

Sanitary justice in scarcity

Justicia sanitaria en la escasez

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Abstract *Justice in health care and the allocation of scarce medical resources must be analyzed differently in affluent as compared to economically weaker societies. The protective functions of the state must be extended to cover basic needs for those too poor to meet them on their own. Medical needs are a high priority, since poor health hampers the ability to secure other basic needs. The state may operate as either a health care provider or supervisor, guaranteeing that citizens be treated fairly by nongovernmental institutions. Two-tiered systems with a vigorous private health care sector are compatible with the explicit right to health care, provided the private tier operates without directly or indirectly draining public funds.*

Key words *Health Rights; Medical Care; Social Justice; Health Policy*

Resumen *Es preciso hacer un distingo entre justicia sanitaria y distribución de recursos médicos escasos, según se trate de sociedades pudientes o aquellas que son económicamente débiles. Las tradicionales funciones protectoras del Estado deben extenderse para cubrir las necesidades médicas, que a su vez tienen prioridad porque la salud es indispensable para poder solventar otras necesidades básicas. El Estado puede operar como proveedor de atención médica, o como fiscalizador de la ecuanimidad de servicios otorgados por otras instituciones. El derecho a atención médica es compatible con un sistema paralelo de medicina privada, siempre que ello no signifique drenar directa o indirectamente recursos del sistema público.*

Palabras clave *Derecho a Salud; Atención Médica; Justicia Social; Política de Salud*

Introduction

In 1978 the Belmont Report, issued by the US National Commission for the Protection of Human Subjects, recommended a number of ethical norms to be duly respected by biomedical research. Clad in academic form, the Report fathered what eventually became known as principlism, unleashing a controversy about the theoretical status and practical usefulness of the four principles. The discussion never died down. Quite to the contrary, it has been compounded by doubts concerning the appropriateness of introducing principlism into the bioethical thinking and practice of other cultures. Although autonomy has probably been the principle most subject to criticism, this paper concentrates on that of justice, since it is conceptually the most difficult to grasp, even as it assumes a relevant position (immediately or by default) in Latin American health care policies.

Justice is a political and philosophical topic that is far too vast to be discussed here in any depth. Highly divergent views have been expressed as to whether justice constitutes an ethical issue, and many writers have been at loss to define it as a principle. In fact, one interpretation has it that the principle of justice in the context of health care policies may well be collapsed into a social good that ranks high but not topmost in the overriding principle of social beneficence (Veatch, 1990). Beauchamp and Childress consistently defend the equal status of all four principles, although they accept their *prima facie* and therefore non-absolute character (Beauchamp, 1995).

Critics of principlism are especially punctilious with regard to justice (Clouser & Gert, 1990), to the point of stating that "*We suspect that even the proponents of principlism do not put much stock in the principle of justice as an action guide. The principle of justice seems to be a prime example of a principle functioning simply as a checklist of moral concerns*" (Clouser, 1995:225). On the other hand, justice together with autonomy have been granted lexical priority because they constitute non-consequentialist or perfect duties and therefore rank as inviolable if in conflict with utilitarian principles (Veatch, 1995). Exactly the opposite view is espoused by Clouser & Gert (1994) when suggesting that justice is an ideal rather (than a rule) which may be encouraged but not required, thus constituting an imperfect duty at best.

In approaching the Latin American reception of principlism, Gracia (1995) has suggested that justice and non-maleficence are the

most fundamental principles because they address communitarian interests. Thus, an important opinion on trans-cultural migration of principlism suggests that Anglo-Saxon views tend to focus on a more libertarian, individualistic, and autonomy-based kind of ethics, whereas Latin American approaches prefer a more communitarian, justice-oriented way of thinking. Such a statement, if at all true, should be confined to bioethics and not extrapolated to political or social realities.

The above-mentioned tentative characterization notwithstanding, North American bioethicists have been especially sensitive to the issue of justice in health care, possibly because they experience the ethical problems and recently unveiled weaknesses of a decentralized, fundamentally private, profit-oriented medical system. Most such authors begin by expressing their discomfort with health-care policies that leave up to 15% of the population uninsured, with financial support often failing in catastrophic diseases or in expensive and lengthy treatments. The impact of managed care on both the quality of medical coverage and the interests of the more vulnerable are also concerns pertaining to justice in health care. These social realities should be borne in mind when reflecting on a variety of proposals brought forth in the name of fair medical services.

Four different health-care schemes have been identified by the still-incipient Spanish-language bioethical literature, and a few more must be briefly mentioned before tackling the issue from a Latin American perspective.

Health care rights in affluent societies

Sade (1978:574) has adamantly refused to accept any right to health services, arguing that "*medical care as patients' rights is immoral because it denies the most fundamental of actions to support it.*" Medical care, therefore, is neither a right nor a privilege, but a service to be freely purchased. Engelhardt Jr. (1997) is also skeptical that the language of rights and duties in health care could be advantageously used among 'moral strangers', believing that only very rudimentary arrangements could be proposed. At best, a voluntary program of commonly agreed-upon health-care services might serve to cover certain basic needs.

A somewhat more flexible position was adopted by Buchanan (1984), but he also shied away from demanding a social obligation in health care matters, except for the rare case where society had instigated certain medical

needs (wars, for example) or had explicitly entered a specific health-related commitment, as in preventative campaigns requiring central organization. Buchanan did see the need for some kind of medical care, which he preferred to anchor as an imperfect duty of charity. The mere call for charity is ineffective, he acknowledged, and collective programs need to be worked out so that people will consistently discharge the duty of charity. His proposal finally takes the form of a revenue which, by way of Mill's concept of social expediency, becomes a mandatory duty towards the state. Still, Buchanan's scheme does not evolve into an obligation for the state to use the taxes thus levied to grant health care rights.

Although few people would endorse radical liberalism with no affirmative state action in health care matters, a more positive view was slow in developing. Fried (1978:583) used the term "*decent minimum*" to convey the idea of a balance between public concern for the poor and the preservation of free and flexible social commitments. The notion of decent minimum is not a mere figure of speech, but an indispensable concept that should replace arbitrary notions of medical needs. "*The main criterion for what health care services should be made available as part of the decent minimum is adequacy of the amount, level, kind, and quality of health care. Tests of adequacy will at the least include whether health care is responsive to certain needs, for example basic, urgent, or life-threatening needs*" (Childress, 1997:252). "*(...) in the absence of humanity, we may have to resort to the political process to define the decent minimum for individuals*" (Childress, 1982:418).

The idea of a decent minimum of health care was taken up and elaborated by Daniels (1981), probably the most influential writer on the subject. He remarked quite properly that the scope of a right required a definition of its object, endorsing Boorse's characterization of health as the adequate functioning of the individual in accordance with standards of the species. Illness means not being able to comply with these norms and therefore losing out in the basic social position of securing equal opportunities to pursue one's idea of the good life.

All these philosophical approaches have had no major impact on actual health care policies, but they do appear as plausible and coherent theoretical frameworks for liberal countries. It is far less evident that they can be relevant to societies with substantially different cultural and political realities. A major point of divergence lies in the social composition of North American communities, where a numer-

ous minority of people lack sufficient medical care, whereas less prosperous societies have a majority of their population living on low incomes, with no health insurance and reliant on grossly under-financed public programs. Under such conditions, the denial or restriction of health care rights leaves vast segments of the population standing in the rain.

Even the more justice-oriented schemes are difficult to fit into a Third World reality. Daniels, for example, appears to believe that organismic normalcy is the major asset that makes all people fit to participate in society's equal opportunity climate. Therefore, if 'decent' medical care is provided, people will enjoy enough support to engage in a satisfactory life plan. But what about education to be competitively qualified? Why aren't housing or perhaps even clothing considered necessary assets to become more attractive job candidates? Furthermore: how good is the fit between individual programs and species-adjusted normalcy?

Protective functions of the state

A distinction must be made between wealthy societies and those that operate in scarcity. Societies in scarcity are not necessarily poor, but their wealth is polarized and their political language does not contemplate deep redistributive changes. They may have excellent schools and universities, even outstanding research facilities. They have an attractive though restricted job market, an agile consumer market, and a general climate of well-being. But they remain profoundly divided into three classes: the wealthy, the striving but fragile and vulnerable middle class, and the destitute, who are numerous and appallingly poor.

Even the most liberal political thought recognizes that a minimal state will offer protection to its citizenry, since violence needs to be curtailed and disciplined into a 'law-and-order' policy. Security-prone states organize a military force against external violence, and the police force subdues internal aggression, while remaining oblivious to other pleas for protection.

Beyond human aggression, there are other menacing forces that come from nature, against which the state cannot or will not give universal protection. A good number of natural forces can be neutralized by individuals provided they have the means to do so. Since influential political leaders for the most part emerge from well-to-do social segments, they tend to adopt a liberal view that dismisses any state interven-

tion in matters that can be solved by private means. Even more socially oriented politicians will often refer to the subsidiary state, an arrangement where state intervention is reserved for circumstances that go beyond the problem-solving capacities of the individual or small group.

Justice in a context of scarcity demands a new approach that will recognize that aggression must be defined according to the economic possibilities of the citizenry. In wealthy nations, international security, national law and order, and certain basic services like urban development or emergency funds may suffice as governmental attributes. Earthquakes and floods affect poor neighborhoods more heavily, but the loss of crops may be equally devastating for rich and poor. When individual efforts are insufficient, the clamor for state intervention and support becomes universal. In countries with a large population of underprivileged and poor, the state must extend its protection to ensure medical care, education, housing, and fair labor opportunities.

Jones (1983) has published a proposal along these lines, but he contends that national protection against foreign enemies is equivalent to health care for diseases that constitute a social menace. Thus, cardiovascular diseases kill more people per year than the Vietnam War, so he considers them a problem the solution to which must be funded by the state. According to Jones' view, since Down's syndrome is not a direct killer and cystic fibrosis affects only a 'fairly small' segment of the population, the two diseases might not qualify for state-supported medical services. On the other hand, acute appendicitis would, since the state has a tradition for taking care of emergency situations. Despite this early contribution, it has not been firmly established what type of medical needs, if any, are to be provided by the state and to whom.

It is hardly surprising that consensus on preventive public health measures dates back no more than a hundred years, when it became clear that no sewage system would work unless all households were connected to it, and that no immunization program was effective until the entire vulnerable population was vaccinated, thus constituting a state obligation and a right for all citizens.

Therapeutic medicine has fared so poorly as a candidate for universal coverage for the same reasons. The first medical insurance schemes were designed by Bismarck for the German Empire, but their only aim was to maintain a healthy and productive labor force.

In fact, the early decades of the *Gesundheitswesen* were restricted to workers, their families being excluded from health-care benefits.

The basic attitude of giving no more than lip service to the language of rights in health care matters has led to only rudimentary public health care facilities, coexisting with a highly sophisticated private-tiered medical system that absorbs a major portion of the resources invested in health care.

A health care scheme that denies access to the poor and that remains oblivious to the fact that justice in health care requires justice in other areas too, is nothing but a theoretical exercise. A more complex concept of health care justice in a context of scarcity needs to evolve.

Justice in scarcity

This proposal may appear at first glance to reedit unpopular and inefficient socialized medicine schemes, but in fact it differs from such obsolete concepts in a number of ways. First of all, it does not limit the extent of medical coverage, but defines the population that may apply. This means that those liable to be affected must receive full coverage, and not only primary care as often happens. There is no convincing ethical argument to concede the basics of medical services but to deny sophisticated surgery, expensive medication, or other forms of health care that are beyond the financial reach of the needy.

Justice demands that medical services be available to all who need them and are unable to pay. Instead of placing limits on the amount of medical expenditures, it is more important to define the population that will require full state support, and those who may need care or subsidies for more costly but necessary procedures. State-financed medicine is ethically acceptable only if it covers all the real needs of the underprivileged and guarantees that such support will be available. In other words, a right to health care is acknowledged and related to medical needs and the inability to pay for them.

A second necessary specification addresses the amount of medical resources each individual is entitled to. The answer is twofold: citizens with health coverage can only claim extant services, and only services with established and acceptable efficiency can be claimed. Every citizen may claim as much antibiotic treatment as required, but multi-organ transplants may be beyond such a claim, since such surgery is still subject to low success rates (Childress, 1984).

Each society will develop its own guidelines concerning the degree and efficiency it accepts as undeniable. Such limits will change according to the systems' solvency and reappraisals of the benefits of the treatments in question. Discrimination based on the severity of disease is avoided, and treatment is allotted according to efficiency rather than cost. Rationing becomes an explicit, fair, and clinically sound procedure (Mechanic, 1978).

Using somewhat untidy rhetoric, a number of authors have expressed their fear that a right to medical care would be open-ended, devouring ever-increasing amounts of resources, erasing the limits between the necessary and the desirable, opening the doors to free riders and generally turning a well-meaning social service into a fuzzy and uncontrollable free-for-all. All these are procedural arguments with no substantive force to affirm or deny a right. It may be difficult to make a right to medical care work in practice, but that is a question of social administration. Furthermore, the financial woes of medical services are largely created by the health-care industry and by profit-oriented providers, so it seems quite unfair to unquestionably accept these practices and use them as arguments to impinge upon the rights of the needy.

Public health and medical services

Establishing the priority of serving medical needs may go a long way to justify fiscal expenditures in public health, but it does not suffice to define *what* actually counts as a genuine medical need. Again, this may depend on finding a definition of health/disease that will satisfy all parties, but there is much more in a definition than meets the eye. The most popular and widely used characterization of health comes from the World Health Organization (WHO), but its scope is so broad as to encompass social services that go beyond medical care. If medical needs were to be recognized for all who are not healthy according to WHO standards, society would have to provide housing, adequate labor, leisure conditions, and much more to provide 'physical, social, and mental well-being'. Medical services would be merely one way of dealing with needs which should really be considered social needs in such a vast scenario.

The preceding discussion suggests that the definition of medical needs differs not only with political factors but also with the economic status of a given society. Affluent communities may narrow their definition of medical

needs to specific clinical situations, whereas the underprivileged will include many functions which are not specifically clinical but still impinge on physical development, function, and well-being. Expanding medical needs beyond strictly defined disease criteria has been resisted by most countries, overlooking that the origins of public health lie in social endeavors to combat disease through non-medical measures, like sewage systems, water supply, and health inspectors.

It should come as no surprise that poor countries continue to require a variety of non-medical measures to cover physical needs or combat deficiencies. Consequently, specific medical services must be viewed in a broader sense than as a mere catalogue of clinical conditions too expensive or too infrequent to be treated on a private basis.

The right to health care ensues from the situation of utter destitution of the sick and poor. Therefore, whoever is sick and unable to pay for medical care has a rightful claim to state-supported medicine. This means defining disease (employing Boorse's criteria, for example) and specifying what is understood by inability to pay: not being able to divert monies towards medical services without leaving other basic needs like food or shelter unattended.

The fair allocation of health care resources varies not only according to the wealth a society may have. In addition, within each society there are various levels of distribution, classified as first and second order decisions, or as macro- and micro-allocation. First order allocation or macro-distribution refers to the amount of goods to be distributed. It involves a political decision, for it is related to all the tasks for which a state may be held responsible. A nation's gross total assets are allotted to different tasks, all of which are considered indispensable and worthy of full financial support. Since resources are limited and insufficient for full coverage of all relevant areas, priorities and reductions ensue, creating a situation which is always tragic (Calabresi & Bobbitt, 1977). Macro-allocations always involve the drama of neglecting essential needs, much more so in poorer nations which have less to allocate. It therefore becomes all the more tragic and urgent if public funds are directed to areas that are not essential in the eyes of ordinary citizens, e.g., inflated defense budgets, diplomatic pomp, conspicuous consumption, or non-essential investments.

Socialized or two-tiered systems?

A tentative conclusion at this point is that the poorer a country is the less it can afford to leave clinical, broader health-related, and other similar social needs in private hands.

Rights and social obligations certainly need to be specified. Who can make a valid claim to medical services, and what medical services may be claimed? The substantive aspects of these questions should be addressed briefly, for the procedural part belongs elsewhere.

The right to medical care for citizens of societies with scarce resources are hardly amenable to ordinary criticism. A right ensues for all those who suffer dire needs they are unable to meet and provided that there exists a level capable of palliating or covering these needs. Being sick precludes the development of strategies to cover other needs. Physical weakness and suffering keeps the afflicted from working, purchasing food, caring for housing needs, or pursuing an education. Medical needs should be considered basic and of the highest priority in order to foster the pursuit of other basic needs (Arras, 1984).

Secondly, if medicine is technically capable of treating disease and public funds can finance medical care, there remains little reason to deny the poor their legitimate right to health care.

Such a vast social support network requires precise recruitment policies and leaves a variable proportion of citizens out of the scheme, depending on how solid the country's economy is. A fundamental difference in regard to socialized medicine is the official tolerance of a two-tiered system, a public one for the needy and a private one for those who can afford it and who do not qualify for state support. Twofold medical systems have been rejected by purists who believe they violate the essence of equal access, and that such an arrangement would drain resources and excellent services from the public to the more rewarding private area. It has even been argued that equal access to health care requires the prohibition of private medicine (Gutmann, 1981; Engelhardt Jr., 1997), as if equality meant that no one can eat anything but potato stew, instead of insisting that everyone should at least have access to potato stew but can well enjoy roast lamb if they can afford it, provided nobody is thereby deprived of his stew.

Nevertheless, the private tier cannot function from a *laissez faire* approach, for two reasons. First, opting out of public schemes means using and supporting profit-oriented private medical services that tend to dismantle

the public system by attracting personnel and resources. Private entrepreneurs are prone to mix the sophisticated with the superfluous, thus offering health care that is splendidous and expensive without necessarily improving medical care. Secondly, as mentioned above, the public health component of medicine is to a great extent a mandatory governmental function that burdens and benefits all alike. Even though all citizens partake of, say, health education or vaccination programs, they are not paying equally, for such campaigns are financed by the public health system to the detriment of its own curative health care programs, while the private system thrives unburdened by such public expenses.

Both these reasons suggest that opting out of the public system should be taxed. Whenever someone enters a private medical care contract, he continues to receive public health benefits. He is also being instrumental in draining resources towards the private area where health care providers are thriving. Moving into the private area should be taxed accordingly, just as staying in the public tier while not qualifying as needy should be taxed to avoid free riding.

Another important proviso addresses the misconception that state intervention must always mean centrally organized services, which allegedly are doomed to be mismanaged and sloppily financed, under the assumption that the state is a poor administrator. Watching a military parade or seeing how efficiently taxes are collected may give one a different view. In any event, the state must function as a controller, and not necessarily as a provider, seeing to it that no citizen is deprived of his right to health care or his right to a fair and transparent health care insurance contract. In a two-tiered system, citizens who partake of the private area must be protected from shark contracts. Patients, even potential ones and those with resources, enter a dependent and more or less unprotected situation when they become sick. They become vulnerable to the profit-oriented strategies of insurers and private health care vendors, often falling prey to contractual loopholes, fine-print addenda, and other coverage-limiting clauses. The judicial spirit of the state is required to protect citizens from abusive situations, and health care justice demands that health insurance and health care contracts be subjected to state control. This may sound arbitrary, but it does not differ from the widely acknowledged state mechanisms of controlling such public goods as water supply, marketing of drugs, or highway safety.

Conclusions

Presented here are a number of arguments that should help construe a concept of health care justice in societies with severely limited resources. First, the well-accepted protective function of the state must be expanded to include certain basic welfare services that are beyond the buying power of large segments of the population. Second, medical care must be a priority among these services, for health is a prerequisite to allow access to other basic services. Third, justice demands that medical coverage be extended to all those who cannot afford to pay for it, and to the extent necessary to effectively treat their diseases. The right to health care should not be limited to certain types of diseases or depend on treatment costs, but should be tailored according to the degree of need. Fourth, such a health care program may be either directly provided by the state or guaranteed and controlled through fiscal channels. Fifth, the state-supported right to health care is perfectly compatible with private-tiered medical schemes. Making use of the private tier puts direct or indirect tension on public funds and should therefore be compensated for through appropriate taxation.

The right to health care and the state's role in providing medical services are often bitterly opposed, not so much on principle, but on the basis of contingent and empirical arguments. This is fallacious, for a possible right must be anchored in the legitimacy of a claim rather than on the availability of material resources. There is also no principled argument against

two-tiered medical systems, which may be conceived in such a way that no one's rights are restricted, at the same time requiring the system to allow a maximum of individual freedom for all citizens.

State-supported health care has traditionally been based on solidarity and constrained by the need for rationing. Two-tiered schemes are currently being discussed on a triad of principles: self-responsibility, solidarity, and subsidiarity (Sass, 1995). There seem to be no ethical qualms with such a development, provided that the "*basic tier is universally accessible and is based on the value of humanitarian solidarity*" (Ter Meulen, 1995:607).

This is not to deny the enormous tension between a state-funded, equality-based service and the vagaries of free-market dynamics, but the efforts of European welfare states go a long way to show that two-tiered systems are viable. For economically weak countries, it is of utmost importance to accept and develop such systems, lest the more affluent and influential deny state-based medical care for fear of losing their privileges to pursue private medical attention.

The substantive aspects of equal access to medical care in destitute societies are far from easy to agree upon and must be translated into procedures that will not distort the underlying concepts. Good rules are necessary but not sufficient, and one does well to remember Freedman's (personal communication) admonition that "*What is needed is a theory which at the least allows one to be a good person while engaging as an actor within a distributive system.*"

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