

That is, there may be some acceptable reasons why some people would want to clone themselves. Those who favor an outright ban on human cloning will find his conclusions troubling in this area, though he approaches the highly controversial subject with caution. The concluding perspective from Christian tradition is very insightful and rightly counters the physicalism and genetic reductionism that pervades the genetics community. In my view, this is a crucial philosophical discussion in which there is a clear conflict of worldviews. As Dorothy Nelkin and Susan Lindee have argued in their book, *The DNA Mystique*, the genome has taken over the language and functions traditionally attributed to the soul. Petersen puts the physical body, and specifically the genome, in its proper context in relation to the soul and the spiritual side of life.

Overall, this is a very helpful volume. The depth of the discussion and theological interaction makes it recommended reading for those with interest in this rapidly changing and controversial field.

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Sorell, Tom, ed. *Health Care, Ethics, and Insurance*. London and New York: Routledge, 1998. 240 pp. Index.

This concise anthology offers useful and challenging essays on the ethical dimensions of health and life insurance underwriting from a European, primarily British, perspective. Initially, this fact may cause the American reader to doubt the book's relevance for the health care debate in this country, but this is one first impression that

soon proves itself wrong. Even from the book's introduction, the reader quickly realizes that both private- and public-oriented health insurance systems are struggling with precisely the same ethical problems and with similarly unsatisfactory results.

Specifically, neither private nor public insurance schemes have been able to deal effectively with the tremendous *costs* contemporary medical treatment imposes on both societies and individuals. Moreover, these costs are not only financial, although that is where many of the ethical difficulties begin. Rather, the notion of "costs" as conceptualized in this volume is considerably broader than that. It includes opportunity costs resulting from providing some benefits rather than others, the human and social costs of including in, or excluding from, risk pools certain groups or individuals, the political costs associated with competing public policy choices, etc. Above all, however, Professor Sorell and his contributors largely succeed in framing these cost aspects within an overview that focuses and refocuses attention on the complex moral and ethical questions they inevitably raise on either side of the Atlantic.

Nevertheless, the economic costs of medical care and health insurance remain the primary drivers of the ethical discussion. The first of the Sorell anthology's two main parts deals with "fairness" issues—fair access to the insurance market, the fairness of charges to high-risk groups, and the tension between risk assessment in a for-profit insurance market and a range of individual rights, including personal privacy. Undoubtedly, these fairness issues are all ethical in nature, yet they have their existential roots in the (at least) perceived necessity to control costs or secure profits.

This complex relationship between the ethical and the economic dimensions is clearly illustrated by the impact of genetics research on health insurance underwriting. Two articles in this first section take up this genetics issue in great detail not possible to summarize here. However, a strong impression emerges through the prism of the

genetics issue that the understandable pre-occupation with the astronomical costs of health care has tended to shift health insurance away from its original ethical basis in both private- and public-oriented markets.

Specifically, health insurance as we know it today began during the Depression in upstate New York when local school teachers paid into a common pool, the first “Blue Cross plan,” to ensure availability of funds to pay hospital costs. This simple beginning shows that the ethical *raison d’être* of health insurance was to provide people with the means to receive needed care when and if they became sick or injured. Both funds and risks were pooled; all that was certain was that most people would require hospitalization at some point or points in their lives, but precisely who, when, why, how often, and for how long remained uncertain. The more widely the risk was spread, the more likely it was that the plan could deliver needed assistance. Thus, the more “subscribers” in the pool the better, and it was a tolerable, calculable range of uncertainty that made the world go round for both insurers and insured.

The article “Genetics and Insurance” by Sheila A.M. McLean and Philippa Gannon in this volume illustrates how far these ethical bases have shifted today. Overall, the focus of the insurance debate, regardless of private- or public-orientation, is as much on how to identify high risks to exclude them from the pool as to ensure delivery of health care to the general run of insureds. Genetic markers for certain diseases or conditions seem an especially efficient and effective way to accomplish this. Of course, McLean and Gannon, as well as other contributors here, also show that genetic testing is not as automatic or as technologically feasible as popularly believed, depending on such variable factors as the specific condition tested for and the often prohibitive cost of the testing itself.

However, a major shift in the basic assumptions of health insurance, highlighted and exacerbated by the genetics debate, has nonetheless occurred—a smaller

“healthier” risk pool is now the industry aim so as to limit costly utilization. Consequently, those most likely to need health care are now most likely to be denied health coverage, just as the already wealthy can obtain personal loans more readily than poorer people who really need them but are often rejected as bad risks. While this may be defensible logic in the loan business, it poses an ethical problem for health insurance, since its original purpose was to facilitate delivery of health care services to those who are sick, not reward the healthy with coverage as if it were a trophy.

The impact of genetics also threatens to seriously constrict that tolerable, calculable range of uncertainty once at the heart of the underwriting process. Already buffeted by burgeoning health care expenditures, as discussed in an interesting exchange between Professor Sorell and Spencer Leigh in this anthology, underwriting guided by genetic markers would become a process of ferreting out certain or almost certain information about particular high-risk individuals and groups. The object would no longer be balancing risks but denying or severely limiting coverage to those most likely to get sick, and the procedures to identify these risks would probably be intrusive. As Heather Draper points out in her article, such an ethically questionable situation already exists in regard to identifying and insuring HIV positive persons.

Given that this first section of the anthology emphasizes private-sector approaches, it may be tempting to conclude that these ethical problems are strictly consequences of the profit motive. However, the second section dealing with government-dominated health insurance programs reveals that these same problems, albeit in different guises, beset those systems as well.

In the most informative and thought-provoking article in this section, Albert Weale argues that the “socialized medicine” of Western European countries, being mixed public-private insurance markets, have not socialized the health care “means of production” but the health care “means of consump-

tion.” With this approach, government planners decide total health care budgets and benefits designs, with private health care and insurance services available in varying degrees to those who can afford to pay for them. In any case, as Weale and, especially, Will Cartwright point out, government decisions on health care delivery are as driven by cost control considerations as they are in private systems, posing the same ethical dilemmas as noted above, and are often as high-handed and organization-centered as those of any giant insurance company.

In addition, decisions as to exactly which benefits to provide are often political in the purest sense of the term. Cartwright offers as an example the stubborn insistence of Britain’s National Health Service that abortion is a legitimate “health care service,” even when not necessary to save the life of the mother, excused by an application of “mother’s health” so elastic as to amount to government-sponsored abortion on demand, an ethical atrocity of the first magnitude.

However, the most important contribution of Weale and the other scholars in this section is to organize the ethical discussion in terms of the basic claims and assumptions that underlie and justify “socialized medicine.” In short, Western European systems promise to deliver health care that is fairly and equally available, comprehensive, and of high quality. However, even these noble goals, seemingly in tune with the original purposes of health insurance, now pose ethical dilemmas because of such hard realities as skyrocketing costs, limited economic resources, and changing or elusive definitions of “comprehensive,” “fair and equal,” and “high quality.”

In short, given the same cost pressures, technological advances, and value choices as private-dominated insurance markets like the United States, the central ethical issue for Western European “socialized medicine” today is the viability of its available-comprehensive-high quality health care triad.

In other words, if all three of these values can no longer be secured, is it either honest or responsible for Western European poli-

ticians to claim that hard choices and radical reforms do not have to be made on their side of the Atlantic also?

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