of the 100 visit limit; elimination of the 3-day prior hospitalization requirement; inclusion of occupational therapy as a primary home health service; expansion of the definition of skilled nursing; inclusion of coverage for nutrition services; and
coverage for preventive care. The difference in this debate was the increased emphasis on cost containment. Many of these strategies were recommended to meet the needs of the elderly at less expense than nursing home care.

8. 1979

In 1979, the Senate Finance Committee conducted hearings to evaluate home health care and review proposals for expansion. These hearings reflected concerns similar to those discussed earlier, i.e., the need to expand home health care as an alternative to institutionalization, the need to provide for coordination of multiple home health care services, and general procedural concerns to limit fraud and abuse. The strategy discussed was a bill introduced by one Senator to eliminate the 3-day prior hospitalization requirement for eligibility to home health care, cover services for the terminally ill, cover dietitian services in the home, allow coverage for one evaluation visit to assess the patient's needs in the home, and expand coverage for homemaker services. Testimony supported this bill and suggested inclusion of such things as elimination of all visit limits for home health care, deletion of the requirement that all nursing care provided must be skilled care, the addition of occupational therapy as a primary service, and consolidation of funding sources for home care services. This committee was an authorizing committee and thus recommended legislation to be considered by the full Senate. The outcome of this hearing was that the bill discussed was not passed by the Senate.
The Senate Aging Committee held another hearing to receive a report on home health care by the Department of Health, Education and Welfare (DHEW), which Congress had mandated two years earlier. This hearing focused on a procedural problem in that the Senators thought the DHEW report did not meet congressional specifications and did not provide recommendations for changes in the Medicare home health care benefit.

On the House side, there were hearings by several committees, and the themes discussed were similar to those of the Senate committees. The House Ways and Means Committee and the House Committee on Aging conducted separate hearings to discuss expansion of home health care along the lines of the hearings held in 1978. In addition, the House Interstate and Commerce Committee conducted a hearing on elimination of the federal government bias toward institutionalization for the elderly and avoidance of costly nursing home care. However, the strategies to encourage home care discussed were developed with the caveat that such services be available to the elderly only if the resulting care in the community was less expensive than the cost of institutionalization for an elderly person. Again, there was no specific legislative outcome from these hearings.

1980

In 1980, the Senate Aging Committee and the Senate Committee on Labor and Human Resources held a joint hearing to discuss a bill which provided a mechanism for coordinating funding for the variety of home health services provided by different federal programs. The problems and strategies discussed were the same as reported earlier, with the
exception of increasing emphasis on the budgetary impacts of home health care expansion. The bill discussed provided coordination of funding for home health care; tax credits for families who were supporting an elderly person in their home; expansion of home health services; and elimination of the 3-day prior hospitalization requirement for home health services under Part A. This hearing did not result in a specific piece of legislation, but aspects of the bill were included in reconciliation legislation. Similar hearings were held by the House Committee on Aging.

A series of hearings by different committees resulted in the Omnibus Reconciliation bill of 1980. The reconciliation process is one by which Congress works to bring existing tax and spending laws into conformity with congressional budget resolutions. Because the budget process separates authorization of programs from appropriation of funds, the appropriated funds are not always consistent with budget goals. Thus, the reconciliation bill was an enormous package which covered many aspects of government spending. It was discussed in many committees, with each committee focusing on the part of the bill for which they were responsible. Although the intent of the reconciliation process was regulatory and not legislative, the flexibility of the process often results in the introduction of new programs (Clark, 1984).

In 1980, the hearings held by Senate and House Committees discussed changes in the home health care benefit, including the elimination of the 3-day prior hospitalization requirement for home health care under Part A, the elimination of the Part B deductible for home health care,
and the inclusion of occupational therapy as a primary home health care service. These provisions were included in the Omnibus Reconciliation legislation which passed both Houses and resulted in P.L. 96-499.

10. **1982**

In 1982, the House Ways and Means Committee conducted a hearing on cuts in the Medicare program suggested by the Administration. This hearing clearly focused on cost containment issues and did not discuss expansion of home health care to meet the needs of the elderly. The problem addressed was the need for new financing mechanisms to cut costs under Medicare. The strategies recommended included charging a 5% co-insurance for home health visits, moving to a prospective payment system for reimbursement for home health care, and adjusting deductibles, co-insurance, and premiums for income levels—all financing solutions. Opponents of such charges argued that cost containment should not mean shifting costs to the elderly, home care is less expensive than hospital care, Medicare only pays 38% of the health care costs of the seniors, and further cuts would renege on the promise of health care to the elderly made in 1965.

11. **1983**

The 1982 debate continued in 1983 with similar issues raised at a hearing by the House Committee on Aging. In addition, testimony charged that home health care benefits had been cut by more stringent applications of regulations resulting in more denials of care. Much of this hearing focused on procedural issues to make interpretation of regulations more consistent when working with intermediaries.
D. Conclusions

In the public debate discussed here, most of the actors represented were government elected officials or health care providers and administrators. In general, health care providers and administrators argued for expansion of care to meet the needs of the elderly. Some government elected officials joined this argument as well, but usually with modest proposals for expansion of existing services. Most of the concern with financing problems and strategies was expressed by government elected officials and government appointed officials. All of the floor debate was conducted by Senators and Representatives only. In hearings, government elected officials spoke, but most of the testimony came from interest group members and government appointed officials.

The majority of the debate about the wisdom and feasibility of government funding for health care occurred in the debate over the enactment of Medicare. The remaining debate focused on expansion of the existing program to meet other than medical needs. That is, most of the debate involved a discussion of the needs of the elderly, and how best to finance programs to meet those needs. There was some discussion of procedural issues, but most of the regulations concerning home health care were developed by the administration and were not reflected in the public debate.

Although policy analysts such as Kingdon (1984) focus on policy as a result of timing of convergence of interest in the problem, politics and policies, much of the debate discussed here reflected an incremental approach to policy change. Incrementalism in policy making means changing
policy by small, marginal adjustments, which are manageable and defensible (Lindblom, 1965). In this case, although the original enactment of Medicare was a major policy change, subsequent changes in the home health care benefits were via small adjustments. Thus, the hearings in the 1970's reflected ongoing discussion of the original issues with minor changes in policy.

However, Kingdon's (1984) analysis of policy change is useful for examining the emergence of issues of cost containment. In the early part of the period studied, need was the focus and cost was secondary. However, as Medicare costs rose and Administrations and the economy changed, discussions of cost containment began to dominate the agenda, diminishing the focus on meeting the needs of the elderly. It is interesting to note, though, that the enactment of a major program such as Medicare had the effect of stimulating debate on health care needs. Over the course of twenty years, the focus on needs moved slowly from acute, medical care needs to custodial, long-term care needs. The outcome of the public debate, however, in incremental fashion, did not result in changes in the policy to reflect this shift.

The setting for the debates presented here is important to the analysis of problems and strategies. Much of the debate about specific bills in authorizing committees is not public. When authorizing committees discuss bills, they publish a report of their recommendations. There is no public record of the process used to reach those conclusions or the discussions of bills which die in committee. Thus, that information is lost to analysis.
It is apparent from the data presented here that much of the discussion of home health care took place in hearings conducted by special committees. While such hearings serve to provide information on issues and add to the public debate, the nature of such committees is such that no direct action on bills via the mechanism of reporting them out favorably to Congress can result. Thus, those committees frequently lack the power found in authorizing committees.

The preceding discussion of the issues, problems, and strategies discussed in the public debate provides a framework for the in-depth analysis of the concept of justice as it related to the debate about home health care for the elderly. This analysis is presented in Chapter V.
V. DATA ANALYSIS II: DISTRIBUTIVE JUSTICE CRITERIA

A. Criteria of distributive justice

The criteria for distributive justice used for the analysis of home health care policy were defined in Chapter III. Content analysis was used to determine the occurrence of each criterion in the debate examined. However, the analysis did not seek incidences of actors making a specific reference to distributive justice using one of the criterion. Rather, it was assumed that what each actor presented was their view of what should be funded by the federal government, i.e., their view of how resources should be distributed. Thus, moral arguments were explicated from arguments about resource distribution. For example, if a legislator argued that coverage include custodial care needs, this argument was categorized as a need based distributive justice argument. In addition, the unit of study was the theme within sentences. Individual expressions of resource distribution were analyzed, and each actor could make more than one argument. This allowed the analysis to be closer to the actual data, the statements of the actor, than if each actor's argument was categorized with one theme for its entirety. Attempts were made to keep statements in context, and statements reflecting two separate themes were analyzed as such. In this chapter each justice criterion is examined in terms of who used it, in what context, and during what time period. Examples are given for each categorization type. Then, all of the criteria are examined in relation to each other over time, using tables to illustrate relationships.
1. Justice as fairness

The definition of the fairness criterion is based loosely on Rawls's (1971) "justice as fairness" concept. As mentioned earlier, this concept refers to a condition whereby, if all involved were blind as to the social merit and worth of themselves and others, they would choose to distribute resources in a way so that the least among them would have essential needs met. For this criterion, the definition is expanded to encompass references to favoring the least well off; providing minimal benefits to the least well off; and living by the Golden Rule of doing unto others what you would wish them to do to you.

This criterion is a more complex concept than some of the others used for this study. It often borders closely on the concept of distributing resources based on need. However, it is differentiated from need based distribution by its reference to those least well off, i.e., the extreme end of the need continuum. Expressions (n = 14) of this criterion are found almost exclusively in the original floor debate between members of each house over the enactment of Medicare.

In the House debate over Medicare, much of the argument was about how the Medicare plan should be financed, i.e., by general revenues or via social security taxes on dollars earned. The fairness criterion was expressed by several members who worried that financing via a payroll tax, a regressive tax based on the first "X" dollars earned, regardless of total income, would penalize the lower income working people. These members felt that often the low income working people were the least
well off. The following is an example of this argument from the House floor debate:

The committee bill's regressive tax will hit hardest at those least able to pay whereas the general fund financing of the alternative proposal would not. (HFD2A65)

and

A regressive tax hits those least able to pay the hardest and the payroll tax is one of the most regressive taxes known. (HFD2A65)

In the Senate, members used this criterion in the same manner, arguing that those least well off should definitely not have to contribute their earnings to finance care for the well-to-do elderly.

I do not believe that the men and women who work, which include the blind and the physically handicapped, and people who work for low wages, should have their taxes increased to pay the medical bill of anyone who has an income of $50,000. (SPD265)

In both the House and the Senate debates, those who supported the Medicare legislation also used the fairness criterion to argue that the bill protected the least well off in society, the elderly.

It is a recognition of our society's growing awareness that with our riches and abilities we can, and we must, insure all American citizens at least a minimal opportunity to the pursuit of health, life, liberty, and happiness. (HFD365)

and

Unfortunately, in our society as in every society, there will always be among our population those who must to some degree depend upon the other members of society to provide some measure of support. Some are blind or disabled. There are others who are indigent, but who can be made self-sufficient. Some are too old to work; others are helpless children. With humanity, out of conscience, in compassion, we provide for those who cannot provide for themselves.
With great good sense, in recognition of mutual advantage, we seek to rehabilitate and to make self-sufficient those who can be made able to provide for themselves. We do this through our public assistance programs. (SFD165)

There were several instances where members argued that the proposed Medicare plan should be expanded to provide coverage for catastrophic illness care. This argument used the fairness criterion to say that those suffering catastrophic illness were the least well off and thus should be assisted.

Ninety-nine percent of the people are covered under the bill. The amendment (to cover catastrophic illness care) would cover the one percent who have waited so long to be covered. They are the ones who should be covered by the bill in order to have a program which is progressive, necessary, and dignified. They are the ones who need this protection. (SFD365)

However, the argument was reversed by a Senator who used the opposite of the fairness criterion. He contended that the Medicare program should not be jeopardized for a minority of the people. This could be interpreted as a utilitarian argument, although, the Senator did not develop this argument further.

It just does not make any sense to expose the program to overutilization and excessive costs for the very few cases—probably one in a thousand—in which older people really have to be institutionalized for longer than 220 days to receive needed medical care. (SFD165)

The last type of reference to the fairness criterion in the floor debate on the enactment of Medicare was a reference to the Golden Rule, i.e., treating others as you would like to be treated.

This is a bill which seeks to put into legislative enactment the principles of the Golden Rule. (SFD365)
During the rest of the period studied, the fairness criterion was seldom expressed \( n = 4 \). In hearings before the Senate Aging Committee (1971) on changes needed in Medicare, a health care provider expressed the idea that society would be judged by its treatment of those least well off.

History will record the judgement of our society, not by our technological achievements, not by our great affluence, not by a man walking on the moon, but by the treatment we accord our aged, our infirm, the lame and the halt. A society is judged by what it does or fails to do for those least able to help themselves. (SAH171)

General concern for the least able or the most vulnerable was again expressed by members of the House in later hearings about potential cuts in Medicare benefits.

I look forward to working with you to preserve these programs that protect our Nation's most vulnerable citizens. (HWMH81)

In general, the fairness criterion was reflected in statements about a social obligation to provide for those in most acute need or least able to engage in self-care. It was differentiated from general discussions of need by its concern for those at the extremes or its placement in discussions of what we would expect from others were we to be in that position. However, the criterion differed amongst those who expressed it in terms of their definition of least well off. Some actors used the criterion to express concern for those least well off financially, and others to refer to those least well off in terms of health or physical capabilities. Clearly, no one argued this criterion in Rawls's sense of what would we judge fair if we did not know where we fit in society.
Probably the closest argument to this was that which referred to the Golden Rule.

Because this criterion was expressed so seldom, no patterns were discernible in terms of the problems addressed or solutions suggested in conjunction with this criterion. No one used this criterion in a specific Rawlsian sense. The "original position" where no one knows where they fit into society is an ideal. Knowledge of social values has immeasurable effects on distributive justice theories, definitions of least well off, and determinations about allocation of minimum levels of resources.

2. Utilitarianism

The criterion of justice as utilitarianism reflects the concept of justice being the greatest good for the greatest number. In the documents examined, this criterion was most often expressed as concern for spreading limited resources over the largest number of people. This criterion was not used often over the twenty-year period under study (n = 9). It differs from the other criteria of justice examined in that it usually refers to the well-being of the population, whereas many of the other criteria are used to refer to individual cases and social responsibility to individuals.

In the documents from the initial debate over the enactment of Medicare (1965) the utilitarian criterion was used several times. During the House floor debate, several references were made to Medicare's being an enactment of the idea of social responsibility, as in the following examples:
We are a prosperous Nation and a country which is fulfilling its obligation to provide for the common welfare. (HFD2A65)

We ask government to provide social insurance where such insurance will do the job better than by leaving each individual to his own resources. (HFD2A65)

Several House members used a utilitarian argument to disagree with the Medicare concept. They contended that Medicare would help a few (the elderly) at the expense of the many (young people or the workers). Several examples of this follow.

Our young people between the age of 21 and 65 are also entitled to some consideration. (HFD2A65)

I believe that a bill which discriminates against one portion of the population in order to give vast compulsory benefits to another segment is unjust and unfair. (HFD2A65)

The burden for a solution to this problem must be the responsibility of this entire Nation and its total tax base—not just be placed on the shoulders of our lower income wage earners. (HFD2B65)

The Senate floor debate on Medicare had fewer references to the criterion of utilitarianism. One example of this was an argument for adding catastrophic illness protection to the Medicare bill.

We are now proposing 60 more days on a shared cost basis, with additional nursing home and home health care. We know that even with these generous additions, the care provided will not meet every last bit of need, but it will prevent catastrophe befalling millions of our elderly. (SFD165)

In later years (1973), this criterion was expressed by several actors in citing the importance of home care. This is illustrated by this comment in a Senate paper, expressed by a health care provider.
The home must be re-established as the center of care so that resources will go where they can do the most good for all. (SAC73)

Again in congressional hearings on home care throughout the 1970s, occasional mentions were made of distributing resources to the best advantage of the majority.

There is a major need to refocus our health strategies to improve efficiency and insure optimum utilization of our scarce medical resources. (HAH75)

and

The purpose was, No. 1, to maximize the funds, to provide the most services to the most people and prevention and/or delay of institutionalization, both acute and long-term care. (SLAH80)

In general, the actors in the debate rarely referred to arguments about the greatest good for the greatest number in the discussions of funding home care for the elderly. This is understandable given the issue debated in these documents, i.e., health care for a small segment of the population, the elderly, financed by most of the remaining adults in the population. By its very nature this issue involved providing benefits to a minority group.

Because there were so few examples of this criterion, no patterns for its usage were deducible. Government elected officials, consumers and government appointed officials made utilitarian arguments but such arguments were rare over the twenty-year period studied. These arguments could not be related to problems or solutions because of their rare occurrence. Utilitarianism was used by both sides in the original Medicare debate, i.e., by actors promoting social insurance as social
responsibility and by actors declaring that Medicare penalized the greatest number for a social good for a minority.

Utilitarianism may be a concept which is used in the abstract, not in the specific. To make arguments for overall social policy reflecting the greatest good for the greatest number has an intuitive appeal. However, for a specific issue brought to public debate by public concerns, such as health care for the elderly, utilitarianism may place a public figure in an indefensible position. It is difficult to defend a utilitarian argument in the face of individual need without appearing callous and losing public support. As mentioned earlier, the documents examined are public records of debate, and all actors involved were potentially speaking to a larger audience.

3. Equality

The criterion of justice as equality is used to describe the concept of distributing resources for all in the same amount. In the debate on the original Medicare legislation, arguments which used this criterion usually referred to distributing benefits and burdens equally within certain groups. Because Medicare involved resource allocation to the elderly, there was little mention of population equality and discussion of equality dealt with subsets of the elderly. Most of the arguments emphasized distributing the benefits/burdens of this new program equally. The following is an example from a Medicare supporter during the House floor debate.

Here we offer the American people a program consistent with both the federal concern for the basic welfare of all Americans, and the individual and private responsibility for self and family. (HFD165)
and

This piece of legislation will mark the boldest and most significant step the Congress has taken in insuring the health and happiness of ourselves and our posterity, for age we all must. (HFD2A65)

Similar views were voiced by the Senate supporters of Medicare.

We should try to provide the benefits on the basis of equality. That is the great principle of the social security system. (SPD365)

or

The purpose of this program has rather been to provide for all persons a basic floor of protection to which the individual can add by his own efforts, acting individually or with others of his group. (SPD165)

In addition, a few members of Congress argued that Medicare was just because the burdens of the policy were borne fairly, i.e., all workers were taxed the same rate on the same amount of income to finance the program.

This provision would apply to all taxpayers of all ages. (HFD365)

And, one House member, a woman, spoke fervently in support of the legislation because the benefits received would be equivalent for men and women.

The medical benefits program, for the second time in social security history, has treated women as equals and pays exactly the same benefits to all, for which I am most grateful to the gentleman from Arkansas. (HFD2A65)

No one used the criterion of equality to argue against the Medicare program. However, the similar arguments made by Medicare opponents using the criterion of financial need will be discussed later.
In the 1970s and into the early 1980s, the idea of justice as equal
distribution of resources was used as an argument to expand Medicare and
the home health care benefit into a program of health care for all U.S.
citizens, or in a related argument for a national health insurance pro-
gram or a national health system. An example of this is the following
statement by a Senator during hearings of the Senate Aging Committee
(1971).

Programs like Medicare and Medicaid, when enacted, were truly monumental legislative milestones in the
social history of the United States. Each program marked an important change in public policy regarding
the value of health as a good in itself, and each program was a beginning step in the direction of ade-
quate health care for all Americans, not just the fortunate few who were able to expend massive amounts
of money. (SAH71)

This debate also took on the general language of "rights" for all,
which corresponds closely to the criterion of merit, to be discussed
later. This argument was made by a health care provider (1971).

At the very outset of our testimony we said health care is no longer a privilege of the few who can
afford it, but is the inherent right of all individuals. (SAH371)

Sometimes the argument was made to support a specific plan for
health care for all Americans.

The AFL-CIO is committed to the full implementation
of a national health security program. And a home service program could be of considerable value, and
is of critical importance to the preventive and direct service aspects of a full and comprehensive
national health security system. (SAC73)

Equality as a criterion of distributive justice was also used as a
specific argument for changes in the Medicare home health benefits. In
the late 1970s, legislative changes to allow for reimbursement of occupa­
tional therapy services as a primary service in the home were debated.
In this context, equality was used to argue that equal treatment should
be allowed, regardless of the setting.

The equitable treatment of our elderly and disabled people, for whom the Medicare benefits are intended, requires the enactment of this proposed legislation. A stroke victim's occupational therapy treatment should be a covered service whether provided in a hospital, clinic, or any other approved outpatient setting. (HWMH178)

For the most part, the arguments for equality as a just manner of
distributing resources were made by those, largely consumers and pro­
viders, who favored a system of national health insurance. Because the
documents studied were focused on home care benefits, such debate
involved expanding home health care services as part of a comprehensive
continuum of care financed via a national system. These arguments were
made most often in hearings on expansion of the Medicare program in the
early to mid 1970s and had diminished by the 1980s.

Equality was not a frequently mentioned criterion of justice
(n = 41), and this may reflect the fact that this data set focused on
policy for distributing resources to the elderly. There were constraints
to the debate from the onset, due to its purpose and the nature of the
legislation being discussed.

4. **Merit**

The criterion of merit was often mentioned in debate over how
to best distribute health care resources (n = 140). The merit criterion
is defined as relating to what resources people have earned or what they deserve.

In the early debate over the enactment of Medicare, merit was often cited in terms of what the country owed to the elderly, the Medicare beneficiaries. Many members of Congress spoke about the contribution of the older generation to building America, and that because of this, they deserved assistance with medical care in the form of the Medicare legislation. Here is an example of a member of the House making this argument.

The bill we are considering today, if enacted into law, will be one of the great landmarks of progress taken by our Government in order to help carry out humanitarian considerations which it owes to millions of older folks throughout the land who have devoted their lives to making this Nation of ours the leader of the world. (HWMR65)

Some House members spoke in general terms, such as

The Social Security Act of 1965 will give our citizens over 65 some measure of the economic security they deserve. (HWMR65)

Others were more eloquent.

Mr. Speaker, in this legislation we deal with nothing less precious than the lives and health, not to speak of the happiness, of the mothers and fathers of our land. One of the commandments says "Honor thy father and thy mother." I know of no way we can better honor the fathers and mothers of America—those who have borne the burdens of a generation, faced or been willing to face the enemy in war, borne the problems of a nation in peace, and developed a mighty land—than to provide a program so that they will not feel, when they come to the end or almost to the end of the day of life, that they are neither neglected nor forgotten. I feel that this bill does honor and justice to the mothers and fathers of America. (HWMR65)
Senators were equally eloquent on the responsibility of the country for the older generation which helped build society. Those who spoke of this debt to the elderly for their past efforts were almost all supporters of the Medicare bill. In addition, several members used the desert or merit argument to call for expansion of Medicare benefits to include coverage for catastrophic illness.

The other merit argument made frequently in the floor debate on the enactment of Medicare was that people needed to contribute to the Medicare program so that they would have earned a right to the benefits. The elderly would not want charity, but would want to earn their medical care. This argument was used by both opponents and proponents of the Medicare bill. Those that supported Medicare contended that the financing mechanism through payroll taxes allowed everyone to contribute during their working years to health coverage in retirement. The following presents an example from the House floor debate.

I long have taken a position in support of a program that is soundly financed on a contributory basis during one's earning years. I believe that the individual should prepare for his retirement years when he must anticipate medical expenses will be higher during this period of reduced income. (HWMR65)

and

Each person pays into the fund during his productive years and is entitled—as a matter of right—to adequate hospital care in his later years. (HFD2A65)

However, those opposed to Medicare argued that it was not a prepayment plan. They contended that workers would pay more to care for others than they would receive on their own.
Further, the committee bill gives false rise to the concept of entitlement by creating the erroneous impression that a wage earner is prepaying for his hospital benefits. A participating individual will pay for 44 years in advance for benefits afforded to those already 65 and those reaching 65 before him. (HFD2A65)

In addition, they argued, telling people that they prepaid for benefits and had a right to them would cause overutilization of services and would not allow any future adjustments in the program. Recipients would feel cheated by any decrease in benefits.

Costs of the program would go up; the potential burden on our hospitals and other health care facilities would be measurably increased; controls would necessarily have to be tightened to guard against the added danger of saturation of these facilities by millions of persons seeking a "free" Government service to which they had a "right." (HFD2B65)

The solution to the problem of participating or earning your benefits was the Republican substitute for the Medicare bill, the Byrnes plan. Those in favor of this plan argued that those elderly who could afford to pay ought to contribute money for their premium.

The Byrnes health care proposal gives these wonderful people the chance to retain their pride by participating in the premium payment to the best of their ability. (HFD2B65)

The general idea was that people should participate as much as possible in financing their health care. These arguments overlapped with those involving the criterion of financial need, which will be discussed later.

The same two arguments that reflected the merit criterion: that people should earn their benefits by contributing; and that the elderly deserve benefits due to their past contributions to building society,
are found sporadically in the remaining debate. However, the arguments are found most often in the original debate on the enactment of Medicare (1965). The discussion of what is owed to the elderly was later expanded to include the general discussion of "rights" to health care in the 1970s. This statement by a health care provider illustrates the argument:

As you so well know, it is now widely accepted that health care is no longer a privilege for only those who can afford it, but rather it is an inherent legal right of all individuals. (SAH371)

The merit argument was also used to claim that individuals had rights to a full life and that the government should provide services as needed to guarantee this right, as exemplified by this quotation from the Senate Aging Committee staff:

Every individual must have the right and opportunity to live a full life. We must provide all services which are necessary to keep the individual in the mainstream of his society. (SAC71)

The argument for expansion of services to guarantee the right to health for all individuals was used to argue for expansion of home care services and for the right of people to home health care. An example from a representative of a consumer organization expresses this concern.

It seems to me it should be a right and not a need that says to the elderly person if you do not wish to leave your house, there are people here who will take care of you. (HAH75)

and

NAJHA affirms the conviction that older people have the inherent right to alternatives, choices appropriate to their lifestyle and functional capacities; therefore, there is an obligation to assure provision of quality solutions. (SAH177)
Some actors used the argument of care owed to people to justify very specific agendas, such as expanding home health care services to include occupational therapy or nutrition counseling as a reimbursable, professional service.

The quality health care due a Medicare beneficiary is one of the strongest—if not the strongest—reason for removing the restrictions on home health and outpatient coverage of occupational therapy. (HWMH278)

In the 1980s, the policy issue for home care under Medicare became a debate over potential cuts in service due to the increasing costs of health care. In hearings on these cuts, the merit criterion was used, as had been predicted in 1965, to argue that the elderly had paid into the Medicare Trust Fund as an insurance program and thus were owed benefits. The following illustration was expressed by a provider of health care services testifying at a House Aging Committee hearing.

It is also worthwhile mentioning that the Medicare program is not a gift from the Congress—it is an expensive insurance program paid for by the people of the United States of America throughout their lives with the clear expectation that upon retirement they will receive enough money to survive, and that their health needs will be provided for. (HAH280)

The merit criterion was used fairly often in the twenty-year period under study. However, it was used to justify opposite policies. Most often, the criterion was used to argue for Medicare and then for expansion of home health care services under Medicare, as a deserved benefit for those who helped build American society. This developed into "rights" language in the 1970s as the debate moved from what society owed to the rights of the elderly. There is a subtle but important
distinction between society's felt obligation and any groups' demand for their rights.

The other use of the concept of merit was found most often in the early debate and involved the need for people to earn their benefits by financial contributions to the program. This was frequently mentioned in combination with a discussion of the importance of independence and self-reliance for the elderly.

The early discussion of resource distribution based on merit came from legislators at the federal level. However, as the concept of rights expanded and was used to justify expansion of home health care services, it was predominantly consumers and health care providers who made the "rights" argument.

As mentioned earlier, during the 1965 debate on Medicare, one contention made was that if Medicare was seen as a right because of employee contributions via payroll taxes, the program could never be amended or scaled down. This argument proved true, as evinced by later discussions of Medicare cutbacks which prompted a response from elderly consumers and from health care providers that they had paid for these benefits and thus had a right to them.

5. Choice

In the earlier chapter on definitions of the criteria used to examine the variable of distributive justice, the criterion of choice was defined in response to a theme discovered in the data (n = 120). This theme was not found in the literature on distributive justice, except as it related to the merit argument whereby resources were
distributed by desert and choice, where choices were allowed for those who could afford to choose. The choice theme reflected in the data was illustrated in arguments by actors calling for distribution of resources which would take into account the personal choice of recipients. This criterion was usually used in conjunction with some other criterion, i.e., choice was a necessary but not sufficient condition of distributive justice.

In the 1965 debate over enactment of Medicare, the choice criterion was reflected in debate over the voluntary or compulsory nature of various alternative medical care for the aged plans. The Medicare supporters contended that their plan included a voluntary, supplementary medical insurance plan (Part B). However, opponents of Medicare who supported the Republican substitute argued for their plan which was wholly voluntary.

Medicare supporters argued that their bill gave recipients a choice, as illustrated by this example from House floor debate:

The basic plan gives the aged protection against the costs of hospital and related care. This is supplemented by a voluntary plan which provides payments for physicians and other medical and health services. Through this method the individual has a free choice as to the extent of medical insurance desired while at the same time being protected against the basic and larger costs of hospitalization and related care. (HFD165)

Those who opposed Medicare argued that this was not good enough and that the entire plan should be optional for the elderly and preferably reflect ability to pay, which will be discussed further in the section on the criterion of financial need.
But there is also a very serious distinction in the matter of whether the program should be voluntary or whether it should be compulsory. I say it should be voluntary; that those who have satisfactory coverage from other sources should not automatically be blanketed in. We should make the health insurance available to everybody over age 65—without discrimination—which the committee bill does not do, and I believe it should be made available to everybody without discrimination. But let the individual make the basic choice as to whether he wants the insurance. (HFD165)

This debate raged more fiercely in the House than in the Senate; in the House the substitute Republican plan (the Byrnes bill) was voluntary and reflected ability to pay or financial need. However, the outcome in both chambers and in the final legislation was a two-part program: Part A, a compulsory hospitalization plan, and Part B, a voluntary medical insurance plan with contributions from all participants.

In the 1970s and early 1980s, the Choice criterion was reflected in discussions of recipients being allowed to choose where they would receive care, i.e., that home care was necessary so that recipients had the choice to remain independent and in the home/community setting. This argument was occasionally made by government elected officials, but more often was expressed by care providers and consumer groups, who were arguing for expansion of home health care services.

We feel that the patient should have every right to stay at home, and receive care at home, and be with the family in surroundings that he enjoys. (SAH271)

and

In short, the provision of medical/social services designed to help elderly patients remain independent in their own homes fulfills the urgent wishes of older persons themselves and is less expensive than nursing home care. (S3)
As we address the issue of alternatives to institutionalization, our prime concern should be the wishes of the older persons themselves. (SAH177)

An expanded home health care program would help preserve the sense of human dignity of the patient. The elderly have a great desire to retain some measure of control over their mode of living. (HWM278)

In the late 1970s, this argument continued; however, a new aspect was added. Actors contended that home was the preferred place of care for the elderly and was cost-effective.

In conclusion, it has been proven that day care and home health for the elderly is a workable, cost effective solution preferred by the elderly and their families to hospitalization. (SAH78)

Whereas earlier the argument was to respect the choice of the elderly, the tone changed to respect their choices, provided they are cost-effective.

There were a few references to the Choice criterion in calls for more consumer involvement in health policy. These occurred rarely and were mostly expressed by representatives of consumer groups.

Unless the consumer is involved at all levels of decision making the system will not be responsive to need. (SAC71)

The Choice criterion was interesting because of how it was used. In general, no actor called for distributing resources purely based on the recipient's choice. The idea of choice was always linked to some other end, e.g., making the health care system responsive to need, making it more cost effective, etc. The autonomy of recipients was defended as a part of human dignity and independence, but pure choice is impractical, except in conditions of limitless resources. The only other argument
for pure choice is in conjunction with the argument that individuals are entitled to the resources they earn, and they can then choose how to allocate these resources.

6. **Financial need**

In the initial stages of data analysis, one key criterion of distributive justice was Need. However, after a short time it became apparent that Need had two dimensions. The first aspect of Need was the general need for health care or social services in order to maintain a healthy, dignified existence. However, another oft-mentioned aspect of Need was that of Financial Need ($n = 162$).

During the 1965 debate over the enactment of the Medicare program, one of the key arguments was over how the program should be financed. Medicare supporters in both Houses argued for a system of hospitalization insurance financed through a payroll tax. Thus, all workers would contribute to the system and benefits would be available to all who were eligible for social security benefits. Medicare supporters argued that in general the elderly were financially needy and/or that financial need should not be considered in benefit calculations because this was a pay-as-you-go plan. All who worked would be taxed and thus deserved all benefits. Thus supporters of the bill spoke little about financial need except in a very general sense.

Certainly these two plans, which complement each other beautifully, will give the elderly financial security they so desperately need. (HFD2B65)

We have amassed steadily distressing evidence that the overwhelming majority of older people cannot afford proper care when illness and emergency strike,
and this is a legitimate interest of the National government. (HFD2B65)

Indeed, supporters of the bill suggest that general coverage for medical care for all the elderly would allow states to concentrate on medical assistance for those who were most financially needy.

The health insurance provisions of the bill reflect the belief that Government action should not be limited to measures that assist the aged only after they have become needy. The establishment of two separate but complementary health insurance programs will contribute greatly toward making economic security in old age a more realistic, more nearly attainable goal for most Americans. Because most of the aged could be expected to have the protection of the insurance program, public assistance would be relieved of much of its present burden. This would permit States to offer truly meaningful aid under the improved medical provisions of the bill, to the few people who are really in specifically needy circumstances. (SFR65)

In addition, supporters stated that the elderly should not have to be put through the degradation of a means test to receive health benefits. They should receive them as an entitlement program, like social security.

One of the basic arguments that has always been made for hospital care and medical care under Social Security is that those who are self respecting ought not to be placed in the position of asking for charity. We want them to feel that their needs will be taken care of without their having to go to the welfare department. (SFD165)

The opposition to Medicare argued that there were elderly who were financially needy, but this was not true of the total population. Therefore, there should be some allowances in the bill for recipients to be assessed for their financial need and contribute towards the cost of their insurance accordingly. As mentioned in the section on Choice,
some members argued that those elderly who had their own insurance ought to be able to opt out of the program entirely. But a stronger argument was made, in both chambers, for Medicare premiums to reflect ability to pay. Different actors had different schemes for accomplishing this. This was especially true in the Senate where multiple amendments to a bill are allowed and any Senator can try to amend the bill in their own way. However, the overall goal was to cut costs by having Medicare cover health care costs based on the financial status of the recipients.

I support the objectives of the bill if it means we are trying to provide adequate—the best possible—health and medical treatment to all people over 65 who cannot afford adequate medical treatment. (HWMR65)

To force wage earners to finance medical assistance for every senior citizen, regardless of whether it is needed, is unconscionable. (HWMR65)

and

In view of the above, Mr. Derwinski, is it morally right or fiscally sound to tax the younger wage earner to pay for the hospital bills for older people who, in the main, can afford to pay their own bills? (HFD2A65)

However, I would suggest that social justice does not mean that we should provide coverage for everybody regardless of ability to pay. I believe it is a strange concept of social justice that is being advanced. (SFD165)

There are numerous examples of the argument to consider Financial Need before awarding benefits. Another perspective on this issue was to discuss financial need of recipients in relation to the underlying financing mechanism of the Medicare program. The bill as presented was to be financed partly from tax on wages, put in a trust fund like social
security; and partly from general revenues. The opposition declared that this financing mechanism was unfair because payroll taxes were regressive, i.e., they taxed everyone equally regardless of income level. The opposition fought to have the entire Medicare program financed from general revenues, with benefits dependent on financial status of the recipient. General revenues come from income tax and other taxes which are more progressive, i.e., tied to level of income.

The key to this conflict was that by making Medicare a social security program, its support among the public was assured because everyone would contribute to the trust fund and it would be envisioned as an entitlement program. If the program was financed from general revenues, however, it would have been seen as charity or welfare care and would have been subject to cuts in future budget plans.

Later hearings and discussions of home health care as financed under Medicare reflected the same concerns with the criterion of Financial Need. As service expansions were discussed, some actors argued that those who could afford it should contribute some to the cost of their benefits. Others argued that Medicare should support a panoply of home based services without regard to the financial status of the recipients. However, such arguments were heard much less often after the enactment of Medicare, in large part because once Medicare was implemented, generations of people became invested in it and felt that they had earned their benefits by their payroll taxes over the years.
7. **Ascription**

The criterion of Ascription, as defined earlier, refers to the distribution of resources based on some ascribed characteristics of individuals. The literature on distributive justice does not focus on a defense of this criterion as a method for distributing resources. However, in reality, ascribed characteristics of individuals were frequently used to justify distribution of resources ($n = 403$). The characteristics were usually viewed in combination with some other criteria, such as need or merit. However, over time, often the other criterion was dropped and an ascribed characteristic became a shorthand for an idea about distribution. Examples of ascribed characteristics used in this way are age, gender or race.

In the case of the policy under examination here, the general discussion was of medical care for the elderly, so there is a bias in the case selection towards discussions of resource distribution based on age. However, again, many of the references to distributing benefits to the elderly use the characteristic of age in conjunction with merit or need. As the debate continued, however, many of the participants merely made reference to granting benefits to the elderly, without further explanation as to why this group was singled out of the general population.

In the 1965 debate over Medicare enactment, many government elected officials referred to the increasing numbers of elderly in the population, their greater health needs, and their fixed income levels. This
was used to set the stage for arguments to provide benefits to this group.

First, since your Committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your Committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. (HWR65)

and

It [Medicare] is a humane measure whereby Americans will be able to show our concern for our senior citizens and our respect for individual dignity. (HWR65)

For the purposes of this debate, the elderly were defined as anyone over the age of 65. This is probably because of the relationship between Medicare and social security, which also defined the elderly as those over 65 years old.

Mr. Chairman, by enacting the program embodied in the Medicare and Social Security Amendments of 1965, the Congress will provide benefits to every man and woman in this country who is over 65. (HFD65)

I believe the moral character of a Nation can be accurately judged by the way it treats its elderly. (HFD65)

Occasionally in the debate, the issue was raised that perhaps all elderly did not need assistance with medical care and that perhaps the more relevant criterion than age was financial need or income level.

First, in my estimation, we are saying here that everyone over 65 is a pauper and everyone under 65 is rolling in wealth. (HFD2A65)
However, the basic argument remained medical care for the elderly. Even within this group of elderly, certain conditions were ascribed as being covered under Medicare and others were not, with little explanation for the difference. A prime example is that medical problems were covered with the exception of psychiatric problems. Coverage for these were limited, and the issues was never raised in debate.

There would be a special limitation on outside the hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to $250 or 50% of the expenses, whichever is smaller. (SFR65)

With no discussion of this limitation, it is difficult to determine the rationale behind it. It could be reflective of the general concept of Medicare covering acute episodes of illness, or it could be a limitation on coverage for an ascribed group of illnesses, due to the nature of these illnesses.

The outcome of the Medicare debate, as mentioned earlier, was passage of coverage for hospitalization and medical care for the elderly. Concurrently, Medicaid was passed, which provided some medical coverage for those whose incomes were below a certain level, regardless of age. However, this coverage was much more limited, due to the differences in coverage allowed between states. So the overall aim of the Medicare legislation was coverage of medical care for those over 65, and this theme was consistent during the rest of the debate analyzed here. The criterion of Ascription was used in conjunction with the Merit or Need criteria, but always the focus was on the elderly.
Every person over 65 should receive the health care he needs. (SAH171)

and

We are most grateful to this committee for the opportunity to present our concerns for the elderly patients who are entitled to quality care in their own homes with the dignity and family comfort they deserve. (SAH371)

This theme was pervasive in all of the debate studied here, so there were no differences in use of this criterion by actor. In general, over the period studied, less explanation was given for the focus on the elderly as time passed. It seemed that the initial Medicare enactment debate set the precedent for rationale for resource distribution to the elderly. Later debate just built on that foundation, and made reference to the elderly as shorthand for the earlier justifications.

8. Need

The criterion most often used in the twenty year period studied here was that of Need ($n = 668$). Need was used in a variety of ways, from general statements about health needs of populations to specific statements about very specific needs for some type of service.

The original debate over the enactment of Medicare in 1965 had many examples of general and specific need arguments. An example of a general statement of need is this argument from a Senator during floor debate on final passage of the Medicare legislation.

Medicare meets the requirements of actuarial soundness and fiscal responsibility, but far more important, Medicare meets the requirements of these times—it meets the urgent health needs of the senior citizens. (SFD465)
However, most of the discussion of Medicare centered around its aim to meet specific medical needs of the elderly. The pending bills were very specific about the extent of medical needs the legislation was intended to cover.

Let us do something for our aged people and make sure that there are none of our older people who want for medical care and that they have the assurance they will have their medical needs taken care of. (HWMR65)

In fact, as mentioned earlier, the major argument in the Medicare debate was not over which needs to cover, but over how best to do it.

The chief bone of contention then comes not on whether to do what we are trying to do—that is, solve the problems of the medical needs of the aged—but how to do it. (HFD2B65)

In addition, it was clear that the medical needs referred to were acute, episodic care needs. This was evinced by the frequent mentions to the criteria for eligibility for care, which focused on acute, medical needs, and the mentions of not wanting to cover custodial care needs.

In the case of home health services, a physician would have to certify that the services were because the individual was confined to his home. He would also have to certify that the individual needed skilled nursing care on an intermittent basis or physical or speech therapy. In the case of home health services, the intermittent nursing care or physical or speech therapy would have to be for treatment of a condition for which the individual had received inpatient hospital services or post-hospital extended care. . . . Often the care in institutions is purely custodial, and it is the intent of the bill to cover only active care intended to cure patients in such hospitals and not to cover custodial care. (SFR65)
It was felt that, above all, we must try to avoid mere custodial care of people who are in poor health and who will continue to be in poor health but who could not qualify under the acute illness requirements of the basic program. (SFD465)

Another specific need mentioned in this debate came up in amendments offered in the Senate floor debate. Senators argued that the bill should cover the small number of cases of catastrophic illness, which were a threat to all elderly, regardless of income level.

I believe that we should do more for those in need than this bill provides—and I am willing to be liberal in my definition of "need," and I think particularly we ought to do more for those who are victims of the tragedy of catastrophic illness than this bill provides. (SFD365)

As mentioned earlier, Medicare did pass both houses, but the bill did not include coverage for catastrophic illness. However, legislators considered it a success and a necessary first step towards meeting basic medical needs of the elderly.

Its [Social Security] purpose is to provide cash benefits to persons reaching the age of retirement, to help them meet their minimum needs for food, clothing, and housing. I consider health care as being similar to a basic need. Who can argue that health care for persons over 65 who are sick, injured, or desperately ill is not as important to them as the provision of cash benefits to others for food, clothing, and housing. (SFD465)

I am sure that as broad a revision as this measure is and as far reaching as its benefits to our people are, we will see the day when the coverage is extended to long-term nursing home care and the cost of drugs in all phases of this program. (HFD465)

The debate of the early 1970s focused on Medicare coverage for home health care and continued the earlier Medicare debate in terms of its discussion of Need.
Although it has never been—mainstream medical care for all—it is an objective which must guide our efforts in the health field. Human need, not money, must be the decisive issue. (SAH171)

Certainly the provision of health care when needed is the absolute bare minimum that the U.S. and its Congress can insure for those people responsible for its growth and development. (SAH271)

However, as predicted early on, arguments were made to expand what qualified as medical need. As discussed in the last chapter, one of the expansions desired was to cover occupational therapy as a primary service under home health care benefits. Arguments for the need for specific services such as occupational therapy were almost always expressed by care providers. Occasionally legislators supported such statements. But in large part, as might be expected, occupational therapists expressed the need to expand coverage to include occupational therapy, etc.

Occupational therapy is medically necessary in cases where physical therapy or speech pathology is not. (SFD172)

By the mid 1970s, however, the discussion began to move towards expanding Medicare home health coverage to cover other than acute, medical needs.

Let's emphasize the concept of a network of services to include all of the services needed to maintain people in the community. (SAC71)

[We support] those policies which would stimulate home health services transforming the service delivery mechanism from its present acute orientation to one which meets the needs of the chronically ill. (HAH75)
In the later 1970s this discussion was articulated in all debate on home health care. Although the general theme of the debate was expansion of care, in general legislators argued for small revisions of current law to lift restrictions on the Medicare home health care benefit. These were discussed in Chapter IV and included such things as removal of the skilled nursing care requirement, occupational therapy as a primary service, removal of the three day prior hospitalization requirement for home care and coverage for homemaker services.

Medicare's three day prior hospitalization requirement for home health eligibility should be removed. Limits on the number of home health visits should be based on medical necessity. (SAH177)

and

Allowing home health care beyond the need for skilled services would bring home health benefits in line with the reality of the recuperative process. (HWMH178)

However, the providers who testified in hearings at this time envisioned a broad program of care in the community which would cover respite care, day care and other forms of family support, extensive home based services, transportation services, etc. They argued that these services were needed by the elderly and would be less expensive in the long run than care in an institution. Also, the hearings by special committees of both chambers tended to have discussions of global expansion of needs and suggested programs to meet such needs.

The services which have been identified as being of greatest benefit to the older person with reduced capacity to function in the activities of daily living are: homemaker services, visiting nurse services, transportation, telephone reassurance, home delivered meals, meals served at congregate sites,
physical therapy, etc. These, of course, should be available in addition to medical care, placement for care in a medical facility (hospital or skilled nursing home), or care in a protected living facility (foster home, home for the aged, etc.) as appropriate to the individual's particular needs. (SAH777)

Whereas in the authorizing committee hearings, the focus was on incremental changes to current legislation as mentioned above, with the intent of broadening current legislation. This example is from a hearing by the Senate Aging Committee.

We urge that the Federal Medicare system be modified to include a broader spectrum of health care services, including those services which have been determined to be essential through the demonstration and that agencies be established to evaluate client need and coordinate and monitor appropriate services to the elderly. (SAH577)

and

Future policies for care of the elderly need to take into account the value of preventive health services that particularly focus on prevention of need for institutional placement. A preventive approach should be both more humane and cost effective than our present tendency to impose an acute care medical model on a population that requires long term health and social services. (SAH5A77)

By the late 1970s and early 1980s, the debate began to focus on an expanded home health care program only if it was a cost-effective alternative for more expensive institutional care.

The Medicare program should include services of these kinds to increase the possibility of appropriate choice, to reduce expensive institutionalization and to meet essential health needs of many beneficiaries. (HWMH278)

The issue is a delivery system that includes more than one thrust, because this is what this country

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needs. Ultimately, it will be more efficient, more cost effective and more importantly, it will probably serve Americans better. (SFH79)

Although discussion continued to center around the need to expand home health care benefits and to look at such benefits as the preferred long term care alternative in conjunction with community based care, actors also stressed the costs of such care in light of finite health care resources.

The critical element in any equitable and efficient plan is to balance the health care needs of the elderly and all other citizens with the need to control national health care spending. To assure that this balance is maintained is a vital role of the federal government. (HWMH82)

This discussion was especially intense in light of Administration-proposed cuts in Medicare in the 1980s. However, proponents of home health care argued that this type of care would save money in the long run and thus should be stressed even in times of cost containment.

In many cases home care is both more appropriate for the patient's needs and less expensive than institutional care. (SAPH79)

B. Conclusions

The next step is to look at the criteria of distributive justice in relation to one another. This can only be done in a general way by discussing patterns of debate in relation to justice criteria. Quantification of the categorizations is not very useful here for several reasons. First, the documents are not equivalent in nature. There are several different types, from different periods, of different lengths and recording debate on slightly different aspects of the issue.
In addition, the actors represented here cannot be compared quantitatively because they did not have equal chances to be heard. Congressional floor debate only allows Senators and Representatives to participate. Even within that area, Senators and Representatives have different levels of access to the floor. In the Senate, everyone is allowed to speak and there are no time limits on remarks. In the House, because of the nature of the rules different members are allowed to speak for finite amounts of time, which may affect what they say. In hearings, participants are asked to testify so there are limits to time, number of speakers, and type of speakers allowed. Thus comparing frequencies of certain statements between types of actors is not useful because there is not an equal chance for different types of speakers to be heard.

The data discussed here reflect statements about distributive justice or rationales for resource allocation. However, many actors who spoke in the debates represented here did not make reference to allocation decisions. Thus comparisons of frequencies again lack context. In addition, for some of the justice criteria the number of times they were mentioned was so small that comparisons by actor or time period are meaningless. Such comparisons can only be made by reference to patterns or trends, and not to significant differences.

Having said all that, the following pages will illustrate some simple comparisons between criteria, as a way of describing occurrences of the criteria in the public debate. Realizing that these numbers have

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limitations, they are used here only to operationalize earlier discus-
sions of certain criteria being mentioned more frequently than others.

In general, home health care benefits under Medicare did not change
much over the time period under study. As mentioned in Chapter IV, the
major policy change in this period was the enactment of Medicare.
Despite a great deal of debate afterwards, only small, incremental
changes were made in the home health care benefit over the next twenty
years. Much of the discussion involved expanding benefits to cover a
broad range of health and social needs, but in reality the concept of
medical need broadened only a bit.

The criterion of Need was most often mentioned in the period under
study, and Ascription was next most frequently cited. As mentioned
earlier, however, references to ascription by age is to be expected in
discussions of home health care benefits for the elderly. Table IV
illustrates the criteria of distributive justice mentioned in the public
debate by time period under study.

The Need criterion was constantly discussed as a means of resource
allocation. As mentioned earlier, this was often used in different
ways. Early on in the discussions, specific medical needs were of con-
cern and over time this concept of need broadened. However, as already
mentioned, the legislation reflected little change in needs covered by
Medicare home health benefits. The criterion of Ascription, as ex-
pected, appears consistently throughout the period of study. Again,
given the nature of the policy studied, this is an expected trend.
TABLE IV
DISTRIBUTIVE JUSTICE CRITERIA EXPRESSED IN PUBLIC DEBATE OVER HOME HEALTH CARE UNDER MEDICARE BY YEAR (%)

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Need</td>
<td>23.7</td>
<td>32.3</td>
<td>80.3</td>
<td>21.9</td>
<td>60.5</td>
<td>54.7</td>
<td>86.3</td>
<td>37.2</td>
<td>42.6</td>
</tr>
<tr>
<td></td>
<td>Ascription</td>
<td>35.8</td>
<td>27.1</td>
<td>3.3</td>
<td>28.1</td>
<td>17.5</td>
<td>31.1</td>
<td>-</td>
<td>19.8</td>
<td>25.7</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need</td>
<td>18.0</td>
<td>4.2</td>
<td>3.3</td>
<td>6.2</td>
<td>4.9</td>
<td>1.3</td>
<td>2.2</td>
<td>11.6</td>
<td>10.7</td>
</tr>
<tr>
<td></td>
<td>Merit</td>
<td>10.8</td>
<td>22.9</td>
<td>6.6</td>
<td>9.4</td>
<td>5.8</td>
<td>4.1</td>
<td>2.7</td>
<td>8.1</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Choice</td>
<td>7.3</td>
<td>3.1</td>
<td>1.6</td>
<td>15.6</td>
<td>10.3</td>
<td>6.8</td>
<td>8.2</td>
<td>10.5</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>Equality</td>
<td>1.9</td>
<td>9.4</td>
<td>3.3</td>
<td>12.5</td>
<td>.9</td>
<td>2.0</td>
<td>-</td>
<td>8.1</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>Fairness</td>
<td>1.9</td>
<td>1.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.5</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>Utilitarian</td>
<td>.5</td>
<td>-</td>
<td>1.6</td>
<td>6.2</td>
<td>-</td>
<td>-</td>
<td>.5</td>
<td>2.8</td>
<td>.6</td>
</tr>
</tbody>
</table>

TOTAL (n) | 738 | 96 | 61 | 32 | 223 | 148 | 183 | 86 | 1567

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The criterion of Financial Need shows an interesting pattern. It is most often mentioned in the initial Medicare debate, then falls off and begins to be mentioned again towards the end of the study period. This is consistent with the earlier discussions of the legislative history of the policy. Initially, discussions of financing mechanisms were key. After Medicare was a fait accompli, little attention was paid to the issue of financial need as a resource distribution criterion. However, towards the end of the study period, cost containment was an issue, so it is understandable that the issue of increased responsibility for costs of care being placed on those beneficiaries who could afford it would rise again. This was one solution to staving off the rise in Medicare costs.

The Choice criterion arose consistently throughout the period of public debate. However, as mentioned earlier the character of this discussion ranged from the importance of allowing recipients to choose participation to the idea that consumers should be allowed to choose where to receive care.

The Merit criterion was most often discussed in the initial debate on Medicare, where it involved the debt to the elderly for their past contributions to society and the idea of people prepaying for their care in later years. Again, late in the period under study, Merit was mentioned more frequently in response to cost containment concerns. The solutions to cost containment included participants paying a larger share of the bills, which was presented in terms of Financial Need and Merit.
The criterion of Equality fluctuated a little throughout the debate. This criterion was perhaps underrepresented due to the focus of this policy on care for the elderly. Equality was used often in conjunction with other criterion. For example, given a distribution of resources based on need, within types of need all should be treated equally.

The last criteria, Justice as Fairness and Utilitarianism, were seldom mentioned. Justice as Fairness is a complicated theory, and as such, it is not surprising that it was so seldom articulated. Utilitarianism, with its similarity to majority rule, could be expected to occur more often. However, the social/political climate of the time encouraged attention to the problems of the elderly. It would have been risky for public figures to clearly discuss utilitarian goals, because of the real possibility of alienating the elderly.

The same issue arises currently when a child is in need of very expensive surgery or other medical treatments. Although clearly spending large sums of money on one person is not an efficient use of resources, people respond to the individual involved without discussion of the larger context. And indeed, such discussion would be unpopular and seemingly heartless to the public.

Table V illustrates the trends for different criteria of justice expressed by actors in different forms of debate. This table demonstrates that Need and Ascription were the most often mentioned criteria by all actors in different debates. The one exception to this is the Senate floor debate, where the most commonly discussed criterion was that of Financial Need. However, as indicated by the number of
### TABLE V

**PRIORITY LISTING OF CRITERIA OF DISTRIBUTIVE JUSTICE**
**BY TYPE OF DEBATE AND ACTOR**

<table>
<thead>
<tr>
<th>Floor Debate</th>
<th>Hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
</tr>
<tr>
<td></td>
<td>Elected</td>
</tr>
<tr>
<td>House</td>
<td>Senate</td>
</tr>
<tr>
<td>Ascription</td>
<td>Financial</td>
</tr>
<tr>
<td>(72)</td>
<td>(73)</td>
</tr>
<tr>
<td>Need</td>
<td></td>
</tr>
<tr>
<td>(165)</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>Need</td>
</tr>
<tr>
<td>Need</td>
<td>(71)</td>
</tr>
<tr>
<td>(54)</td>
<td></td>
</tr>
<tr>
<td>Merit</td>
<td>Merit</td>
</tr>
<tr>
<td>(40)</td>
<td>(40)</td>
</tr>
<tr>
<td>Choice</td>
<td>Choice</td>
</tr>
<tr>
<td>(33)</td>
<td>(10)</td>
</tr>
<tr>
<td>Fairness</td>
<td>Fairness</td>
</tr>
<tr>
<td>(7)</td>
<td>(7)</td>
</tr>
<tr>
<td>Equality</td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td></td>
</tr>
<tr>
<td>Utilitarian</td>
<td>Utilitarian</td>
</tr>
<tr>
<td>(3)</td>
<td>(1)</td>
</tr>
</tbody>
</table>
statements made in that category (in parentheses), the difference between that criterion and the next two is small.

The next three most often mentioned criteria are Merit, Choice and Financial Need. While government elected officials discussed Financial Need frequently in the floor debate, it became less important to them during the hearings. This could be related to the fact that much of the floor debate was about enactment of Medicare, where the financial status of future recipients was a key issue. However, all of the debate during hearings took place after Medicare was enacted when the decision had been made to provide care to elderly beneficiaries regardless of financial need.

The last three criteria mentioned were Equality, Utilitarianism, and Justice as Fairness. Equality was mentioned more often than Financial Need by interest group members. This is understandable because interest group members are more likely to argue for services that they think are necessary for all than they are to be concerned with government financing issues. The last two criteria were discussed earlier in terms of their rare appearances in the debate studied.

Relationships between the criteria of distributive justice and problem statements and strategies were alluded to in the earlier sections on the justice criteria. These relationships were difficult to determine for two reasons. The numbers of statements reflecting criteria and statements reflecting specific problems and strategies were small. Second, because of the nature of political debate, actors could and did use the same justice criteria for different or opposing strategies. Someone
arguing for Medicare might use Need and Merit based arguments to contend that the federal government must provide for the health care needs of the elderly who deserve it because of their past contributions. Someone who opposed Medicare might use the same justice criteria to argue that the health needs of the elderly should be met, but that the elderly needed to earn these benefits by their financial contributions, as outlined in the Medicare substitute bill. Thus, the two strategies would have been very different.

These criteria for allocation of resources were often used as political statements, i.e., broad statements of values used for public speaking. If these value statements are not developed further or discussed in the context of other values, they become meaningless. As discussed above, often the same criteria were used to justify different ideas and it is difficult to assess the arguments made because no specific development of the value criteria was given. The history of our government has been focused on operationalizing definitions of concepts such as liberty and justice and balancing them against one another. If some attempts are not made to do this in policy debate, such concepts become cliches and part of empty political rhetoric.

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VI. CONCLUSIONS AND RECOMMENDATIONS

This chapter will discuss the results of the study in three parts. The first part presents the utility of the methodology developed to answer the research question and suggests other methodologies for future work. The second part discusses the results in response to the research question and the area of ethics and social policy. The importance of nursing inquiry in the area of ethics and social policy will be addressed in the third part.

A. Methodology

In Chapter III the strengths and weaknesses of the methodology used to study the concept of distributive justice as reflected in one example of social policy were chronicled. One concern in this study was the issue of reliability. The researcher used a case study approach which allowed for an in-depth examination of a phenomenon but limited the generalizability of the findings. However, because there is some thought that distributive justice arguments are situation specific, generalizability becomes less important. Medicare is the most comprehensive program of health services funded by the federal government and the first large-scale federally funded health program. Thus, the public debate examined here represents a comprehensive discussion of rationale for allocation of resources to health services. Although the case studied is not representative of the population of social policies, it is an excellent example of health care policy. The amount of public debate
surrounding Medicare provided ample material for examination of the arguments relative to resource allocation.

To determine whether the debate examined here is representative of that found for other health policies, several other examples of policies should be examined in a case study approach to determine if there are similarities between the debates in terms of the justice arguments. While similar justice arguments may be used in different policies, the outcomes, or which argument prevails, may vary by the policy and the context for its development.

Another methodological issue addressed in detail in Chapter V was the lack of quantification of results. Content analysis is generally thought to result in quantification of results, but an argument against this outcome was presented and will be reviewed briefly. Table IV illustrates the frequencies of occurrence for each justice criterion over time, merely as an illustration of how commonly such references occurred. However, given the lack of comparability between number of documents and length of documents, number and type of actors, and purpose of each example of public debate over time, such frequencies are not meaningful. There is no common context for the comparison of such numbers.

The intent of the study was descriptive, i.e., to look for trends and general patterns, as well as test out operational definitions of criteria for distributive justice. Thus, elaborate measurement schemes were judged not appropriate for the problem addressed in this study. Instead, multiple examples of statements classified in each category
were given to illustrate the analysis, to give detailed descriptions of the concepts discussed and the manner in which they were used, and to allow enough detail for discussion of the methods used here and replication of these methods.

There are validity issues in the work presented. The content validity of the categories used for the analysis was discussed earlier. In addition, there are validity issues of whether these data can be said to represent statements about values, i.e., criteria for just distribution of resources, of the actors involved. The documents used as data were political documents. That is, they were accurate records of the debate, but each actor involved knew that public records were being made of what was said by all involved parties. For all actors involved there were self-interest concerns about being recorded as saying things which would meet public approval. This is especially true for the elected officials involved who could be quoted based on these debates and judged by their constituents on the basis of such statements. However, even if the statements made by each actor were more reflective of their perceptions of the public's values than their own, the argument still stands that such data would reflect social values. In fact, this enhances the validity of the responses because they could be said to represent the actor's perceptions of social values of the public.

Another validity issue is the specificity of the statements about values which underlie allocation decisions. As mentioned above, much of the debate examined here was political in nature, that is, global value statements were made as tools for political purposes and were so broad
as to be meaningless. This was mentioned earlier in the discussion about distributive justice criterion being used to support two opposing positions on an issue. The use of value statements in such a broad manner causes them to become cliche. Thus the occurrences of statements categorized as distributive justice statements does not necessarily indicate the presence of coherent, reasoned discussion of the values underlying policy alternatives.

A more difficult question to answer is whether important legislative decisions are made on the basis of hearings and congressional floor debate or whether such decisions are, in large part, made beforehand in discussions which are not a part of the public record. Many other factors influence political decision-making and much interesting and informative discussion is never made public. Examples of this are the fact that legislators frequently have made their decision on a bill before the floor vote and that committee reports present conclusions without documenting the discussion which took place.

There are two answers to the question of whether important legislative decisions are made during public debate and are thus a matter of public record. First, if such decisions are made in nonpublic forums, they will be more difficult to examine. Data from nonpublic meetings would be more difficult to obtain in a valid manner. Interviewing the actors involved would probably only elicit the same type of public statements made in hearings and floor debate, i.e., statements of values which the actors were willing to make for the record. Studies using participant observation might elicit this nonpublic data on the values
or, more specifically, justice criteria, involved in allocations decisions, but these would be time consuming to conduct. Government elected officials might be reluctant to allow an investigator to be present at meetings, especially those informal types where much deal making and political decision-making takes place. To gain trust of the legislators and to be able to be present for important discussions would take more time and energy than merited for the results which could be expected. In addition, it is likely that such decision-making is more reflective of political realities than of social values. There is undeniably a relationship between social values and politics, but this study did not examine political factors. These would have to be examined in another study which looked at a broad range of values and political processes.

The second answer to the question of whether legislative decisions are made in public debate is that even if political decision-making concerns are different from those expressed publicly, the public statements still provide a great deal of information on social values.

Despite other considerations which affect decision-making, it was argued earlier that policy decisions are statements of social values, some more explicit than others. Resources are allocated based on such decisions, and this allocation is a version of social justice. The philosopher Wittgenstein argued that to determine a society's morals one needs to examine that society's actions (Edwards, 1982). Thus, even though many factors influence social decisions, the resulting resource allocation reflects social values or a social conception of distributive justice.
In general, the methodology used here worked well to describe different arguments for just distribution of resources. It allowed an examination of arguments in their context, including the time frame, the actors involved, the problem being addressed, the solutions being offered, the type of debate, and the outcome of the debate. However, implementation of the methodology was very time consuming. That is, it took a long time to collect and analyze data to achieve the results reported. Despite the time constraints, this method worked for examining the discussion of resource allocation in the policy formation process. Future research using this methodology should include multiple investigators or coders to both assess the reliability of the categorization system and to make the methodology less time consuming and more feasible to replicate. Additionally, the methodology should be replicated with different policies to determine whether there are similarities in justice arguments between policies or whether such arguments are situation specific.

Other research which would be useful includes examination of justice arguments in policy decisions related to larger portions of the federal budget, such as reconciliation bills or budget hearings and debates. These hearings and debates relate federal funding priorities to one another, as opposed to focusing attention on individual programs. Historically, the federal budget process evolved to its current state in a piecemeal fashion. However, most discussions of new federal spending initiatives have been introduced in isolation from other federal programs or from the budget as a whole (Rivlin, 1986). There have been
recent attempts to force consideration of federal spending items in relation to the whole budget, thus putting federal programs in the context of their relationships to each other. While such attempts have their limitations, it would be interesting to examine public debate on social policies comparing the character of justice arguments before and after the enactment of one such attempt, the Balanced Budget and Emergency Deficit Control Act of 1985, also known as the Gramm-Rudmann-Hollings legislation. This legislation set spending limits which have to be negotiated, thus forcing discussion of federal programs in relation to one another. Before this time, many new programs were initiated independently and took on a life of their own, never being discussed as a piece of the finite pie of federal spending. It would be interesting to see whether the Gramm-Rudmann-Hollings legislation has any effect on resource allocation discussions.

The process of meeting the Gramm-Rudmann-Hollings budget targets allows for general discussion of spending in categories and does not require discussion of specific programs within those spending categories. Thus, the process is limited in terms of its effect on encouraging debate on spending priorities in relation to one another. However, it could be the first step towards such discussion.

Other related studies are needed to determine public perceptions of resource allocation priorities or justice criteria. These studies might be conducted by interviews in which people are asked to react to vignettes which depicted different justice criteria in conflict. This would provide some sense of what the public claims is just. The concern
with such a study is that people's actions do not always agree with their words, especially on moral questions where there is a tendency to give an expected response demonstrating moral ideals. Studying existing policy provides the closest reflection of perspectives on justice by looking at actions. In short, a variety of other studies could be planned to address the problem of clarifying the role of, or nature of, distributive justice in social policy decision-making.

In addition to studies which further examine distributive justice principles exemplified in social policy, other studies would be useful which integrate the examination of social values into more traditional policy analysis. Studies which examined other variables which affect policy decisions, such as political party affiliations of actors, changing actors and power bases, in conjunction with an examination of the distributive justice concepts involved, would be useful. An example of such research would build on the study reported here. Further work to look at political variables, economic variables, or other health policy occurrences during the time studied here could then be compared to the results on distributive justice criteria, to determine if other policy relevant variables were related to the changes in the concept of justice discussed.

Policy analysis using such other variables to examine Medicare and home health care for the elderly has been done (Marmor, 1973; Mundinger, 1983; Trager, 1980). Studies such as these trace the development of the policy in terms of the actors involved, the political climate, and the economic climate. Comparing these results with the analysis of the
changing values reflected throughout the development of the policy would indicate whether the value changes were a response to changes in other policy variables or whether they preceded these changes. Work like this could also be done for other health policies.

B. Results

The importance of the work reported here is that the concept of distributive justice was operationalized. As detailed in Chapter I, there is general agreement that social policies reflect social values, including the concept of distributive justice. However, little work has been done to operationalize that concept. While philosophical research depicts the results of applying particular theories of justice in specific cases, few would agree that one theory of justice is applicable to all policies of resource distribution. Rawls (1971) tried to develop one theory of justice that would transcend all situations. But as discussed in Chapter II, his theory would be very difficult to implement and would probably be situation specific, i.e., determination of what the least well off should receive would vary by what goods were being distributed. Rawls's theory is a new conception of justice and, as discussed in Chapter V, was not used often in the public debate considered in this study. His argument is not simple, and the idea of the original position complicates what otherwise constitutes a need based argument.

Daniels's (1985) application of Rawls's theory to health care distribution is easier to understand but is vulnerable to Englehardt's (1981) question about the natural lottery. To what extent would or should society choose to distribute resources to individuals whose
suffering can be seen as unfortunate rather than unjust? Does Daniels's concept of the normal opportunity range for people need to be maintained for victims of misfortune as well as those who are treated unjustly? For example, the resources needed to provide organ transplants for children born with malfunctioning hearts or livers represent medical needs which are not unjust, but are unfortunate. Additionally, it is very expensive to meet these needs and there is often little hope for a successful outcome. What are society's responsibilities for resource distribution in such cases?

The question of individual responsibility arises in relation to the concept of the natural lottery as well. Does social responsibility for health differ for health problems which are related to the lifestyles of individuals? Examples of such lifestyle effects on health are such problems as the effects of substance abuse or riding a motorcycle without a helmet. If individuals make potentially harmful decisions, with some awareness of the risks involved, is society responsible for the provision of health care?

The criteria of justice evidenced most often in this study were Need and Ascription. Merit was mentioned frequently, but not often as Need. While the use of the criterion of Ascription is understandable in light of the focus on care for the elderly, it is interesting to note that Need is more often discussed than Merit. According to Lockhart's (1981) study of health policy values, the dominant values in American policy were freedom and merit, with the health care system based on free market principles. The results of the study presented here indicate a focus on
health care needs as well as merit. Much of the debate analyzed reflected attempts to balance allocation of resources by Need with allocation by Merit. This balance leads to limitations on the needs to be addressed via resource allocation. The argument is that all people should have certain needs met, but other needs are to be met only if the individual has earned the resources necessary. In the Medicare debate this was illustrated in the debate over meeting medical versus social needs.

Much of the debate centered around defining which needs of the elderly were to be met with government controlled resources. This debate was important because the needs addressed by a policy must be well defined in order to evaluate the effectiveness of the policy. A problem with the original Medicare legislation was that it was intended to meet only acute, medical care needs, but over time it was criticized in terms of the multiple social needs of the elderly.

Another depiction of conflict between the Need and Merit criteria illustrated in this analysis was the argument between social good and individual good. This tension is reflected in much of the literature on the concept of distributive justice. For example, how much protection does society owe people in terms of resource distribution to meet their needs? And what are the responsibilities of individuals to care for themselves and use the resources they have earned to meet their needs? The two extreme policy positions on this question are 1) the idea of a minimal state and maximum individual responsibility for gaining the resources that individuals need, and 2) social responsibility mediated
via the state to meet basic needs of all individuals and th's eliminate large differentials in resource acquisition.

Beauchamp (1976) discussed this tension as the difference between two types of justice: market justice and social justice. He described market justice as the dominant model of justice in the American culture. In the market, people are entitled to valued ends, such as status, health care, and income, that they have acquired by their own efforts. This model emphasizes individual responsibility and freedom from collective obligations except to respect the fundamental rights of others. The alternative to the market is Beauchamp's (1976) model of social justice where all people are equally entitled to valued ends. In applying this model to health, the goal is to control the hazards of the world though collective action shared equally by all except where unequal burdens result in increased protection of everyone's health. This model relies more on social responsibility to individuals, whereas market justice focuses on the individual's responsibility for self.

Callahan (1981) similarly argued for a stronger social ethic or increased emphasis on communal values. He contended that in the 1960s the American economic situation was good and thus an individualistic ethic was appropriate. People were prosperous and able to focus on individual liberties and autonomy. However, in hard economic times community responsibility is required, and public and private pressure should be brought to bear on those who would focus on civil liberties to the exclusion of communal needs. He denied minimizing the importance of
individual rights but argued that this focus had to be mitigated by attention to social responsibilities.

Another approach to the discussion of societal responsibilities for individuals is Gaylin's (1981) concept of beneficence. Gaylin (1981) discussed the innate responses of humans to care for their children. Coinciding with this is the children's learned sense of dependency on their parents, mixed with their realization that parents care for their children's needs because they love the children. This realization gives the children some feeling of self-worth and attachment which mitigates the early feelings of total dependence on parents. Gaylin (1981) argued from this that society needed to "do good" for those who were neediest, to care for them and love them. If society did not do this, these needy people would not have a sense of self-worth and attachment to society and their behavior as adults would not conform to social morals and standards. Thus, Gaylin (1981) argued for beneficence and, in a sense, justice for the needy so that they will invest in society and not disrupt it with antisocial behavior. He concluded that it is in society's long-term best interests to be inclusive and care for each other. This is a concept of doing justice not because it is "right," but because it is in society's best interests.

These arguments are interesting and worth further discussion. But how do such views get operationalized in the policies which affect the coexistence of people in society? The importance of the research presented here is in operationalizing such concepts and stimulating discussion of the values and goals of social policy. This is an exercise in
values clarification, i.e., that understanding and discussing the goals and values which are the ideal result of policy will result in better social policy. However, a first step in this process is research which indicates how these values are currently operationalized. This then serves as the discussion point for ideas on how people ought to coexist.

The result of values clarification research will be more informed policy debates. If consumers and researchers raise questions about the values evidenced in social policy, policy makers will be forced to address such issues in a coherent and reasoned way. Such discussion will improve policy formation by forcing attention to policy goals and their congruence with social values, as well as encouraging debate on those values.

Another example of operationalizing the concept of distributive justice in health policy is the Oregon Health Decisions model (Hines, 1985). This model was used by the state of Oregon to encourage the citizens of that state to think about how they wanted their health care resources distributed. The model used citizen education sessions and town hall meetings throughout the state of Oregon to raise issues and provoke discussion about the allocation of health care resources. The outcome of the Oregon project were documents on allocation which reflected the views of Oregonians. The documents were used by legislators, local citizens, and community groups to discuss resource allocation issues and provide ongoing education and support for community activities in this area. This model has since been imitated in several other states.
There are, of course, limits to citizen participation in debates about resource allocation. Lowi's (1979) work on interest group liberalism in American politics, pointed out that the democratic system is currently structured so that every interest group in society is represented. When these groups discuss issues, the majority rules. Lowi (1979) argued that a majority outcome was not always the decision that was "right" in a moral sense, because the current political system favored negotiated, majority-approved solutions. This argument is very convincing and there are many examples where the majority decision was not right. Such a system allows little room for moral "rightness" and can allow for the abuse of minority rights. However, given the absence of alternatives to the current system, the question of the moral "rightness" of a policy should be raised. Citizens should be encouraged to address moral issues and discuss what is "right" and what "ought" to be done.

Over the period of time studied (1965-1984), it became apparent that increasing attention was paid to economic criteria for judging policy, including the goal of economic efficiency. When the major political issue of the day became balancing the federal budget, discussion of almost any policy reflected this concern. As stated in the beginning, the concept of distributive justice assumes a condition of resource scarcity. Where resources are plentiful, allocation decisions are not difficult or necessary. Conversely, attention to economic concerns, i.e., how to use resources effectively, is understandable in a situation of scarcity. However, it can be argued that economic efficiency
calculations are a tool in establishing overall policy goals. The overall goal is not economic efficiency, but rather, the allocation of certain resources to carry out the functions of government in an economically efficient manner. The tool of economic efficiency should be used as a means to achieve policy goals and not be confused with the goals themselves. Schelling (1981) discussed analytic methods and the ethics of policy by arguing that economics should be used to formulate policy issues, conceptualize resolutions to such issues, and compare solutions by their adequacy. However, he contended that such tools were to clarify ethical issues, not to resolve them. Social policy needs to have social goals, which have ethical implications, and then analytic methods, such as economics, can be used as tools to achieve these goals.

The current literature about the allocation of health care resources refers to the concept of rationing health care. While this concept did not appear in the data, it is worth noting that the concept is ubiquitous in the current discussions of health policy. Rationing is most frequently mentioned in relation to hospital services and high technology health care. One well-known study of rationing of health services in Great Britain depicted the physician as gatekeeper to the health care system (Schwartz and Aaron, 1984). In this gatekeeper role, physicians revealed that they avoided the ethical implications of their behavior by not discussing all the treatment options with patients. They further acknowledged that if patients persisted and presented at health care facilities to demand services which the government funding policies were
rationing, the patients were almost always treated. No one wanted to turn them away.

A good discussion of the concept of rationing was presented in a report to the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Baily, 1984). The author of the report was a staff economist for the Commission and wanted the Commission to include the concept of rationing in their report. She differentiated the concept of allocation, which is earmarking something for a specific purpose, from rationing, which is a method of sharing resources determined by the supply. There are many different criteria for determining what share is given to whom. These distribution criteria are not different from the justice criteria discussed in this research except that rationing presupposes a finite limit on the supply of resources, with distribution techniques working within that limit. The upper limit on available resources could be applied to any level of the health care system, the individual, the program, or the entire system. That is, rationing could allow each individual a preset amount of health care, such as a voucher system; allow each program a certain amount of resources, so that decisions would have to be made between programs; or allow health care to consume a set amount of social resources, for example a certain percent of the Gross National Product. Whatever the focus of distribution, decisions would reflect distributive justice criteria. In this sense, rationing is another term for distributive justice decisions, i.e., decisions to allocate resources in a certain way and the justification for such allocation.
The concept of rationing was not reflected in the data as it would be a politically unpopular argument to make. The development of the policy to fund home health care for the elderly was undertaken at a point in history when there was not much attention to the costs of care, the expense of health care in relation to the federal budget, or the limits to federal spending. The more recent cost containment concerns began most noticeably in the 1980s. In her report to the Commission, Baily argued that rationing of health care was common and did not represent a negative concept. While the Commission's reports did refer to the need to limit expenditures for health care, and the fact that the federal government could not give all people all the health care they might want or need, the Commission refused to use the term rationing.

In relation to the discussion of rationing, it is necessary to discuss the idea of policy goals. As the data analysis for this study progressed, an underlying theme became apparent in the public debate. Discussions of allocation of resources often referred implicitly to the role of government. Perspectives on the purpose of government relate to resource allocation decisions, even when actors did not explicitly discuss this role. As mentioned earlier, those who believe in maximum individual responsibility and a minimal state as the hallmarks of a democratic society, take the position that the government should not be involved in resource allocation to meet human needs. From this perspective, the government is involved in such things as common defense, retributive justice, and those functions which individuals cannot do more efficiently for themselves. Conversely, those who believe the
government should be involved in guaranteeing certain minimal conditions of a good life, emphasize the importance of allocation decisions in determining those minimal conditions.

C. Relationship to nursing

The question that remains is why the inquiry presented here should be important to nursing. There are several ways to answer this challenge. First, as mentioned by MacPherson (1987), there is a need for the profession to become involved in health policies other than those which have direct benefits for nurses. Nursing has long supported the concept of health for all; however, such support is meaningless unless the profession can influence policy designed to implement such ideals. As nurses become more sophisticated in dealing with health policy, whether in the policy process or in policy research, they need to understand the context in which policies are developed. Health is a complex process with physical, social, psychological, and environmental components. Health policy must reflect all of these components and cannot be seen in isolation from other policies which affect human lives. For nurses to be effective in the policy process and research arena, they must understand the goals of policies and the mechanisms by which policies are developed to meet such goals. Such a perspective requires an understanding of health policies in relation to other policies, national goals and priorities, and the purposes of government.

The ANA Social Policy Statement (1980) urged nurses to be involved in promoting the public good as part of fulfilling the profession's social responsibilities. This statement requires nurses to engage in
discussions of what the public good is and how it is achieved. Such a sense of social responsibility meshes well with an examination of the social values, e.g., justice, expressed in health policy.

The ANA Code for Nurses (1976) also asked nurses to act as patient advocates by safeguarding the public when health care is jeopardized by the incompetent, unethical, or illegal practice of others. This could be interpreted broadly as a challenge to nurses to protect the public's health. In addition, the Code also noted that nurses collaborate with others to promote community and national efforts to meet the health needs of the public. The two segments of the Code implicitly suggest the need for nursing involvement in health policy, promoting policies to meet the health needs of the public, and protecting the public from illegal or unethical practices or policies. Much discussion in the nursing profession has involved the concept of the nurse as patient advocate. The role of advocate is usually described as a role whereby the advocate assists others to make informed decisions for themselves. Nursing involvement in the policy process illustrates the concept of advocacy, as well as the concepts delineated in the ANA Code.

The many facets of nursing scholarship include the combined perspectives of several other disciplines applied to human problems of health and illness. This perspective facilitates areas of inquiry that are of interest in nursing. For example, in the area of nursing ethics, much work was been done by nonnurses. Philosophers examine the "ought" questions relating to ethical dilemmas in nursing practice. Psychologists examine such concepts as moral development and how this relates to
nurses' responses to ethical dilemmas in practice. Sociologists analyze the decision-making processes involved in nurses' responses to ethical dilemmas in practice. The unique aspect of nurses' work in this area is their synthesis of different perspectives to assist the practicing nurse with ethical decision-making. Clearly, nurses cannot carry philosophical tracts with them to read various perspectives on moral autonomy whenever a moral dilemma occurs! Nurses working in the area of ethics have tried to combine the different perspectives so that nurses can be taught moral reasoning to identify moral dilemmas in practice, discuss issues involved, and know where to seek assistance when necessary. The intent of such work is that the decisions made in response to moral dilemmas in practice will be more thoughtful, more informed decisions, and that nurses will practice in an environment which allows them freedom to make decisions reflective of morally autonomous professionals.

The work presented here describes a similar approach to the issue of values and health policy. The question presented here was addressed in a manner which combined several perspectives. The methodology attempted to allow consideration of the political science/governmental aspects of policy, the sociological dimensions of the policy process, and the philosophical/moral values which underlie policies. A better understanding of these components of policy sets the stage for more informed policy formation and open debate of the values underlying policy. In addition, such an approach helps nurses and others interested in social policy to articulate their overall policy goals and delineate strategies for reaching them.
Studying the values underlying social policy is an endeavor well suited to nursing research. If nursing has a unique perspective which results from combining the perspectives of other disciplines and applying this combination to health, and the profession has staked a claim for itself as advocates for others in health care, and the overall professional goals are consistent with the ideal of health for all, then nursing is a discipline best suited to undertaking research in social policy.

The results of such research have other uses. One is to use the framework presented here with work on values involved in the policy process in order to educate nurses on policy formation. As discussed above, nurses need to understand the context for health policy, including the social values which it reflects. In addition, understanding the social values expressed in health policy in relation to other segments of the policy process helps nurses develop and articulate social goals and the policies needed to achieve them. In this way, nurses can be in the forefront of health policy formation and develop policies to meet health and social goals.
VII. APPENDICES
### Appendix A

#### DATA SOURCES

<table>
<thead>
<tr>
<th>Year</th>
<th>Document</th>
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| 1965 | Social Security Amendments of 1965, P.L. 89-97, passed 7/30/65  
House Ways and Means Report #213  
House Floor Debate, 4/7-8/65  
Senate Finance Report #404 (parts 1 & 2)  
Senate Floor Debate, 7/6-9/65  
Conference Report #682  
House Floor Debate, 7/27/65  
Senate Floor Debate, 7/28/65 |
| 1971 | Cutbacks in Medicare and Medicaid Coverage—Hearings (3), Senate Special Committee on Aging, Health Subcommittee, 5/10/71, 6/14/71, 9/20/71 |
| 1972 | Social Security Amendments of 1972, P.L. 92-603 (sec. 222), 10/13/72  
House Ways and Means Report #92-231  
House Floor Debate, 6/21-22/72  
Senate Finance Report #92-1230  
Senate Floor Debate, 3/28/72, 9/27-30/72, 10/2-6/72  
Conference Report #92-1605  
House and Senate Floor Debate, 10/17/72 |
| 1973 | Senate Special Committee on Aging, Working Paper, July 1973 |
| 1974 | Barriers to Health Care for Older Americans—Hearings, Senate Special Committee on Aging, Health Subcommittee, 7/9/74 |
## Appendix A (continued)

### DATA SOURCES

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<tr>
<td>1974</td>
<td>P.L. 93-641, National Health Planning and Resources Development Act of 1974</td>
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<td>1975</td>
<td>P.L. 94-63, Special Health Revenue Sharing Act of 1975</td>
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<td>Comprehensive Home Health Care: Recommendations for Action—Hearings, House Select Committee on Aging, Health and Long Term Care Subcommittee, 11/19/75</td>
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<td>1976</td>
<td>Study of Home Health Care Under Medicare—Hearings, House Committee on Ways and Means, Health and Oversight Subcommittees, September 1976</td>
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<td>1977</td>
<td>Health Care for Older Americans—Hearings (7 parts), Senate Special Committee on Aging</td>
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<td>1978</td>
<td>Amendments to Medicare—Hearings, House Committee on Ways and Means, Health Subcommittee, June 1978</td>
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<td>Federal/State Efforts in Long Term Care for Older Americans—Hearings, Senate Special Committee on Aging, 8/30/78</td>
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<td>1979</td>
<td>Community Based Long Term Care—Hearings, House Interstate and Foreign Commerce Committee, Health and Environment Subcommittee, 12/11/79</td>
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<td></td>
<td>Amendments to Medicare Program—Hearings, House Committee on Ways and Means, Health Subcommittee, June 1979</td>
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<td>Medicare and Medicaid Home Health Benefits—Hearings, Senate Finance Committee, Health Subcommittee, May 1979</td>
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<td>Home Health Care for the Elderly—Hearings, House Select Committee on Aging, Health and Long Term Care Subcommittee, 8/14/79</td>
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<td></td>
<td>Home Care Services for Older Americans—Hearings, Senate Special Committee on Aging, 5/7/79, 5/21/79</td>
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Appendix A (continued)

DATA SOURCES

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<tbody>
<tr>
<td>1980</td>
<td><strong>HHS Appropriations—Hearings, Senate Appropriations Committee, 1/31/80</strong></td>
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<td>Home Health Care for the Elderly—Hearings, House Select Committee on Aging, 8/7/80</td>
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<td></td>
<td>House Budget Report #96-1167</td>
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<td></td>
<td>House Floor Debate, 9/4/80</td>
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<td></td>
<td>Senate Floor Debate, 6/3/80, 7/23/80</td>
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<td></td>
<td>Senate Floor Debate on H.R. 7765 in lieu of S.2939 and S.2885, 9/17/80</td>
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<tr>
<td></td>
<td>Conference Report #96-1479</td>
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<td></td>
<td>House and Senate Floor Debate, 12/3/80</td>
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<td>Home Health Care: Future Policy—Joint Hearings, Senate Labor and Human Resources and Senate Special Committee on Aging, 11/23/80</td>
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<td>Medicare Oversight—Hearings, House Select Committee on Aging, 8/8/80</td>
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<td>1982</td>
<td>Proposed Budget Cuts Affecting Medicare—Hearings, House Committee on Ways and Means, Health Subcommittee, March–June 1982</td>
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<td>1983</td>
<td>Home Health Care—Hearings, Senate Labor and Human Resources Committee, 7/14/83</td>
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<td>Medicare at the Crossroads—Hearings, House Select Committee on Aging, Health Subcommittee, 6/13/83</td>
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<td>Home Health Care: Progress and Impediments—Hearing, House Select Committee on Aging, Health Subcommittee, 3/13/83</td>
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Appendix B

SAMPLE DATA CODING

Distributive Justice Codes

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<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Crit-Ascr</td>
<td>criterion of ascription</td>
</tr>
<tr>
<td>Crit-</td>
<td>criterion of choice</td>
</tr>
<tr>
<td>Crit-Eqin</td>
<td>criterion of equality</td>
</tr>
<tr>
<td>Crit-Fair</td>
<td>criterion of &quot;justice as fairness&quot;</td>
</tr>
<tr>
<td>Crit-Fneed</td>
<td>criterion of financial need</td>
</tr>
<tr>
<td>Crit-Mer</td>
<td>criterion of merit</td>
</tr>
<tr>
<td>Crit-Need</td>
<td>criterion of need</td>
</tr>
<tr>
<td>Crit-Ut</td>
<td>criterion of utilitarianism</td>
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Need-based Problems

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<th>Code</th>
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<tr>
<td>P-Cneed</td>
<td>catastrophic illness needs</td>
</tr>
<tr>
<td>P-Typcar</td>
<td>appropriateness of care</td>
</tr>
<tr>
<td>P-Sneed</td>
<td>social service needs</td>
</tr>
<tr>
<td>P-Mneed</td>
<td>medical care needs</td>
</tr>
<tr>
<td>P-Cusnd</td>
<td>custodial care needs</td>
</tr>
<tr>
<td>P-Limits</td>
<td>limits of care system</td>
</tr>
<tr>
<td>P-Prev</td>
<td>preventive care needs</td>
</tr>
<tr>
<td>P-Fam</td>
<td>lack of family support</td>
</tr>
<tr>
<td>P-Coord</td>
<td>lack of coordination of care</td>
</tr>
<tr>
<td>P-#</td>
<td>growing numbers of the elderly</td>
</tr>
<tr>
<td>P-Depend</td>
<td>dependency needs</td>
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### Financing Problems

<table>
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<th>Code</th>
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<td>P-Cost</td>
<td>problem with cost of care</td>
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<tr>
<td>P-Fineed</td>
<td>financial needs</td>
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<tr>
<td>P-Fund</td>
<td>funding problems</td>
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<tr>
<td>P-Socmed</td>
<td>problem of moving towards &quot;socialized medicine&quot;</td>
</tr>
<tr>
<td>P-FSS</td>
<td>problem of social security financing</td>
</tr>
<tr>
<td>P-Priv</td>
<td>problems with private insurance</td>
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<tr>
<td>P-OK</td>
<td>problem with harming current medical care system</td>
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### Justice Problems

<table>
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<tr>
<th>Code</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>P-Fair</td>
<td>fairness of financing system for health programs</td>
</tr>
<tr>
<td>P-Choice</td>
<td>lack of consumer choice</td>
</tr>
<tr>
<td>P-Eqin</td>
<td>unequal treatment</td>
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### Procedural Problems

<table>
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<tr>
<th>Code</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>P-Proc</td>
<td>problems with regulations and procedures</td>
</tr>
<tr>
<td>P-Stan</td>
<td>problems with quality assurance/standards of care</td>
</tr>
<tr>
<td>P-Con</td>
<td>problem with control of services</td>
</tr>
<tr>
<td>P-Study</td>
<td>need for further study of an issue</td>
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<tr>
<td>P-FAB</td>
<td>fraud and abuse problems</td>
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Appendix B (continued)

SAMPLE DATA CODING

Alternative Strategies Codes

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
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<td>Al-Mneed</td>
<td>strategy to meet medical needs</td>
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<td>Al-Sneed</td>
<td>strategy to meet social needs</td>
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<td>Al-Cat</td>
<td>strategy to meet catastrophic illness needs</td>
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<td>Al-Prev</td>
<td>strategy to meet needs for preventive care</td>
</tr>
<tr>
<td>Al-Gdgin</td>
<td>strategy to promote dignity and independence in elderly</td>
</tr>
<tr>
<td>Al-Comcr</td>
<td>strategy to provide care in the community</td>
</tr>
<tr>
<td>Al-LTC</td>
<td>strategy to provide long-term care</td>
</tr>
<tr>
<td>Al-HC</td>
<td>strategy to provide care in the home</td>
</tr>
<tr>
<td>Al-Fam</td>
<td>strategy to encourage family support</td>
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<tr>
<td>Al-NH</td>
<td>strategy to promote proper use of nursing homes</td>
</tr>
<tr>
<td>Al-Coord</td>
<td>strategy to coordinate care of the elderly</td>
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<tr>
<td>Al-Assess</td>
<td>strategy to assess needs of the elderly</td>
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<td>Al-Dem</td>
<td>demonstration programs</td>
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Financing Strategies

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<tr>
<th>Code</th>
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<tr>
<td>Al-Fin</td>
<td>strategy to care for those in financial need</td>
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<td>Al-Gnrev</td>
<td>strategy to fund programs from general revenues</td>
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<td>Al-Priv</td>
<td>private sector financing</td>
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<td>Al-Contr</td>
<td>financing through recipient contributions</td>
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<td>Al-Econ</td>
<td>promote economic efficiency of care delivery systems</td>
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<td>Al-Fund</td>
<td>general program financing methods</td>
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### Alternative Strategies Codes

#### Justice Strategies

<table>
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<tr>
<td>Al-Choice</td>
<td>allow for consumer choice</td>
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<tr>
<td>Al-Eqin</td>
<td>equal treatment of recipients</td>
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#### Procedural Strategies

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Al-Con</td>
<td>strategies for control of services</td>
</tr>
<tr>
<td>Al-Stan</td>
<td>quality control/standards of care</td>
</tr>
<tr>
<td>Al-Study</td>
<td>plans for further studies of an issue</td>
</tr>
<tr>
<td>Al-Local</td>
<td>local government control of services</td>
</tr>
<tr>
<td>Al-Demo</td>
<td>demonstration programs</td>
</tr>
<tr>
<td>Al-Sup/Al</td>
<td>support or opposition of bills being discussed</td>
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SAMPLE DATA CODING

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<tbody>
<tr>
<td>MCSD: I doubt whether any of us here will ever have the opportunity to vote on a more important piece of domestic legislation. The program we are going to pass in this this body will be a declaration of economic independence for millions of Americans. This hospital and medical insurance will, I am fully confident, put an end to the folly and the waste that has characterized this nation's treatment of its senior citizens throughout the twentieth century.</td>
<td>Al-Sup</td>
</tr>
<tr>
<td>There is, in my view, nothing more hypocritical than to encourage citizens to work to earn homes, to raise and educate children, to pay taxes, to spend their lives contributing to an economy and a way of life unequaled anywhere in the world and then, when they are too old to contribute further, subject them to the humiliation and planned poverty of a means-test medicine. I am hopeful that the proposed legislation will put an end to that hypocrisy for millions of Americans.</td>
<td>Crit-Ascr</td>
</tr>
<tr>
<td>We believe that there are many proposals which will actually hurt the older people, budget cuts which will call for increased cost-sharing and reduce provider reimbursement, will force the elderly to pay more for the same inefficient health care system which now inadequately meets their total health care needs. Plans which would encourage private market competition, and/or Medicare vouchers, Mr. Chairman, could lead to higher out-of-pocket costs for the elderly, adverse risk selection, a dual system of unequal care.</td>
<td>Crit-Mer</td>
</tr>
<tr>
<td>Before I discuss these points, I would like to underscore two of the elderly's essential needs which must not be neglected in the search for budgetary savings of any kind. One is that their health insurance protection be adequate, efficient, and effective. The other is that their Representatives in Congress, recognizing the vital link between the Medicare program and the elderly's health and financial security, act responsibly to preserve Medicare benefits and strengthen the program even as budgetary savings are being achieved.</td>
<td>Crit-Fneed</td>
</tr>
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VITA

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M.S., Nursing Sciences, Public Health Nursing, University of Illinois at the Medical Center, Chicago, Illinois, 1983

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PROFESSIONAL EXPERIENCE:

Project Coordinator, Community Health Advocacy Training and Assessment in Two Chicago Communities: Grand Boulevard and West Town, College of Nursing, University of Illinois at Chicago, 1987-present

Research Assistant, Graduate Nursing Concentration in Women's Health, College of Nursing, University of Illinois at Chicago, 1984-1987

Research Assistant, Self-Study Evaluation Committee, College of Nursing Graduate Program Evaluation, University of Illinois at Chicago, 1983-1985

Editor, News & Commentary, College of Nursing, University of Illinois at Chicago, 1983-1984


Research Assistant, Urban Women's Health Advocacy Training Project, College of Nursing, University of Illinois at the Medical Center, Summer 1982

Staff Nurse, Grant Hospital, Chicago, Illinois, 1979-1980

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VITA (continued)

PROFESSIONAL MEMBERSHIPS:
Sigma Theta Tau, Zeta Sigma Chapter
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Illinois Nurses' Association
Chicago Nurses' Association
American Public Health Association
Midwest Nursing Research Society
Society for Health and Human Values
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RESEARCH:
Awarded National Research Service Award Predoctoral Fellowship by the Division of Nursing, Public Health Service, Department of Health and Human Services, 1 F31NU05830-01. Approved and funded for two years. Study title, Distributive Justice and Social Policy: A Case Study, 1985-1986

Co-investigator, Ethical Decision Making in a Bureaucratic Context: Registered Nurses. Funded with Biomedical Research Support Grant funds, Division of Nursing, Public Health Service, Department of Health and Human Services, January 1985

Ethical Decision Making in a Bureaucratic Context: Senior Students in Nursing. Master's thesis, University of Illinois at the Medical Center, Chicago, 1983

PUBLICATIONS:


VITA (continued)

PRESENTATIONS:

Historical Perspective on Third Party Reimbursement for Nursing Care in the Home. Keynote presentation at Mary Kelly Mullane Nursing Symposium, "Hospital to Home: Patient Options for Nursing Care," College of Nursing, University of Illinois at Chicago, Chicago, Illinois, May 9, 1987


Attended invitational conference, "Institute for Bioethics," Kennedy Institute of Ethics, Georgetown University, Washington, D.C., June 1-6, 1986

Third Party Reimbursement and Control over Nursing Practice. Paper given as part of a symposium, "Nursing and Health Policy: Participation and Outcomes," at Tenth Annual Midwest Nursing Research Society Conference, Omaha, Nebraska, April 14, 1986

Ethical Decision Making in a Bureaucratic Context: Registered Nurses. Poster presentation with Beverly J. McElmurry at Tenth Annual Midwest Nursing Research Society Conference, Omaha, Nebraska, April 14, 1986

Changing Risks and Lifestyles for Today's Working Women. Workshop presented at conference, "Women's Health," sponsored by Indiana University Continuing Education in Nursing, Jackson County Hospital, Seymour, Indiana, May 14, 1985

VITA (continued)

Patient as Person. Co-presenter at workshop offered as part of a series of workshops developed under a grant from the Illinois Council for the Humanities, "The Humanities, Health Care and the Elderly," Chicago, Illinois, August 8, 1984

Refusal of Treatment. Co-presenter at workshop offered as part of a series of workshops developed under a grant from the Illinois Council for the Humanities, "The Humanities, Health Care and the Elderly," Brookfield, Illinois, August 7, 1984

Ethical Decision Making in a Bureaucratic Context. Poster presented with Beverly J. McElmurry at Eighth Midwest Nursing Research Conference, Minneapolis, Minnesota, April 2, 1984

Ethical Decision Making in a Bureaucratic Context. Poster presented at Second Annual Conference of Chicagoland Chapters of Sigma Theta Tau, March 22, 1984


Everything You Ever Wanted to Know about Women's Health But Were Afraid to Ask. Address to local leaders at University of Illinois Home Economics Extension Service, Kankakee, Illinois, January 19, 1983

Ethical Dilemmas in Public Health Nursing. Graduate student speaker at University of Illinois Second Annual Nursing Ethics Workshop, April 23, 1982