SPECIAL SECTION

RATIONING, EQUITY, AND AFFORDABLE CARE

Americans Have Never Understood That There Is a Price to Be Paid for Universal Healthcare

BY DANIEL CALLAHAN, PhD

Few social problems in the United States have had as bewildering a history as healthcare. An experimental mouse subjected to its ups and downs would long ago have been driven crazy, the victim of high hopes followed by dashed hopes, followed once again by high hopes only to be let down still another time. Harry Truman tried shortly after World War II to get universal healthcare but failed. Senators Edward Kennedy and Jacob Javits gave it a shot in the mid-1970s; no go that time. President Clinton tried in 1993-1994 but fell on his face—and none of the competing proposals at that time, liberal or conservative, made it either.

At the moment, not much of anything is happening, even as the number of uninsured steadily rises, now standing at 45 million. There is some agreement that nothing but a real crisis in the system—for instance, a collapse of the employer-based programs that provide most of the health insurance in this country—could make a difference in the prospects for universal healthcare. There's no evidence that's about to happen.

Meanwhile, although too little noted here, many of the European countries that have long had equitable and popular healthcare systems are running into trouble, as is Canada. Maintaining those systems in the face of aging societies, constant and usually expensive technological developments, ever-rising public demand—and increased public resistance to higher taxes that might keep pace with the rising costs—is proving difficult. In short, even as we in the United States struggle to find a way to get universal healthcare, many other countries are desperately struggling to hang on to it.

The typical response to this pressure, here and abroad, is one form or another of managerial technique: a turn to the market, managed care, tougher measures of cost containment, a demand for higher out-of-pocket copayments or higher deductibles from the insured, and reduced payments to providers. None of these techniques is working well. Healthcare costs are once again on the rise in America and debates about privatization heat up in Canada.

Sustainable Healthcare

What's being missed here? Why is it that almost every country in the world, *regardless* of its type of healthcare system, is having a problem? My answer is this: None has recognized the need for a new model of healthcare, what I call a "sustainable" model. By that I mean a form of healthcare that is affordable over the long run—indefinitely into the future—and that is equitably available to all. It should by now be clear that not one of the present methods of organizing healthcare systems can achieve that goal. Despite a blitzkrieg of cost-containment techniques, constantly rising costs everywhere provide ample evidence that affordable care is not in the offing.

Meanwhile, as that aim has proved elusive, inequities in healthcare are also on the rise, whether in the stark form of an outright absence of insurance for many or in an increasing gap between the kind of care that the affluent and the poor can get. Pleas for greater justice and equity, for more compassion, for greater empathy for the sick poor, have made little difference. And even if

Dr. Callahan, a cofounder of The Hastings Center, Garrison, NY, directs its international programs. His latest book is False Hopes: Why America's Quest for Perfect Health Is a Recipe for Failure *(Simon & Schuster).*

they were heeded, they might do no more than drive the cost of healthcare up further, making the financial struggle all the worse.

At the very least, rationing—which to me is not a dirty word—will be necessary in any and all future healthcare systems. The kind of complaints now heard about managed care would be heard in any universal healthcare system, which would of necessity have to incorporate rationing in order to survive. No system, however efficiently managed, is likely to be able to keep up with the constant stream of new and expensive technologies, most of them offering only marginal improvements over those that have gone before. And none will be able to cope through managerial techniques with the combination of aging societies and technological innovation. From a financial angle, it is a hopeless, impossible mix that, if allowed to continue, can only create financial misery and increased inequity.

Sustainable healthcare, by contrast, would have to be based on a different model of medicine and healthcare. Let me contrast the present model and a sustainable model.

The Present Model The current model of healthcare features, at its heart, a commitment to constant medical progress, assuming that progress—any kind of progress—is an indisputable good. The model aims at the conquest of all diseases, one disease at a time. It seeks an indefinite increase in average life expectancy. It aims to relieve all suffering it can get to, physical and mental. And it allows the progress itself to change and set medical goals—which in effect constantly raises the standard of what counts as "good health."

This model has helped engender a number of characteristic biases in the provision of healthcare. There is a bias toward cure rather than care, another toward acute rather than chronic disease, still another toward length of life rather than quality of life, and yet others toward technological interventions rather than health promotion and disease prevention, toward subspecialty medicine rather than public health and primary care, and toward the increased medicalization of life and its social problems.

The Sustainable Model A sustainable model of healthcare would start with a more limited idea of progress, not an open-ended one. It would have finite, achievable goals, beginning with the goal of helping people to avoid a premature death, not death itself. It would have a different set of biases. It would accept death as an inevitable part of the human condition just as it would understand that not all suffering can be medically eliminated. It would understand that some degree of dependency is a necessary feature of life together in community, just as it would understand the necessity of setting limits and rationing healthcare. The setting of priorities would be imperative, with public health providing the broad base and high-technology medicine the narrow tip.

Most important, a sustainable healthcare system would take seriously what is now widely known: It is socioeconomic conditions and good public health programs that decisively determine the health of populations, not the provision of medicine and healthcare. Medicine makes a difference, of course, but not the greatest difference. Accordingly, sustainable healthcare would work with that well-established knowledge as the foundation of a healthcare system.

That foundation would require a population perspective on healthcare, one that would need to have at least a moral parity with the present individualistic bent. The latter bent has powerful credentials, including the Hippocratic tradition with its patient-centered values, the Christian tradition with its respect for individual dignity, and the reigning American (and Western) liberal individualism. The problem is that the individualism, though surely a worthy value, is itself the major obstacle to an affordable, sustainable medicine.

By putting the needs of the individual ahead of the common good—in this case defined as population health—this perspective enshrines a set of values that knows no boundaries. A healthcare system dominated by individualism has no good way of saying no to individual needs, however much they may hurt the common good. It takes all rationing and all limits as an offense against human dignity. When added to aging societies and constant tech-

nological innovation, that is a perfect recipe for budgets that must constantly grow.

A constant plea for justice, for decent access to healthcare for the poor, simply cannot get off the ground in the face of this kind of relentless pressure. If it made sense earlier to see this country's failure to enact a universal healthcare program as a failure to seek justice for all—and even if that is still true—justice is now only part of the problem. The larger part is that modern medicine is now itself out of control, aiming not for a medicine that can be equitably distributed, but for one hell-bent on an expansive, limitless drive to constantly improve health, but the health of individuals—not of the population as a whole.

The Necessity of Rationing

Americans, even American liberals, have never understood that the necessary price to be paid for universal healthcare is rationing. If everyone is to have access to a decent level of care, not everyone can have access to the most optimal care. Although there are many legitimate complaints about the way some managed care programs are run, the least valid complaints are those that focus on the denial of full choice for both physicians and patients. The most effective way of controlling costs, and thus insuring access for all, is to use primary care physicians as screeners for specialized care. That is why that practice is a prominent part of European healthcare systems. Screening means, however, that patients cannot get the specialists they may want when they want them. Closely related to screening is the use of evidence-based medicine (when the evidence is available) to determine appropriate treatment for patients. Again, that means saying no to physicians and patients who want treatments known to be ineffective.

A sustainable medicine, as with sustainable HMOs, requires rationing to insure affordability. And affordability, I have tried to argue, is a basic requirement of sustainable healthcare. Why does this point seem to so hard for Americans to grasp? Why, when it *is* grasped, is it looked on with such suspicion? Three reasons seem likely.

The Best and the Most Just One reason is that the idea of the best possible healthcare is confused with the most just healthcare. That is wrong. In the nature of the case, just healthcare must, on average, be something less than the best possible healthcare. As a matter of simple logic, not everyone can have access to the best heart surgeon in the country or the best hospital. Unless we have unlimited wealth, we will have to settle for something less. The fact that a rich person might be able to command the services of the best heart surgeon does not, however, demonstrate injustice. Injustice would consist of a failure to command the services of a competent surgeon and access to a hospital of average quality.

Quality and Hype A second likely reason is that many people seem to assume that last year's drugs are not as good as this year's drugs, or that last year's surgical procedure is not as good as this year's. In many cases, this will simply not be true. But, in a culture dominated by the expectation of constant progress, people begin to think that only the latest can be the best. Of course, even in those cases where the latest *is* better, the improvement may be marginal only, not one that leads to decisively improved health. Still, in our society, because of advertising and media hype, only what is new is thought acceptable, and people are, unfortunately, interested in marginal benefits.

Living Conditions and Behavioral Patterns The third likely reason is our failure to realize that good health is very much a function of living conditions and behavioral patterns, not the availability of the latest and best medical technology.

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I know that people nowadays hear much about the need to live a healthy life, and that disease prevention is actively promoted. But I have come to think that, in the end, what counts for most people is the kind of care they get when they become sick. If it is hard for many people to live healthy lives—if only because they can't take seriously what might happen to them in 10 or 20 years if they don't—it is no less hard for them to want less than the best medicine when they *do* get sick. That would probably be true even if they had a society and healthcare system that postponed the onset of illness much longer than is currently the case. In other words, health promotion and disease prevention efforts may not effectively help to control healthcare costs if everyone wants expensive, high-technology medicine when—finally, inevitably—they do become sick.

There is another consideration having to do with health promotion and disease prevention efforts. They are much less likely to succeed if the public continues to think, as I suspect it does, that strenuous efforts to live a healthy life are not really necessary since medicine is there to rescue us from our folly when our bodies at last succumb to the indignities our behavior has visited upon them. The belief in medical miracles is alive and well, fed by media that tout the latest breakthrough and the great hopes that medical advances engender. Medical rationing, it might truly be said, would be a necessary condition for effective health promo-

tion programs, because it would remove the escape valve of last-minute rescue.

Those programs would give a clear message: Take care of yourself and don't count on medicine to save you from yourself. At present, health promotion must rely on persuading people to live in salutary ways to avoid future problems; and not enough listen. But why should they, if they can kid themselves into thinking that they will ultimately be saved? And if there is no rationing, then they may in fact be saved. But, of course, as the costs of the rescues increase with the increased cost of technology, not everyone can be saved, only those who can afford to pay for it. The irony at present is that the poor, who are least likely to have access to the constantly evolving new and expensive technologies, are exactly those who would most benefit from health promotion programs if they could be successfully put in place. But the poor are the group that finds it most difficult to leave healthy lives, that possibility being diminished by poor education, inferior food, inadequate housing, low incomes, dangerous neighborhoods, and the threat of violence.

I surely would not want to contend that the kind of medicine available would ever be the sole determinant of the likelihood of a just distribution of that medicine. I only want to argue that it is a great mistake to *dis*sociate them, as if just distribution had nothing to do with the cost and kind of medicine available. The evidence seems clear enough to show that there is a close connection, and that the creation of an increasingly more costly kind of medicine will not fail to jeopardize the likelihood of just distribution, even with the best will in the world. It is like trying to improve access to transportation for the public by retooling Rolls-Royces and BMWs, or trying to feed the hungry by enhancing the quality of caviar. Any theory of fair resource allocation that is developed apart from a consideration of the cost and nature of what is to be allocated makes increasingly less and less sense. An unaffordable medicine can be nothing other than an unfair medicine—which is what our country, and indeed the world, is getting now. □

JUSTICE, ALLOCATION, AND MANAGED CARE

Continued from page 37

among the many legitimate claims made on them. Managed care can play an important role in this fair allocation. But to do so, it must first build legitimacy and trust. □

NOTES

1. See, for example, Robert H. Blank, *Rationing Medicine*, Columbia University Press, New York City, 1988, and Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society*, Simon and Schuster, New York City, 1987.
2. See, for example, David Mechanic, "Changing Medical Organization and the Erosion of Trust," *Milbank Quarterly*, June 1996, pp. 171-189, and Stanley Joel Reiser, "The Ethical Life of Health Care Organizations," *Hastings Center Report*, November-December 1994, pp. 28-35.
3. See Norman Daniels and James Sabin, "Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy," *Hastings Center Report*, March-April 1998, pp. 27-41.
4. See Joseph J. Fins, "Drug Benefits in Managed Care: Seeking Ethical Guidance from the Formulary?" *Journal of the American Geriatrics Society*, March 1998, pp. 346-350.
5. See E. Haavi Morreim, "The Ethics of Incentives in Managed Care," *Trends in Health Care, Law & Ethics*, Winter-Spring 1995, pp. 56-62.
6. See Mark Schlesinger and Bradford Gray, "A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities," *Health Affairs*, May-June 1998, pp. 152-169, and Mark Schlesinger, et al., "A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits," *Health Affairs*, September-October 1998, pp. 27-49.
7. See, for example, Robert Kuttner, "Must Good HMOs Go Bad?" *New England Journal of Medicine*, May 21 and May 28, 1998, pp. 1,558-1,563 and 1,635-1,639; Bradford H. Gray, "Conversion of HMOs and Hospitals: What's at Stake?" *Health Affairs*, March-April 1997, pp. 29-47; Emily Friedman, "A Matter of Value: Profits and Losses in Healthcare," *Health Progress*, May-June 1996, pp. 28-34, 48; and Gary Claxton, et al., "Public Policy Issues in Non-profit Conversions: An Overview," *Health Affairs*, March-April 1997, pp. 9-28.
8. See Christopher J. Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States*, Crossroad, New York City, 1995.
9. See Kuttner.
10. See Daniels and Sabin.