

Tentative issue assignments  
for long-term monitoring/communications role

**Bob Boorstin**

Health care  
Foreign policy  
Defense policy  
Welfare reform  
National service  
Gays in the military  
Immigration  
AIDS  
Terrorism  
POW/MIA  
☺♥ Families ☺♥

**Marla Romash**

Reinventing government  
Environment  
Space  
Technology  
Superconductor

**Michael Waldman**

Political reform  
Crime bill  
Defense conversion  
Economic stuff (consistent  
with Dreyer's role)  
Trade (NAFTA/GATT)  
Reinventing government (work  
w/ Marla)  
Job training/labor  
Drugs  
Urban policy  
Regulatory reform  
Education 2000  
Civil rights  
Credit crunch  
Airline commission

**Ricki Seidman**

Appointments  
Choice

the

c o m m u n i t a r i a n  
N E T W O R K

*File  
Communitarians*

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May 11, 1993

TO: Bruce Reed  
FAX: 456-7739

FROM: Amitai Etzioni

## Endorsements

Signatures signify that we are of one mind on the broad thrust of *The Responsive Communitarian Platform* and the necessity of this intervention into the current dialogue, without necessarily agreeing to every single, specific statement. Copies of the platform are available from The Communitarian Network.

- Enola Aird (Activist mother, Connecticut)  
 Rodolfo Alvarez (University of California, Los Angeles)  
 John B. Anderson (Presidential Candidate, 1980)  
 Benjamin R. Barber (Rutgers University; signing with exception to moral education section)  
 Robert N. Bellah (University of California, Berkeley)  
 Warren Bennis (University of Southern California)  
 Janice M. Beyer (University of Texas, Austin; signing with exception to the family section)  
 David Blankenhorn (President, Institute for American Values)  
 John E. Brandl (University of Minnesota; former Minnesota State Senator, Representative)  
 James Childress (University of Virginia)  
 Bryce J. Christensen (President, The Family in America, The Rockford Institute)  
 Henry Cisneros (Former Mayor, San Antonio, Texas)  
 John C. Coffee (Columbia University Law School)  
 David Cohen (Co-Director, Advocacy Institute)  
 Anthony E. Cook (Georgetown University Law School)  
 Harvey Cox (Harvard Divinity School; signing with exception to cleaning up the polity section)  
 Thomas E. Cronin (Colorado College)  
 Thomas Donaldson (Georgetown University)  
 Joseph Duffey (President, The American University)  
 Thomas W. Dunfee (Wharton School, University of Pennsylvania)  
 Stuart E. Elzenstat (Alimony, Washington, D.C.)  
 Lloyd Elliott (President Emeritus, George Washington University)  
 Jean Bethke Elshtain (Vanderbilt University)  
 Amitai Etzioni (The George Washington University)  
 Chester B. Finn, Jr. (Vanderbilt University)  
 James Fishkin (University of Texas, Austin)  
 Carol Tucker Foreman (Partner, Foreman & Heidepriem)  
 Betty Friedan (New York City)  
 William A. Galston (University of Maryland)  
 John W. Gardner (Stanford University)  
 Nell Gilbert (University of California, Berkeley)  
 J. Richard Gilliland (President, Metropolitan Community College, Omaha, Nebraska)  
 Mary Ann Glendon (Harvard Law School)  
 T. George Harris (New York, NY)  
 David K. Hart (Brigham Young University)  
 Jeffrey B. Henig (George Washington University)  
 Albert O. Hirschman (Institute for Advanced Study, Princeton)  
 James Hunter (University of Virginia)  
 Nicholas deB. Katzenbach (Attorney, Riker, Danzig, Schere, Hyland, & Perretti, and former Attorney General of the U.S.)  
 Daniel Keumala (Mayor, Missoula, Montana; signing with exception to second amendment section)  
 Hillel Levine (Boston University)  
 George C. Lodge (Harvard Business School)  
 Malcolm Lovell Jr. (President, National Planning Association)  
 Duncan MacLure, Jr. (University of North Carolina, Chapel Hill)  
 Frank Markiewicz (Vice Chairman, Hill and Knowlton)  
 Gary Marx (Massachusetts Institute of Technology)  
 Thomas McCollough (Duke University)  
 Sanford N. McDonnell (Chairman Emeritus, McDonnell Douglas)  
 John L. McKnight (Northwestern University)  
 Catherine Milton (Executive Director, The Commission on National and Community Service)  
 Newton N. Minow (Former F.C.C. Chairman; Attorney, Chicago, Illinois)  
 Charles Moskos (Northwestern University)  
 Ilene H. Nagel (U.S. Sentencing Commission and Indiana University)  
 Richard John Neuhaus (President, Religion and Public Life Institute)  
 William C. Norris (Chairman, William C. Norris Institute, Minneapolis, Minnesota)  
 John Parr (President, National Civic League)  
 Michael Pertschuk (Co-Director, Advocacy Institute)  
 Chase N. Peterson (President Emeritus, University of Utah)  
 Grethe B. Peterson (University of Utah)  
 Terry Pinkard (Georgetown University)  
 David Popenoe (Rutgers University)  
 Lonnie C. Rich (City Council Member, Alexandria, Virginia)  
 Elliot L. Richardson (Partner, Milbank, Tweed, Hadley & McCloy and former Attorney General of the United States)  
 David Riesman (Harvard University; signing with exception to cleaning up the polity section)  
 Alice S. Rossi (Former President, American Sociological Association; Amherst, Massachusetts)  
 William D. Ruckelshaus (Chairman of the Board and Chief Executive Officer, Browning-Ferris Industries; Houston, Texas)  
 George Rupp (President, Rice University)  
 Isabel Sawhill (Senior Fellow, The Urban Institute)  
 Kurt L. Schmoke (Mayor of Baltimore)  
 Philip Selznick (University of California, Berkeley)  
 Albert Shanker (President, American Federation of Teachers)  
 Fred Siegel (Cooper Union)  
 Gilfan Martin Sorensen (President, National Conference of Christians and Jews, Inc.)  
 Thomas Spragens, Jr. (Duke University)  
 Margaret O'Brien Steinfeld (Editor, *Commonweal*)  
 Adlai E. Stevenson (Chicago, Illinois)  
 Peter L. Strauss (Columbia University)  
 William Sullivan (LaSalle University)  
 Robert Thuobald (New Orleans, Louisiana)  
 Lester C. Thurow (Dean, Sloan School of Management, Massachusetts Institute of Technology)  
 Daniel Thursz (President, The National Council on the Aging)  
 Kenneth Tollett (Howard University)  
 Barbara Dufoe Whitehead (Amherst Massachusetts)  
 Dennis H. Wrong (New York University)  
 Daniel Yankelovich (President, Public Agenda Foundation)  
 American Alliance for Rights and Responsibilities
- The affiliations and titles of those who endorsed the platform are listed as they were at the time the platform was endorsed.

May 11, 1993

TO: Bruce Reed, 456-7739

FROM: Amitai Etzioni

This is a memo on some limited points regarding rights, responsibilities and health-care reform. (I am sending you under separate cover a Communitarian Position Paper on Core Values in Health-Care Reform.)

Each year there are many thousands of would be physicians and other health care professionals who receive medical education. Even those who get no special fellowships or loans, gain a "silent" subsidy from the federal government and states. Its precise value is difficult to estimate but it is at least \$70,000. It would seem these beneficiaries owe something back to society.

If this basic point is accepted, we can proceed by thinking of three categories of persons:

1. Those who received loans, fellowships and silent subsidies, who would serve in designated areas say four years.
2. Those who received only silent subsidies (paid "full" tuition) -- two years.
3. And those who really paid in full, both tuition and for the subsidy (Saudi princes) -- none.

Any of those in groups one and two could buy out of their obligation by agreeing to contribute a given percent of their income (collected as an income tax surcharge) for a given period, say twenty years, to a national trust to be used for future medical training.

While the system currently encompasses only physicians, the new health service corp obligation should include all health care professionals.

Regarding those who are now uninsured: for reasons discussed in the enclosed excerpt from our position paper, they should be asked to contribute to their own health by acting responsibly by abstaining from smoking, drinking to excess and abusing drugs. Those who ignore this expectation might be asked to contribute a small amount -- \$12.50 per month -- toward their health insurance, as a way to indicate societal disapproval. (Such surcharges should be applied to one and all if they act irresponsibly. Not only to the hereto uninsured.)

Finally, we should keep alive the American ethnic tradition that every family and group has an obligation to do their best to take care of their own. The way immigrant groups do, rather than dump them on public institutions.

The government has the greatest obligation, but it should not step in as the first or second resort.

enclosure

~~Enclosure~~ From  
Commission Position  
Paper "Core Values in  
Health-Care Reform"

Prepared by A. Etzioni,  
Christine Cassell, Charles Dowdenty,  
C. MacCollister Everts, John Griffith,  
James L. Nelson, Maria Osterweis,  
and Daniel Wikler.

elementary package of health care), they be dedicated to children, especially to prenatal care.

Children are the most vulnerable group of society. They do not swing elections or demonstrate in Washington. Ensuring their health is a highly commendable way to use new resources because children still have a whole lifetime ahead of them, and they will be called upon to provide for the nation. As children grow older, we hope that an extended package of care will grow with them until there is no one left without extended coverage.

#### 4. Responsibilities and Rights

##### 4.1. Individual Responsibilities

Every person has a basic responsibility for his or her own health. This entails taking care of oneself to the best of one's ability, minimizing dangers to the health of others, and reducing the burdens one may impose on the community. No person is an island; we are all members of a community, responsible for one another and the world which we share.

In the past, when most diseases were of an acute, infectious character caused by poor sanitation or some other social condition, there was relatively little

individuals could contribute to the improvement of their personal health and to public health. In recent decades, however, as the disease mix has changed and our knowledge of the role of behavior has grown, it has become evident that changes in one's individual lifestyle have significant affects on personal and public health, and on the social and economic burdens imposed on the community.

It follows that even under adverse circumstances, out of concern for others and one's own dignity, all persons are expected to do their share to enhance their health and to reduce their burdens on others. To take an extreme example: a quadriplegic, permanently committed to a bed, able only to turn the pages of a book by the use of a small device controlled by his or her mouth, should be expected to do that much rather than to call for an aide each time a page is to be turned. The same holds for all Americans. The fact that social forces may account to a significant extent for one's condition and limit one's choices does not exempt one from the duty of helping oneself and not unnecessarily burdening others.

In particular, all members of the community should be expected to change their lifestyles in ways that ensure that they do not harm others, unnecessarily impose health-care burdens on the community, or abuse their own health, in and of itself a treasure of the community. Smoking, drinking alcohol to excess, and irresponsible sex are clear and significant examples of irresponsible behavior that

meet all three criteria. Such behaviors also satisfies an important fourth criterion to qualify as a legitimate communitarian claim: there is a clear and significant correlation between behavioral changes on the one hand and health outcomes on the other.

Health is determined by many factors. Often, the connection between behavior and changes in health is not firmly established, the efforts needed to improve unhealthy behavior are gigantic and the results are limited. Dieting to reduce cholesterol, for instance. The moral claim we seek to establish arises most clearly when the change in behavior is either relatively easy to make, and/or the health outcome is well-established, and/or the consequences of one's effort is substantial. Wearing seatbelts and motorcycle helmets meet all these criteria. Refraining from smoking, drinking alcohol only in moderation, and engaging only in safer sex are a close second. Dieting, exercising, and sleeping eight hours a night, while commendable, do not seem to qualify at the present state of our knowledge.

To argue that there is a moral claim for people to act responsibly suggests that those who do not live up to these claims ought to be subject to social censure, while those who do discharge their responsibilities are to be awarded social approbation. Before any stronger enforcement measures for poor-health behavior are considered, and while they are undertaken, intensive efforts should be made to inform and

educate the public about the health consequences of their behavior, and the need to act in socially responsible ways, as well as to call upon their nobler selves to live up to their personal responsibilities. Informing and educating should encompass the provision of those services, from counseling to rehabilitation, that people require to help them change their habits.

Those who have been informed and educated but disregard the message may be prodded by the imposition of some extra charges. These will not prevent them from obtaining care but will serve as symbolic reminders of communal displeasure that these people continue to neglect their health. These charges will also shift some of the extra costs they generate back to those who contribute an excessive burden. Thus, we see merit in assessing additional health insurance charges to those who smoke or accumulate speeding tickets, and, conversely, granting discounts to those who do not, as long as such premiums are moderate. At the same time, because such poor behavior is, in part, driven by social and genetic factors over which individuals have little control, these charges should not be so severe as to absorb fully the extra costs entailed (for instance, a \$12.50 a month surcharge which some insurance companies exact on smokers, rather than, say, a \$125 surcharge).

For the same reasons, it is justified to tax "sins" because raising the costs of cigarettes and alcohol are a particularly effective way of discouraging both young

people from becoming addicted and also encouraging those addicted to rehabilitate themselves<sup>3</sup>. The regressive character of sin taxes can be corrected for, as the Clinton Administration already plans to do, by introducing a graduated earned income-tax credit to all those below a certain level of income.

Society has been reluctant to use its regulatory power to encourage changes in lifestyle that promote health. We believe that regulations that require seatbelts, motorcycle helmets, and sobriety checkpoints -- as long as they encompass only those changes in lifestyle singled out above -- are fully justified. Given that we live in an age of exploding health-care cost that are forcing us to consider draconian measures to reduce health-care costs -- even to the point of cutting off services that are clearly beneficial in order to save money -- some regulation of ill behavior seems appropriate. At the same time, it is unduly harsh and flies in the face of human nature to refuse treatment to those who did not abide by these claims. The community has a responsibility to care for one and all, even if individuals have failed to fulfill their responsibilities in one way or another.

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<sup>3</sup> K.E. Warner, "Smoking and health implications of a change in the federal cigarette excise tax." *The Journal of the American Medical Association*, 1986, (255), 1028-1032.

It should be noted, however, that whenever regulatory power is used, special measures must be taken to avoid undesirable side effects. For instance, should HIV testing be introduced, special pains must be taken to provide counseling and to protect privacy.

Some argue that the body is our own property and hence we should be free to treat it as we wish, that a person has an inalienable right to, say, abuse drugs. They further argue that since adults have to live with the consequences of their acts, they should be free to make their own choices, and that all other approaches to human behavior are "paternalistic." We note, first of all, that individuals who act irresponsibly do impose "their" costs on the rest of us; smokers, drunken drivers, and those who engage in irresponsible sex endanger others and not merely themselves. There is no way the irresponsible can limit dire consequences to themselves.

Second, we care about the persons involved. Some became addicted to unhealthy behavior before they reached adulthood; many others clearly indicate that they wish to break out of their addictive behavior but are unable to act without community help. Thus, while we would deem it paternalistic to impose our preferences on a person (say, make a person who is an avowed atheist attend a prayer, or vice versa), to help a person who already has been to several clinics,

bought nicotine patches and otherwise tried to break the habit of smoking, is like providing a drowning person a life preserver.

There are others who argue that people conduct themselves irresponsibly simply because of social conditions not of their own making. Indeed, increases in unemployment, for example, help drive thousands to drink and smoke. Society should work to mitigate these stress-producing and other unhealthy conditions. However, it does not follow that, however pressing the social factors, individuals are left without any room for personal choices nor that the community must assume all responsibility for their care just because the social conditions are unfavorable.

While the preceding observations hold true at all times, they are especially compelling under the crisis conditions in which we seem now to find ourselves. Indeed, it might be argued that a major way of enabling us to provide health care to all Americans would be for Americans to act more responsibly in such matters than they did in the past. Just as it is always inappropriate to waste water, but especially in a drought, so we hold, all Americans must help bring health-care costs down by acting more responsibly.<sup>4</sup>

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<sup>4</sup> For additional discussion of personal responsibility for health and related policy issues see R. Bayer and J. Moreno "Health promotion: Ethical and social dilemmas of government policy." *Health Affairs*, 1986, 5(2), 72-85; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral

#### 4.2 Responsibilities to and by Others.

All Americans should be expected to take the best care they can of those closest to them. Elderly men and women should not be dumped into nursing homes and left there with rare family visits. Children should not be left unattended in public libraries or placed in child-care centers that parents have barely examined. Of course, it is true that our society should do much more to enable families to earn an income that is sufficient, in turn, to enable them to discharge their responsibilities to their parents and children. But we must also avoid creating ever more government-financed institutions that seek to replace the care that families, as a rule, best grant to their members. Dying in a hospice, for instance, might be more humane than dying in a hospital, but we should not rush to institutionalize the dying; rather, whenever possible, we should enable people to die at home with their families. Visiting nurses and counseling services should be made available to families and individuals as an important first step.

#### 4.3 The Role of the Government and Its Responsibilities Versus a Right to Health Care

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Research, *Securing Access to Health Care: A Report on the Ethical Implications of Differences in the Availability of Health Services*, (Washington, D.C.: U.S. GPO, March 1983); and, D. Wikler, "Persuasion and coercion for health: Ethical issues in government efforts to change life-styles." *Milbank Memorial Fund Quarterly/Health and Society*, 1978, 56(3), 303-338.

To the extent that people cannot take care of themselves and their own, directly or indirectly (by pooling resources), the government should step in to ensure that health care is available to all. It should be the government's responsibility to provide health care when all else fails. This responsibility is rooted in our elementary sense of compassion for the more vulnerable members of our communities.

There has been a long and intensive debate regarding whether or not individuals have a right to health care or whether it is merely a community's responsibility to provide it.<sup>5</sup> Those of us who are concerned about the incessant minting of new rights, the spiraling social and economic costs of new entitlements, the tendency to interpret rights as absolute "trumps" and to litigate over rights, are troubled by this development.<sup>6</sup> At the same time, we recognize that calls for a right to health care are rooted in a deeply-held conviction -- one that we fully share -- that no one should be left without needed health care.

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<sup>5</sup> See T.H. Bole and W.B. Bondeson (ed.), *Rights to Health Care*, (Norwall, MA: Kluwer Academic Publishers, 1991).

<sup>6</sup> For additional discussion, see A. Etzioni, *The Spirit of Community*, (New York: Crown Publishing, 1993); and, M.A. Glendon, *Rights Talk: the impoverishment of political discourse*, (New York: Free Press, 1991).

As we see it, the debate is now reaching a socially beneficial and fair conclusion: once health care is available to all Americans, under government prodding, supervision and partial funding, the question of whether or not Americans are entitled to health care as a matter of right or as a matter of social responsibility, becomes largely a theoretical one.

Now, the discussion by necessity focuses on the scope of responsibility -- what is to be encompassed in the elementary package of health benefits. Nobody can seriously argue that everyone has a constitutional right to a particular list of treatments (a check up every year, an x-ray but not necessarily an MRI, and so on). Accordingly, the range of available treatments clearly must be sorted out by a set of principled criteria and through the democratic process.

## 5. The Social Responsibilities of Health-Care Professionals

Because of their special knowledge in matters of health, their unique moral commitments, and their privileged and powerful positions in society, health-care professionals have a special social responsibility to minister not merely to their patients as individuals but also to the societal conditions that deeply affect their patients.