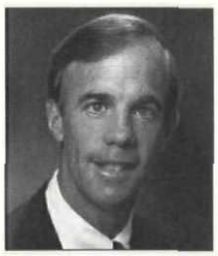
Toward a Just Policy on Healthcare Rationing

Ethical Principles Must Inform the Debate Concerning the Distribution of Services

BY PAUL B. HOFMANN



Mr. Hofmann is a visiting scholar, Stanford University Center for Biomedical Ethics, Palo Alto, CA, and a senior fellow, Stanford University Hospital, Stanford, CA.

The American healthcare system, hailed by some as the best in the world, is rarely depicted in glowing terms by those who have examined it closely. Instead, it has been described as a "paradox of excess and deprivation"[1] and as "addicted to increasing costs and decreasing equity."[2] These perceptions of inequity and excess have given rise to a debate over whether policymakers should consider some form of rationing as a means of achieving a more just and efficient healthcare system.

As the debate intensifies, three factors will be critical in determining whether the policies ultimately developed at will be just and equitable. First, participants must grasp relevant facts involving the current distribution of healthcare services in the United States. Second, the debate must be based on a clear understanding of who has ultimate responsibility for making decisions regarding healthcare rationing. Finally, those committed to implementing a just approach to the issue must ensure that ethical principles relevant to policy-making are made clear to everyone and affect the debate's outcome.

Is Rationing Necessary?

The first question policymakers must face is whether there is, in fact, a need for rationing. Some have argued that taking steps such as reducing administrative costs and unnecessary surgeries will make rationing—or the deliberate limitation of potentially beneficial services—unnecessary. But as other analysts have noted, the debate over whether to ration healthcare services obscures the fact that healthcare is, in practice if not in policy, rationed pervasively now.[3] The relevant questions, V. Fuchs has argued, are: Who will ration? Who will be rationed? What will be rationed?[4] Ironically, even these questions may

Summary Perceptions of inequity and excess have given rise to a debate over whether policymakers should consider some form of rationing as a means of achieving a more just healthcare system. Three factors will be critical in determining whether the policies ultimately developed will be just and equitable. First, participants must grasp relevant facts involving the current distribution of healthcare services in the United States. Second, the debate must be based on a clear understanding of who has ultimate responsibility for making decisions regarding healthcare rationing. Finally, those committed to implementing a just approach to the issue must ensure that ethical principles relevant to policy-making are clear to everyone and affect the debate's outcome.

The controversy over whether to ration healthcare services obscures the fact that healthcare is, in reality if not in policy, rationed now. A key advantage of promoting formal public policy decisions about the provision and limitation of healthcare services is that it shifts responsibility for these decisions from providers to society.

Applying four classic bioethical principles to the question of rationing can also help ensure implementation of an appropriate public policy on healthcare rationing. For the debate on rationing to be meaningful, it must be conducted in a way that respects and promotes participants' autonomy. Policymakers should also observe the principle of nonmaleficence, which dictates that their policies not harm those they affect. A proper rationing policy should also fulfill the criterion of beneficence (i.e., actively promote the good of others). Last, such a policy should conform to the principle of justice by being fair and impartial.

leave the impression that healthcare is currently not rationed.

Thus, although the rhetoric of the healthcare debate suggests that rationing does not exist and can be avoided, neither is the case. Resource constraints will continue to restrict society's ability to provide unlimited healthcare services to everyone.

Unless personal choices are constrained, rationing will not and cannot occur.

Who Decides?

The healthcare reform debate has focused new attention on the cost, quality, and distribution of services. Because one of the major goals of any reform proposal should be universal access, the definition and design of a basic benefit package are particularly critical. Of necessity, some benefits will be excluded from coverage. Historically, physicians have properly viewed themselves as patient advocates and resented any attempts to force them to perform as de facto rationing agents. Therefore different approaches must be developed.

A key advantage of promoting formal public policy decisions about the provision and limitation of healthcare services is that it shifts responsibility and accountability from providers to society. In addition, it is much easier to deal with statistical rather than individual lives. As contrasted with physicians, who must confront actual patients, policymakers have the "luxury" of constructing programs for people who are largely anonymous and invisible.

Another major advantage of encouraging formal public policy on healthcare rationing is that it tends to empower those who are underserved by the current system. Because these nonrecipients are usually politically impotent (including children, the medically indigent, the chronically ill, and the frail elderly), the implicit and arbitrary rationing that deprives them of needed services usually goes unnoticed.

An Ethical Approach

Applying four classic bioethical principles to the question of rationing can also help ensure implementation of just and effective public policy on healthcare rationing. Although these principles are most often considered in the context of clinical decision making, they have clear relevance to the question of rationing healthcare services.

Respect for Autonomy For the debate on rationing to be meaningful, it must be conducted in a way that respects and promotes participants' autonomy. Although the applicability of the concept of autonomy to issues involving patients' informed consent to treatments is generally well understood, its implications for rationing health services may be less obvious.

Those involved in the rationing debate must be competent and informed, they must understand the issue, they must enter the debate voluntarily, and they must authorize policymakers to arrive at a position on the issue. The elements that make them fit for entering the debate are the same prerequisites for autonomous action on the part of an individual.

Respect for the autonomy of those affected by rationing decisions makes public education on the issue essential. Without disclosure of the economic pressures and other factors that explain why finite resources cannot accommodate infinite expectations, citizens will neither understand the issues nor be competent to participate in the decision-making process. Furthermore, given the American form of government, rationing will not succeed unless it is accepted voluntarily and authorized through the democratic process.

None of the prerequisites to achieving active, knowledgeable, and legitimate participation in rationing decisions will be easy to accomplish; but without support for the principle of autonomy, it is unrealistic to expect significant progress. Any unilateral attempt to enforce healthcare rationing not only would fail, it would make subsequent efforts much more difficult.

However, although ethical and successful rationing will largely depend on extensive public input, unconditional adherence to the principle of autonomy is unrealistic. Unencumbered individual freedom is unsustainable when limitations are imposed, regardless of how democratically the development and implementation processes are designed. Indeed, unless personal choices are constrained, rationing will not and cannot occur, and unless social goods are distributed more equitably, the common good will not be served. Ultimately, an ethically sensitive rationing system will be overt, reflect broad societal involvement, and promote public understanding and support.

Nonmaleficence The principle of nonmaleficence prohibits doing harm to others. Although the principle appears self-explanatory, its application and interpretation can be complex.

The notion of double effect is particularly germane to a discussion of nonmaleficence in rationing healthcare. Because rationing leads inevitably to withholding potentially beneficial services (and thus to doing some harm), an appreciation for the significance of double effect is especially important.

According to T. Beauchamp and J. Childress, four conditions must be satisfied for an act with both a good and a bad effect to be justified:

> 1. The action itself, independent of its consequences, must not be intrinsically wrong; it must be morally good or at least morally neutral.
> 2. The agent must intend only the good effect and not the bad effect. The bad effect can be foreseen, tolerated, and permitted but must not be intended; it is therefore allowed but not sought.
> 3. The bad effect must not be a means to the end of bringing about the good effect; that is, the good effect must be achieved directly by the action and not by the way of the bad effect.
> 4. The good result must outweigh the evil permitted; there must be proportionality or a favorable balance between the good and bad effects of the action.[5]

These four conditions illustrate the most challenging paradox in complying with the principle of nonmaleficence in rationing healthcare services. Depending on whether one insists that all four be satisfied or places more emphasis on intentionality or proportionality, it is possible to defend or criticize the various decisions involved in rationing. Nonetheless, struggling with the conflict of reconciling competing values and obligations is an inescapable responsibility in designing an allocation process.

Examining each condition separately, we can demonstrate how rationing can be justified:

- The first—that the action not be intrinsically wrong—is certainly the most problematic because one could argue that *any* action which results in withholding beneficial services is unacceptable and morally wrong. If resources were infinite, such an argument would be difficult to refute, but it is clearly not feasible to provide unlimited care to all citizens.
- As noted previously, any rationing policy will produce bad effects. Nonetheless, these effects are unintentional, they can generally be predicted, and, as recommended by the Catholic Health Association's publication, *With Justice for All? The Ethics of Healthcare Rationing*, they can be monitored and evaluated on a timely basis.[6]
- With reference to the third condition, the good effect (a more equitable distribution of a finite resource) is the direct consequence of a legitimate rationing policy. As a result, the harmful consequences do not constitute the means by which the desired goal is achieved.
- The last condition is also satisfied. Rationing will allow allocation of available resources to optimize the delivery of healthcare services. Negative outcomes will be substantially outweighed by the benefits accruing to the common good.

Beneficence Beneficence can be defined as acting with charity and kindness, but this definition is inadequate. Inherent in the term is an active promotion of actions to benefit others.

> Beneficence implies active promotion of actions to benefit others.

Also implicit in the concept is a duty both to provide benefits and to balance benefits and potential harms. One of the immense difficulties in developing an acceptable rationing system is determining the proper balance. Unless we can decide how to achieve maximum benefits within a clear set of formally accepted goals, true beneficence will be unachievable. Mere rhetoric and commitment to act are not sufficient to satisfy this principle.

Beneficence is usually cited as the main argument for shifting resources from the elderly to the young. Daniel Callahan, the best-known and -respected proponent of using an age-based rationing approach, questions both the benefits and costs of our society's relentless drive to extend the elderly's life expectancy.[7] He says this obsession with extending the number of years without enhancing quality of life compromises not only the elderly but the population as a

whole. Therefore Callahan proposes using age as a policy standard to limit some forms of government-subsidized medical care. He asserts age is a necessary and valid basis because there is no better or less-arbitrary criterion, medical need is too elastic to serve as an allocation principle, and age is a meaningful and universal category.

Anticipating strong criticism of this approach to rationing, Callahan notes, "There is nothing unfair about using age as a category if the purpose of doing so is to achieve equity between the generations, to give the aged their due in living out a life-span opportunity range, and to emphasize that the distinctive place and merits of old age are not nullified by aging and death."[8] Despite his attempt to defuse arguments against his proposal, opponents have not been dissuaded. Questions raised in *Ethical Implications of Age-based Rationing of Health Care*, a report issued by the American Medical Association's Council on Ethical and Judicial Affairs, were representative of the numerous concerns expressed by critics of Callahan's proposition. The report forcefully rejected the idea that the elderly constitute an unacceptable burden on the healthcare system and should be allowed to die without consuming inordinate resources.[9]

Justice Regardless of the merits or drawbacks of using age as a criterion for allocating healthcare resources, the debate itself focuses on the correct issue: how distribution decisions can be made more ethically both now and in the future. No other principle of bioethics is more relevant to a discussion of rationing than that of justice.

Three major theories of justice have been identified: *egalitarian theories*, which emphasize "equal access to the goods in life that every rational person desires (often invoking the material criterion of need as well as equality)"; *libertarian theories*, which stress "rights to social and economic liberty (invoking fair procedures and systems rather than substantive outcomes)"; and *utilitarian theories*, which emphasize "a mixture of criteria so that public utility is maximized."[10]

An egalitarian form of rationing would demand that both economic and noneconomic barriers to basic health services be eliminated. To the extent access to these services is defined as a right, rather than a privilege, egalitarians would insist that personal income, preexisting conditions, employment status, and other variables no longer influence availability of care to those in need.

> No bioethical principle is more relevant to rationing than justice.

In contrast, libertarians would view almost any form of rationing with deep reservations if there were significant restrictions on individual prerogatives. Personal freedom, economic efficiency, and an unfettered marketplace would be considered central elements of a libertarian approach to rationing. At a minimum, justice would require agreement among those whose resources were subject to redistribution to benefit the common good.

The utilitarian model has dominated the traditional decision-making process. However, although it advocates the greatest good for the greatest number, it does not guide the distribution of resources. Distribution not only should reflect fairness, it should also consider the legacy of previous inequities. Consequently, justice mandates a close examination of the "moral traces" remaining from past practices of discrimination.

Any dispassionate analysis of how resources have been allocated historically must conclude that such moral traces are ubiquitous. This assessment is consistent with P. Werhane's observation that "a form of economic egoism has corrupted the health care system, replacing the caring and professional models with that of competing self-interests, encouraging greed, confusing professional interests with profit, depersonalizing patient relationships, diluting benevolence and charity with a concern for economic viability, and thus excluding those who cannot afford health care from the system."[11] Unfortunately, until economic incentives are realigned for healthcare providers, distributive justice issues will not receive the attention they deserve.

A New Mind-set

H. Aaron and W. Schwartz believe that rationing of "beneficial services, even to the well-insured, offers the only prospect for sustained reduction in the growth of health care spending."[12] The possibility that the well-insured will have to submit to rationing represents one of the largest political obstacles to a just rationing policy.

This resistance could be greatest in confronting

Continued on page 83

RATIONING

Continued from page 61

resource allocation decisions near the end of life. To overcome such resistance, those advocating a formal healthcare rationing policy must define a basic package of benefits to which everyone is guaranteed access. They must also encourage a change in the mind-set of Americans who, perhaps more than any other nationality, have come to view death as optional.

Finally, advocates must convince participants in the rationing debate of the importance of applying ethical principles in determining how best to distribute healthcare services. Admittedly, the use of these principles does not ensure the process will be smooth. Nonetheless, unless the inequitable rationing that exists today is acknowledged and an explicit rationing policy is enacted, there is little hope that an acceptable resolution will be identified. □

NOTES

1. A. Enthoven and R. Kornick, "A Consumer-Choice Health Plan for the 90s," *New England Journal of Medicine*, January 5, 1989, pp. 29-37.
2. D. Callahan, "Rationing Medical Progress: The Way to Affordable Health Care," *New England Journal of Medicine*, June 21, 1990, pp.1,810-1,813.
3. C. Dougherty, "Ethical Problems in Healthcare Rationing," *Health Progress*, October 1991, pp. 32-39.
4. V. Fuchs, "The Health Sector's Share of the Gross National Product," *Science*, February 2, 1990, pp. 534-547.
5. T. Beauchamp and J. Childress, *Principles of Biomedical Ethics*, Oxford University Press, New York City, 1989, p. 128.
6. *With Justice for All? The Ethics of Healthcare Rationing*, Catholic Health Association, St. Louis, 1991.
7. D. Callahan, *Setting Limits*, Simon & Schuster, New York City, 1987.
8. Callahan, p. 140.
9. R. Patterson, *Ethical Implications of Age-based Rationing of Health Care: Report of the Council on Ethical and Judicial Affairs*, American Medical Association, Chicago, 1988.
10. Beauchamp and Childress, p. 265.
11. P. Werhane, "The Ethics of Health Care as a Business," *Business and Professional Ethics Journal*, Fall-Winter 1990, pp. 7-8.
12. H. Aaron and W. Schwartz, "Rationing Health Care: The Choice Before Us," *Science*, January 26, 1990, p. 418.

FORGING A FUTURE

Continued from page 64

over, in completing the strategic planning process, the nurse executives have come to better know and understand the system, as well as the concerns and issues of their colleagues. The group has come a long way toward moving beyond preferences to find areas of mutuality and improved information sharing.

CHALLENGE OF REFORM

Perhaps the most critical task for nurse executives in the coming years will be to meet the challenges posed by ongoing reform initiatives. Most of the institutions belonging to the Sisters of Providence Health System are located in states where healthcare reform legislation has already passed. In April 1993 the Washington State legislature enacted a comprehensive healthcare reform bill designed to ensure access to nearly 700,000 uninsured residents. Oregon has also received a waiver to expand its basic benefits package for persons eligible for Medicaid.

During their fall 1993 meeting, the nurse executives reaffirmed their resolve to better define nurses' role in creating integrated care delivery systems. Council members from each state within the system and from all nursing specialties remain committed to coming together to discuss ways to improve the efficiency of the care-giving process and enhance the health status of the communities they serve.

The nurse executives have made this commitment with the clear understanding that implementing *Strategic Directions for Nursing* will be a challenge. They know they must work with limited resources, not the least of which is time. They must also cope with the pace of change within the system and the healthcare industry in general, which will require them to regularly reassess and modify their assumptions and to clarify new issues that arise as a result of reform.

But despite the need to adapt and modify implementation strategies, the NEC's vision for the future remains clear. □

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