The Conversation Underneath the Truth in Between

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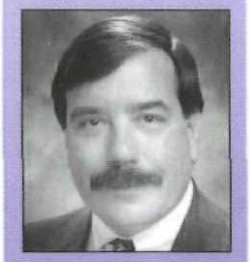

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Emily Friedman, in her article "Managed Care: Devils, Angels, and the Truth in Between," asks that we "tone down the rhetoric" and think in terms of distinctions. She makes many valid points.

But underneath the distinctions lies another set of needed conversations, apart from the managed care myths. These conversations are about the values that should shape the delivery and financing of healthcare. I say "should," but in reality there is not agreement about which values should and which do—a reason, I suspect, for another set of distinctions.

A first value might be the "sometimes cure, always care" attitude of our physicians and nurses, hospitals and clinics, health maintenance organizations, and insurance companies. We care because health services are for people, vulnerable people, who need our help. We care because there are limits to access, to technology, to cures—to almost everything.

Second, there is the question of those limits. Some are the results of human finitude; others arise from our commitment to a common good. Some reflect personal values and choices about where we want to live, how we want to live, with whom we will share our lives, and what we value and cherish. Limits bump up against the sometimes too-consuming value of choice. Limiting choices should never limit care. But maximizing choice often leads to too much, and, as a result, too little for too many.

Third, in our concern about managed care as a financing mechanism for healthcare services we often forget (as Friedman suggested) that too many have no access to the overabundant supply of hospital beds and physicians. Don't we really believe that at least some healthcare services are vital to all, and that the pursuit of daily living requires a little healthcare attention from time to time? The rhetoric of many healthcare debates drowns out the voices of the underserved. Even if managed care were a perfect system, the number of uninsured and underinsured would remain unacceptable and problematic in light of our justice commitments.

Fourth, is healthcare in our society a reflection of our shared wisdom and knowledge, binding us together in our common life through attention to those in need? Or is healthcare really big business, best left to the open market, helping to fuel our growing economy? Perhaps, in our individualistic society, there are not enough of us sick at the same time to reach consensus. Unless and until we share a public vision of what we think healthcare services should be about, we will not be able to answer some of the vexing questions raised in Friedman's article.

Beyond these four value questions, others cry for civil conversation. For example, what is healthcare, ultimately? How can we stop medicalizing our social issues? When will we learn that many things—not healthcare—will heal us and help us remain healthy, including education, housing, a clean environment, and a livable wage? What do we do in a world increasingly without borders where healthcare disparity is so stark? How can some enjoy a wealth of technology and the finest that medicine has to offer while others watch their children die of treatable diseases? Where is the forum for the conversation that really builds healthy communities beyond the real and troubling questions of managed care?

As with managed care—rhetoric is not the answer.