Chronic illness and disability are much-discussed topics in the world of health policy. Arguments rage as to whether the nation’s population is growing sicker as it grows older.¹ It certainly seems that more people who in previous decades would have died from congenital conditions, injuries, or severe illnesses are now being kept alive but with varying degrees of impairment and morbidity. It is commonly noted that the price of successful acute care medical interventions is a population that will live longer but be sicker.

Economists, politicians, and the occasional physician seem to take a perverse delight in proffering Cassandra-like forecasts of an America overwhelmed by the demands of the aged, the diseased, and the disabled. The practitioners of the dismal science are living up to their name by engaging in a somewhat unseemly competition to see who can issue the most doleful assessment, the direst warning about the imminent insolvency of Medicare, social security, and special federal programs such as the Veterans Administration hospital system. Professional wisdom has it that these programs will soon be awash in a torrent of chronically ill and disabled persons who will in turn drown them in a sea of red ink.²

In the context of these hotly contested political and policy debates, it might seem naive if not downright stupid to suggest that the issues raised by chronic illness and disability require ethical rather than economic analysis for their resolution. Nonetheless, I believe that this is so. Answers to the questions of how much should be spent on the chronically ill and disabled, what priority ought to be accorded

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policies aimed at helping those who are chronically ill or disabled, and what goals should guide health care interventions directed at these populations depend on the ethical weight that is accorded chronic illness and disability.

Perhaps the major question requiring critical reflection is whether chronic illness ought be understood as a category or type of illness in itself. Do disability and chronic illness bear important similarities to acute illness? If not, they may require different responses from patients, health care providers, and policy makers.

If chronic illness does not require the same response from society as acute illness and if the services sought and needed are different, then the consequences for social policy and fiscal solvency may be different as well. Only if chronic illness and disability fit—or are forced to fit—into the prevailing conceptual framework for treating and paying for acute disease do increases in the proportion of chronically ill and disabled need to keep so many of those charged with balancing local, state, and federal budgets awake at night.

What Is the Relationship between Acute and Chronic Conditions?

If chronic illness and disability differ in no important respects from acute illness or injury and are merely diseases that afflict a person over an extended period of time, then deciding how much should be spent to help the chronically ill and disabled will require nothing new to be added to existing debates about equity and justice in the domain of health care. Chronic illness and injuries, as well as genetic anomalies capable of producing long-term impairment or dysfunction, while differing in degree from acute illness, would not be different in kind.

Those who have disabling pain, chronic arthritis, or chronic emphysema would gain or lose little in their efforts to secure a share of the resources available for health care by noting that their afflictions are permanent and incurable. The fact that a medical problem persists over time might increase the needs of the chronically ill and disabled relative to those of others with medical problems, but it would mean nothing in terms of the moral weight assigned to the needs of those with chronic or incurable disabling conditions.

If the chronically ill and disabled are concerned with securing a greater share of the nation’s health care resources, they might indeed be happy to have their conditions treated as possessing the same moral weight as bacterial meningitis, a myocardial infarction, a sudden severe depression, a gunshot wound, or other dramatic examples of acute injury and illness. The treatment of acute illness and injury
dominates the organization of our health care system, the educational orientation of our academic medical centers, the norms that guide interventions by health care professionals in hospital and other institutional settings, and the kinds of regulatory and reimbursement schemes that have evolved for treating illness and disease. Simply viewing chronic illness and disability as a subcategory of illness and disease generally, therefore, would require a drastic revision in both clinical and societal policies concerning the allocation of health care resources to the chronically ill and disabled.

Advocates of the chronically ill and disabled are well aware of this fact. A great deal of the political advocacy on behalf of the chronically ill and disabled focuses on the similarity of their needs to the needs of those with acute illnesses. The language of equal rights is much in evidence when advocates for the disabled and the chronically ill present their case in Washington or in the various state capitals.

The case for lumping disabilities and chronic conditions in with acute and emergency medical problems is based on the premise that our society seems willing to recognize the moral claim generated by the needs of those with life-threatening illnesses. The push to create a program of insurance to cover the costs of catastrophic illness within the Medicare program illustrates the moral power of acute medical problems in commanding scarce federal dollars. Since needs for acute medical care can generate societal obligations to satisfy these needs in the context of a hospital emergency room, as many have observed, it would seem the most effective political strategy for those trying to secure resources for the chronically ill and disabled to draw analogies between these conditions and acute, life-threatening diseases.

This strategy might, in fact, be practical for obtaining more resources than are now being allotted for the needs of the chronically ill and disabled. Chronic illnesses and disabilities have not evoked the same degree of concern as acute, life-threatening illnesses. On first inspection, therefore, there might appear to be no benefit in distinguishing between acute and chronic medical problems.

The inadvisability of drawing any sharp distinctions between acute and chronic health care needs is further reinforced by the well-known aversion of insurance companies, the federal government, and other third parties to paying for those with chronic medical problems. Such attitudes are not unique to reimbursement programs. Prepaid health plans such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are notoriously reluctant to assume the financial costs of chronic illness and disability. Our financing schemes for reimbursing the costs of illness are oriented toward acute episodes of disease, precise categories of diagnosis and treat-
ment (most recently exemplified in the diagnosis-related group—DRG—system used in Medicare's prospective payment scheme), and measurable outcomes of progress and cure. Chronic illness and disability do not fare well under these criteria.

The reason for the relative underfunding of services and institutions aimed at helping those with chronic illnesses and disabilities is also well known. There is a fear that if third-party payers were to cover the costs of disability and chronic conditions they would soon go broke. If chronic illness and disability were treated on a conceptual par with acute illness, there seems to be a very real threat that the chronically ill and disabled—because of their complicated and continuing medical needs—would simply "hijack" all the resources made available for health care or any other social purpose. The fiscal burden that might be created by more generous reimbursement policies for chronic conditions is illustrated by Medicare's only attempt to reimburse the costs of chronic illness—the end-stage renal disease program for those with chronic renal failure.

In 1972 Congress created a special program to cover the costs of dialysis for all who suffered from kidney failure. At the time, the program was expected to cost $200–300 million and to extend benefits to approximately 20,000 people. Today, the end-stage renal disease program pays more than $2 billion to cover the costs of dialysis for more than 80,000 patients. Experts predict increases in both the number of eligible claimants and the amount of money spent for at least another ten years.

The costs of treating chronic renal failure left a searing impression on the minds of policy makers. Avoiding the creation of another program like that for end-stage renal disease has become dogma among many legislators and bureaucrats in Washington.

The threat of injustice in the distribution of resources is the most important political reason for distinguishing between acute and chronic illness. The projected costs of covering nursing home care, outpatient medications, the provision of therapies in the home, and comprehensive care of the handicapped and mentally ill are so large as to make it difficult for politicians to allow disability and chronic illnesses to be considered as deserving as acute illness.

But cost is not the only reason for drawing a distinction between acute and chronic medical problems, nor is it obviously a morally sound reason. If the only thing special about chronic illness and disability is that they are expensive to treat, this in itself is not a particularly impressive basis for drawing sharp distinctions between what we feel obligated to pay for in health care and what we do not. There is another reason to hesitate before arguing that chronic illness
and disability merit the same societal concern and fiscal outlays that acute medical problems and emergencies currently receive: possible loss of personal autonomy.

**Professional Authority and Individual Autonomy**

Acute illness is the province of medicine. Physicians have almost complete sovereignty over diagnosis, treatment, palliation, and rehabilitation where acute illness is concerned.

If those concerned with securing a greater share of society’s resources for chronic medical problems try to do so by arguing that these problems are nothing more than a subspecies of the general class of disease, chronic illness and disability will be subject to the same models, standards, evaluative criteria, and professional control as acute illness. The resulting threat to independence and autonomy posed by dependency on the medical system and medical professionals may be a higher price than the chronically ill and disabled ought to be willing to pay.

Time and again newspaper and television broadcasts show how difficult it is for the acutely ill to retain control over their own medical care. Decisions are often made with little or no consultation with competent patients. And when competent patients issue clear directives about the nature and course of their care, be they Jehovah’s Witnesses or members of the Hemlock Society, physicians and hospital administrators sometimes pay little attention. All too often the only way of retaining autonomy over health care decisions concerning one’s own body is to threaten a lawsuit or media campaign.

A very real danger of extending the medical model to chronic illness is the potential loss of personal freedom and autonomy to professionals. Thus, calls to extend acute care models of medical practice to settings such as nursing homes must be viewed with caution. While turning a nursing home into a hospital or a private home into an intensive care unit may improve the quality of care for the elderly who reside in it, personal autonomy may yield to the kind of professional authority that characterizes the practice of acute care medicine. There is little time for talk in the increasingly impersonal and technological world of acute care medicine.

**Are We Obligated to Help the Sick?**

Americans, despite their aversion to chiselers, malingerers, and sluggards, do acknowledge a moral obligation to help those who cannot help themselves. Those with acute illnesses have been able to secure a
share of public funds obtained by compulsory taxation primarily on the ethical ground that each citizen has an obligation to help meet the health needs of others who are unable to meet their own needs.

The citizens of the United States like to believe that those with heart attacks or broken bones will not be left to fend for themselves even if they lack the means to pay for treatment. Our public philosophy seems to be that those who become acutely ill or who suffer acute injuries are entitled to receive government assistance as long as they can demonstrate clear-cut need. The existence of a need is seen as necessary to create an obligation on the part of society.

Recent interest in making transplants available without regard to the ability of the recipient to pay and in providing catastrophic health insurance coverage reflects precisely this degree of perceived moral obligation on the part of the public. In health care, unlike other areas of life, a need for life-saving medical treatment is held by most citizens to be a sufficient moral ground for requiring others to help pay for its provision, assuming that the needy cannot afford to pay out of their own pockets.

Why should this be so? Why is it that in a society that tolerates enormous differences in access to housing, education, and employment opportunities, health needs occupy a position of special moral standing?

To understand why health care needs elicit a degree of compassion that other needs do not, it is necessary to consider the moral foundations of beneficence in American society. Nearly every moral theory that has any currency in our society posits a duty of beneficence, a duty to aid when the following conditions are met:

1. A need is obvious, serious, and life-threatening.
2. Assistance rendered must stand some chance of meeting or alleviating the need.
3. Those requiring assistance from others must not have any reasonable alternative sources of aid.
4. Providing assistance must not create undue burdens on or risks to those giving the help.

These conditions say nothing about the liability or culpability of those who are in need. At least when lives hang in the balance, our society has remained relatively indifferent to the cause of a person's need in determining a general obligation of beneficence. People who do not wear seat belts or whose drinking leads to the need for a liver transplant may receive aid from publicly funded sources if the conditions outlined above are met. We do not, at least in theory, make
allocation decisions based on the worthiness of patients or their social status.\textsuperscript{11}

If the major moral outlooks current in our society, both religious and secular, countenance at least a minimal duty of beneficence—an obligation to help others or to meet the needs of others when the conditions outlined above are met—then it is easy to see why life-threatening medical needs have generated so much concern in American health policy. People who have heart attacks or sudden renal failure have clear-cut, life-threatening needs and are not in a position to help themselves. Since in most cases it does not cost very much to pay for the services required to help each individual and since health care professionals know how to treat heart or kidney failure, it would seem that we have a duty to provide resources or to tolerate a degree of taxation sufficient to enable those who cannot pay for the requisite services to have access to them.

But clarifying the moral underpinnings of this obligation of beneficence reveals why those with chronic medical problems may continue to find it difficult to tap into the same vein of moral concern—even in a society as enamored of independence and personal autonomy as the United States. Chronic conditions and disability do not tap the same reservoir of beneficence as acute illness and injury.

Chronic conditions, although they can be severely limiting and can cause serious dysfunction, often lack the obvious need for assistance associated with acute illness. Those in chronic pain with hypertension, diabetes, or arthritis may not be visibly in need of help. Those with disabling injuries or suffering the aftereffects of a mild stroke, while surely in need of assistance, are nevertheless still able to perform many of the activities of day-to-day living.

Chronic conditions and disability not only permit disagreement and uncertainty about a person's level of need, but also have not been demonstrated to be as responsive to treatments as most acute medical problems.

In general, physicians and nurses know how to help those with acute medical problems. Although organ transplants sometimes fail and not every heart attack victim can be saved, the vast array of everyday health problems admit of a course of treatment that is both routine and likely to work.

It is generally not clear, however, and it is far from scientifically proved what kinds of assistance would help those with chronic conditions to gain relief. Whether it be low back pain or rehabilitation after a massive stroke, the efficacy of standard treatments for chronic conditions is not well established.
If more were known about the effectiveness of attempts to rehabilitate persons with spinal cord injuries or coping with chronic pain, perhaps more money would be made available to ensure that persons with these conditions had access to care. But with so little known about whether medical intervention does any good in such cases, it is hard to command a greater share of public resources when so many other claims are being made on them for acute and emergency medical services and for other types of social goods (education, defense, public works, and so on).

Matters are made worse by the emphasis our society places on autonomy and free choice. One way to view curing is to see it as restoring a person to a state of autonomy and free choice, unimpaired by illness or disease. But the chronically ill and disabled often are left in permanent states of dependency by their conditions—not an especially popular status in our culture.

The obligation to help the chronically ill and disabled is also weakened by the belief that, whereas only physicians and trained medical personnel can help the acutely ill, many other people—spouses, children, relatives, friends, members of religious and fraternal organizations—are capable of providing the kind of aid that is in fact most useful for those with chronic medical problems. No one believes that a husband has a special duty to relieve a case of bacterial meningitis that his wife might contract. But many people believe that it is his duty to provide for her should she become blind, wheelchair bound, demented, arthritic, or diabetic. The possibility of family assistance undercuts the moral pressure felt by others to provide for those with chronic medical needs.

Finally, the provision of aid to those with acute illness and injury seems not to entail undue risks or burdens (or at least did not seem to do so until health care costs began escalating rapidly). But chronic conditions demand aid that is burdensome, both financially and in the ways it affects the lives of those giving it. Society views it very differently when a person is asking for help to pay for having a gall bladder removed than when that person requests assistance for spina bifida, Alzheimer’s disease, or cystic fibrosis. The needs are great in all cases, but the burden of providing help seems much more onerous and, to put the point baldly, endless in the case of chronic conditions.

One final reason for the moral asymmetry between the provision of public funds for acute and chronic medical problems is confusion about whether chronic medical problems or disabilities really are diseases. Uncertainty about the categorization of chronic medical
problems condemns those with such impairments and disorders to a kind of conceptual limbo, in which lines of responsibility among those with disabling conditions, their families, health care professionals, social welfare agencies, and other social institutions are not clearly drawn.

Chronic Illness, Disability, and the Medical Model

The dominant philosophical outlook on chronic illness in the United States is that it does not require any special ethical status. Although we are willing to acknowledge the possibility that mental illness differs in important and significant respects from physical illness as a category or type of disease, there is little inclination to consider chronic diseases as constituting a significantly different class from acute conditions.

There are many articles about the limits of the medical model in understanding and treating mental illness, but there are no analogous discussions where chronic disease is concerned. With the possible exception of mental disorders, modern medicine views disease as a single category or, in more philosophical terms, as a natural "kind," with acute and chronic disease just variants on a single theme.

But is this classification valid? Should chronic disease and disability be lumped together with acute illnesses and injuries? Or are there differences significant enough to place them in two separate categories of disease? And if so, do they require different methods of care and different responses from those responsible for creating health policies?

What Is the Medical Model? In the medical model the goal of health care is to cure disease. Disease is defined as any dysfunction of an organ, organ system, or structure, and health is understood as the absence of disease. Those who subscribe to these definitions see little need to make value judgments about whether or not a person is sick; one merely measures the appropriate physiological variables, and the answer is obvious to anyone with the proper training. The medical model presumes that all diseases have quantifiable physiological causes with definite onsets and, if left untreated, predictable outcomes.

Some may protest that this description of the medical model is a straw man, that health care providers know better than to treat patients simply as vessels containing dysfunctional kidneys, bladders, or thyroids. But despite recent efforts to broaden the goals of medical
care beyond the narrow aim of restoring normal function, for many kinds of hospital-based medical care this account is accurate.\textsuperscript{16} It is certainly a model that dominates many textbooks of surgery, immunology, pathology, infectious disease, and, increasingly, psychiatry.

**The Sick Role.** One of the most important contributions made by those studying the sociology of medicine has been to show how different the perception of illness by patients and society is from that of professionals within the medical system. Perhaps the best known exposition of the cultural and social dimensions of disease is Talcott Parsons's definition of what he termed the "sick role."\textsuperscript{17}

Parsons noted that health and disease have a special status in American society. He observed that in our achievement-oriented society health is given an especially high priority because it is a prerequisite for being able to work, which is a critical capacity in a competitive free-market society.

The social construction of disease, according to Parsons and those who have extended his analyses, is a far cry from the professional understanding of disease as defined by the medical model.\textsuperscript{18} Our ordinary understanding of disease—what Parsons termed the sick role, or what might usefully be termed the illness model—is based on four conditions that cause us to recognize someone as ill: a person is incapable of curing himself; is exempt from usual roles and duties; wants to get better; and wants to seek help from experts and to receive treatment.

**Disease, Chronic Illness, and Disability—A Poor Fit.** What is interesting about the analysis of disease in the medical model and the more expansive analysis in the illness model is that chronic illness and disability do not fit well into either model. Chronic illness and disability are remarkable for the fact that they often lack a clear-cut physiological cause, onset, or outcome. The disabled and the chronically ill cannot have function restored. Part of the very definition of a chronic condition is that it is incurable. Moreover, many of the problems of the chronically ill have as much to do with sociology and politics as with physiology.

Those with chronic conditions obviously would like medicine to cure or alleviate their disabilities. But in lieu of cures, access to buildings, jobs, housing, and education are of greater concern than what neurology, rehabilitation medicine, or psychiatry has to offer.

Even at the social level, though, the chronically ill and disabled are in trouble even under the illness model. To some extent health
care professionals in particular and society in general hold the chronically ill responsible for their own cures.

Motivation and compliance are the virtues expected of the chronically ill and disabled in health care settings. Patients seen to have "motivational problems" risk fast abandonment by their health care professionals. Society has equally high expectations, at least to the extent to which the media celebrate those who have stopped "whining" about their ailments and gotten on with their lives.

The chronically ill and disabled, while exempt from some social roles and duties, are often capable of doing what everyone else does—if society will let them. They face a peculiar Catch-22 dilemma, though: they want to carry out the roles and duties that they are capable of, but they must depend on society's recognition that they cannot and should not be expected to carry out all the usual roles.

As noted earlier, a key ethical requirement for feeling a duty of beneficence to another is that the recipient be truly in need of help. Yet a critical precondition for receiving respect from others in our society is that a person not be perceived as dependent, needy, or receiving aid. The acutely ill can face this dilemma with the knowledge that their state is temporary. The disabled and the chronically ill have a much harder time of it, since their needs are seemingly endless.

The chronically ill and disabled often encounter medical problems that require professional help. But, like those who require only brief, episodic interactions with the world of medicine to cope with acute or emergency medical problems, they do not want to spend their entire lives dependent on health care institutions and professionals. Thus, they do and yet do not want to seek out medical expertise, another tension that tends to delegitimate the authenticity of their needs and claims.

On strictly medical grounds, chronic illness and disability do not fit the model of disease that prevails within our medical system. Nevertheless, there are many reasons for those who are chronically ill and disabled to conform to the requirements of that model, both to gain access to the medical system and to gain legitimacy for their conditions in a society disinclined to be tolerant of anyone who will not pull his own economic weight.

The wisdom of securing resources or the sympathy of the public by squeezing chronic illness and disability into the medical model, however, is disputable, as some health policy commentators have cogently observed. The goals of the chronically ill and the disabled are not necessarily those of the acute care patient. If chronic illness and disability are not readily subsumed under the standard definition
of disease and illness, meeting the needs of the chronically ill and disabled may require a redefinition of their problems as well as a reassessment of the kinds of services that can best meet their needs.

Reclassifyng Chronic Illness and Disease

To a great extent, recent policy debates about chronic illness focus on whether it is worthwhile for society to invest resources in medical care that results in large numbers of persons living longer but being sicker. As the pressure to contain health care costs escalates, policy options are framed as requiring a choice between paying for acute medical care needs of the many and providing exotic care for the unusual medical care needs of the few. The needs of children, the mentally ill, the elderly, the disabled, the dying, and the chronically ill are seen as competing against one another for a finite and diminishing pool of resources.

Is it necessary, however, to see health policy as constrained by the need to make hard choices among the competing claims of those with various types of disorders and diseases? Is it true that what constitutes optimal care for one group will necessarily be the same for others?

As we have already seen, there are significant differences between the definitions of acute and chronic diseases. These differences significantly weaken attempts to fit chronic illness under the rubric of acute disease or to draw upon the kinds of arguments for beneficence that have been persuasive in pushing our society to meet the acute and emergency medical needs of its poor and elderly.

The solution to helping those with chronic diseases and disabilities may not require government officials and physicians to perform health care triage. Rather, the prospects of governmental fiscal insolvency occasioned by the provision of public funds for chronic illness and disability might be lessened if they could be removed from the domain of the medical model of disease and placed in a separate category. Such a redefinition might contribute to a more precise understanding of both chronic illness and disability while appealing to the beneficent impulses of the American public to help those who cannot meet their own needs, either for want of economic means or for lack of willing helpers.

The Chronically Ill and Disabled Are Not Diseased

The solution to the public policy dilemma of how to afford the costs associated with chronic illness and disability is very much a function
of the classification or conceptualization of these conditions. We have seen that chronic illness and disability do not meet the requirements of the traditional medical model of disease. Surprisingly, they do not conform to the criteria of a more inclusive illness model either. And perhaps most surprisingly, they do not meet the requirements for eliciting a duty of beneficence on the part of others as this obligation is understood under most theories of ethics.

Two strategies might be chosen in light of these findings. One approach would be to broaden either the standard medical model of disease or the illness model to incorporate chronic illness and disability. In doing so, it may be possible to appeal to the same principle of beneficence that has proved so effective in securing resources for those with acute or catastrophic diseases.

The other strategy would be simply to admit that chronic conditions and disability, while often having their roots in disease or illness, are conceptually distinct from these categories. Although those who are disabled or chronically ill often endure medical crises just as other members of society do, it may be conceptually confusing—and may deprive them of their autonomy—to lump them under a medical or illness model of disease.

Numerous advocacy groups for the disabled and the chronically ill have objected to the notion that those with chronic impairments or disabilities ought to be viewed as permanently sick. Such a classification, while commanding great moral force for securing resources from the health care system under the principle of beneficence, comes at a high price. It means that the chronically ill and disabled will be seen by both health care professionals and society as permanent patients meriting assistance, but also meriting paternalistic charitable aid. In a society that treasures independence and autonomy, assuming the role of permanent patient is not likely to ensure the dignity and equality of those in constant need of medical treatment.

"Demedicalizing" Chronic Illness and Disability

In listening to what those with disabilities or chronic impairments say they want, it becomes plain that we need to abandon the attempt to squeeze them into the framework of disease or illness or to make them the recipients of societal beneficence by expanding their access to models of care inspired by acute care medicine. Those with impairments or disabilities that are not immediately life-threatening do not want constant access to medical care and the ministrations of health care professionals; they want to be given the same opportunities other Americans enjoy to maximize their abilities and capacities.
The disabled seek equality of opportunity with respect to housing, education, employment, and recreation. They wish to be seen as ordinary citizens who may require social interventions or accommodations to allow them to participate as fully as possible in the ordinary activities of daily life. Consequently, efforts to expand the medical system to absorb more of the chronically ill and disabled, while well motivated, are misguided. Of course, the medical needs of the chronically ill and disabled ought to be met, but on the same moral grounds that our society recognizes as appropriate for guaranteeing access to health care for any citizen, disabled, impaired, or not.

To argue that we need more medical specialists in chronic illness or disability, more hospitals and long-term care facilities for the chronically ill and disabled, and a greater emphasis on the provision of medical therapies for the disabled is to miss the point. What many of those with chronic illnesses or disabilities need is equal opportunity, not beneficence or charity. The acutely ill or those facing catastrophic health care emergencies require our beneficence and charity, but those with chronic illness or disabilities who are not facing an acute medical crisis deserve something radically different—the right to equality of opportunity.

The key to sound public policy with respect to chronic illness and disability is not the creation of more teaching nursing homes in academic medical centers or a greater emphasis on chronic illness in our schools of nursing or medicine. Medical professionals need to understand the nature of acute illness in a person with impairments or disabilities to the extent that such illness is more likely or different when disabilities are present. But those with chronic illness or impairments need from society less emphasis on the medical aspects of chronic disease and more emphasis on the social adjustments necessary to assist them in becoming full participants in society.

In other words, the disabled and chronically ill have a right to expect the “demedicalization” of chronic disease in favor of the provision of social services, educational programs, the removal of architectural barriers, and vocational training. We need social policies aimed at restoring and enhancing the autonomy of persons whose impairments or disorders cannot be cured.

The moral foundation for access to such services is different from that for claiming access to medical services that are beyond a person’s financial means. Those with disabilities or chronic impairments can lay claim to requisite social services for themselves or those with whom they live on the grounds that, while they may be no more entitled to equality of outcome than any other citizen, they are entitled to equality of opportunity. Those with non-life-threatening
chronic impairments cannot be cured, but they can require social policies that maximize their opportunities for choice and freedom.

To say that those with chronic illnesses or impairments do not require access to health care is not to say that they need little or no contact with physicians, nurses, and other health care providers. Obviously, many aspects of chronic illness or disability are amenable to some forms of medical intervention, either for the palliation of symptoms or because those with chronic conditions may be more vulnerable to acute or emergency medical problems than other members of society are.

To say that the social or public policy response to chronic illness is better formulated under the rubric of opportunity than of beneficence is to say that access to health care should not be the major preoccupation of public policy. This is not because it would be expensive to attempt to help those with chronic impairments or disorders in this way, although in fact it would be. It is because treating chronic illness and disability strictly as medical problems requiring medical responses “disenfranchises” a large segment of society by making them permanent objects of social beneficence, a status that few if any members of our society would wish to occupy.

If the chronically ill and disabled can be weaned from the medical system, they may be able to reach their full potential at less cost. Moreover, every individual’s enjoyment of autonomy and independence may be enriched.

Chronic illness and disability have a remarkable power. Those who endure a disability must think long and hard about the nature of their own identity and about what it is that they want to be and become. The onset of a chronic illness or disabling condition may actually enhance autonomy by forcing direct decisions about goals, personal plans, values, and life-style choices, which are all too often pushed aside by the able-bodied or healthy as too frightening.

Perhaps it is easier to fit chronic illness and disability into a medical or illness model because doing so avoids the challenge that impairment and disability pose to our sense of personal identity and responsibility. The impaired and the disabled become persons worthy of charity, not of choices.

Chronic illness and disability remind us all not only of our technological or scientific limits but also of how difficult it is to be truly independent or autonomous. While we pay much lip service to these lofty notions in our political rhetoric, the prospect of confronting choices about who we are and who we really want to be is simply too terrifying for many of us. Disability is a reminder that to be truly autonomous one must be willing to reflect consciously on one’s iden-
tity and aspirations. If that is so, the appropriate public policy response is not to figure out how our society can afford to pay for access to medical technology or health care professionals for those with chronic illness or disability. Rather, it is to confront, openly and honestly, the challenge of creating social policies that are necessary to enhance the opportunities of those who lack certain abilities or capacities. Reflection on the ways our society can maximize opportunities for those with impairments and permanent disabilities will inevitably enhance the freedom and autonomy of everyone, disabled or not.

Notes


6. Lamm, *Megatraumas*; and Lamm, "We Can't Afford the Health Plan."


