Healthcare Reform, Rationing, and Equity: a Societal Challenge

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Healthcare reform and rationing have become almost household words in many Western countries, including Israel. The public, health professionals, and political leaders are united in the belief that a serious problem exists in providing comprehensive healthcare to the entire population at an affordable and politically acceptable price.

It is important to preserve our sense of proportion. Most of the literature on healthcare rationing comes from countries representing a relatively small percentage of the world's population – basically, the wealthier countries. According to World Bank figures, the world's total health expenditure for 1990 was $1.7 trillion, or eight percent of the world's product.[1] High-income countries spent ninety percent of this amount, with the United States alone consuming forty-one percent of the global total. The average annual expenditure in high-income countries was $1,500 per person. Developing countries spent approximately ten percent of the global total, an annual average of $41 per person – four percent of their gross national product and one-thirtieth of the amount spent by the wealthy countries.

Let us not forget that healthcare inequities are mostly intranational. In the worst of the developed countries these do not even approach the magnitude of the catastrophic differences between the developed and the developing countries. These gaps are so great and so seemingly unbridgeable that we generally avoid the topic, but the point should be made, if only to pay lip service to our consciences.

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1. World Bank, *World Development Report 1993: Investing in Health: World Development Indicators* (New York).

The past decade has seen the virtual collapse of the Soviet-style socialist economies, with serious disruption of their poor but – at least superficially – relatively egalitarian health services. South Africa is undergoing a major crisis in its healthcare system, trying to raise the services provided to the long-neglected black majority to a minimal level without totally destroying the outstanding academic and scientific infrastructure that for generations served a largely white elite.

The World Bank, long regarded by many as a bastion of incorrigible conservatism and lacking adequate social consciousness, broke precedent by devoting its entire 1993 World Development Report to health.[2] It went on record stating loudly and clearly that spending on health is an investment. Indeed, the impressive three-hundred-plus-page report was entitled, as might be expected from a bank document, "Investing in Health."

This decade has been one of almost incessant struggle by different Western societies to cope with a seemingly inexorable rise in healthcare needs, demands, desires, and costs, almost invariably outstripping the available – or made available – resources. The coping methods used vary from country to country, as does the degree of success, and neighboring countries often try each others' failed methods. Clearly, the solution is still a Utopian dream.

One of the most important achievements of the decade is the serious attempt to devise more rational ways of decision-making. Many of the initial attempts are ultimately abandoned and may, in retrospect, seem pathetically simplistic, but terms such as rationing, efficiency, cost-benefit analysis, priority-setting, QUALYs (Quality Adjusted Life Years), DALYs (Disability Adjusted Life Years), and evidence-based medicine have become integral parts of the vocabulary of almost everyone involved in healthcare. Serious attempts at rational priority-setting have been made in a number of countries. Laudable steps have also been taken to arrive not only at medically and economically sound bases for healthcare planning and reform, but at healthcare systems that meet a civilized society's concept of equity and fairness.

For a variety of reasons, rationing and priority setting were not discussed very much when I was a medical student in the early

2. ibid.

1950s. One reason is that when you do not have any really effective treatments, there is little need to focus on how to distribute them.

There is a common misconception that rationing of healthcare services is the result of the economic and societal changes that are sweeping many countries and that it is a uniquely modern phenomenon. In 1984, Victor Fuchs, a leading health economist, described a statement that "the United States will soon have to begin rationing" as "sheer nonsense" because, he pointed out, rationing and priority-setting, both on micro and macro levels, have been with us since the dawn of time.[3] They are inevitable and ubiquitous phenomena, whether overt or undiagnosed.

When a primary-care physician spends only ten minutes with a patient, he is, in essence, rationing his time. When a hospital physician-in-training goes home leaving more work behind from which patients might benefit, she is rationing her time. When a nurse hastily dispenses a pill without listening and reacting to the patient's emotional needs, she is rationing her services. Professional economists and health planners did not usually find these kinds of rationing very interesting. It is similar to the difference in prestige between small claims court and the supreme court. When you open the deal with hundreds of millions of dollars, economists and healthcare planners are obviously attracted.

How one rations – or, more euphemistically, how one sets priorities – is of course the crucial question. Rationing decisions made on an ad hoc basis by the physician at the bedside are obviously far from ideal. Also undesirable, but very widely used, even if not articulated as such, is what Gerald Grumet called "healthcare rationing through inconvenience": by placing administrative barriers in the way of health-care services one can definitely reduce costs.[4] At a recent conference on rationing, David Eddy described the system in the United Kingdom as "arbitrary, inconsistent, unsuccessful and harmful," and the leaders at the conference sent a letter to the secretary of state for health, pointing out that "smart" rationing is definitely preferable to "dumb" rationing.[5]

The past decade has witnessed significant progress in that today, even the US – and even the traditionally reactionary

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3. V.R. Fuchs, "The 'Rationing' of Medical Care," *N Engl J Med* 311 (1984): 1572-73.
4. G. Grumet, "Health Care Rationing through Inconvenience," *N Engl J Med* 321 (1989): 607-11.
5. ibid.

American Medical Association – have finally acknowledged in word if not in deed that healthcare should be recognized as a basic human right in a wealthy and civilized country and that equity in healthcare distribution is an important value.[6] Unfortunately, a coalition of special interest groups in the US successfully blocked the enactment of programs that implement that right.

There are several points worth highlighting when examining the overall picture. First, I want to emphasize the "Inverse Care Law."[7] This law, which is probably as powerful as any law of thermodynamics, was first described by Julian Tudor-Hart. Tudor-Hart is an anachronism, a Marxist true believer in the best, idealistic sense of the term: he is a family physician who has devoted his professional life to caring for underprivileged and impoverished Welsh miners. Tudor-Hart stated that even in allegedly egalitarian societies, the best healthcare is generally given to those who need it least and the worst to those who need it most. Enormous gaps remain between the haves and the have-nots. While the existence of such gaps is an almost inevitable consequence of the human condition, awareness of this "law" and conscious efforts to redress these unfair situations can narrow these gaps. We have an ethical and societal obligation to strive continually to close them, and certainly at least to prevent them from expanding.

The second point is even more obvious. Probably the major contributing factor in ill health, even if we define illness in a purely biomedical sense, is poverty. This is neither the time nor the place to examine the pathophysiology of this relationship, but it is universal in all societies in which it has been examined. Morbidity and mortality among the poor is much greater than among the well-to-do. In Israel, for example, morbidity and mortality in Yeruham or among the Bedouin greatly exceeds the rate in Savyon. Even mortality among pets of the poor is higher than among those of the rich, as a recent article has shown.[8]

Of course, poor health, in turn, is a major contributing factor in poverty, and the poor sick are often trapped in a vicious cycle. The consequences of this relationship are most relevant to health policy

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6. Council on Ethical and Judicial Affairs, American Medical Association, "Ethical Issues in Health Care System Reform: The Provision of Adequate Health Care," *JAMA* 272 (1994): 1056-62.
7. J. Tudor-Hart, "The Inverse Care Law," *Lancet T* (1971): 405-12.
8. G.D. Smith, B. Bonnet, "Socioeconomic Differentials in the Mortality of Pets," *BMJ* 317 (1998): 1671-73.

issues. The poor have much less money to spend on health- care after the non-optional expenses – food, housing, clothing, and education – are paid for. Copayments of most kinds, which seem trivial to many decision-makers and are a very tempting "solution" to budget deficits, are therefore often real barriers between the poor and the healthcare they need. The institution of even quite progressive health insurance payments, in and of itself, still does not fully redress disadvantaged populations. These points must be hammered home to everyone involved in healthcare, at any level and in any role. Unfortunately, many policymakers unwittingly – or, more likely, deliberately – do not adequately address compensation for the health burdens of poverty. It is distressing that in Israel, even with its long tradition of concern for the underprivileged, regressive co-payments are increasingly being introduced.

Third, the potential benefits of competition and market forces as ways to increase efficiency are usually greatly exaggerated. More often than not, competition is likely to enrich particular interest groups and contributes less than might be expected to lowering the overall costs of healthcare.

In the 1960s, many experts told us that one of the reasons for the high cost of healthcare in the US was a shortage of physicians. If we just produce more doctors, they said, they would compete with each other and the cost of healthcare would plummet. This sounds incredibly naive today, but it was promulgated and widely accepted as public policy. Medical schools were subsidized to increase enrollment and the results are of course well known. I still remember reading what was for me an eye-opening article by the remarkable and prolific nonagenarian Eli Ginzberg, whose response characterized the then-popular economic view as "nonsense." He testified before US Congress that if you turn out more physicians they will order more tests, write more prescriptions, perform more procedures, and run up more bills, which will raise – and not lower – healthcare expenditures. He was right, of course, because the healthcare system is such that the required conditions for equilibrium by normal market forces do not prevail. In the presence of a surplus of physicians it is probably cheaper to pay their salaries while they sit idle at home than to set them loose to increase healthcare costs.

Much is said about the efficiency of the private sector over government bureaucracy, but the highest percentage of the total US

healthcare budget goes toward administrative costs, where profits and administrative costs skim off twenty-five percent. Just ask any American physician today about the myriad insurance companies, their bureaucracies, and their efficiency.

Dan Wikler, the former president of the International Association for Bioethics, delivered a talk at its 1993 meeting entitled "Privatization and Human Rights in Health Care: Notes from the American Experience." He described the impact of relatively untrammeled market forces in rather dramatic terms; "skim and dump" was one of his picturesque terms for the policies of many for-profit, and even so-called non-profit institutions that have to compete for economic survival. He described a closed meeting of hospital administrators who considered a variety of tactics to discourage the poor from using the institutions' emergency facilities. He also described the initial diagnostic procedure in American emergency rooms as a "wallet biopsy." Obviously, the US is at one end of the spectrum with respect to minimal regulation of profit-making and competition. There are certainly specific carefully regulated areas, too, in which competition and market forces can have a positive impact indeed and should be introduced and encouraged.[9]

If equity is to be given serious consideration, one must be ever alert to avoid the potentially pernicious effects of unregulated competition on fair distribution of healthcare.

There is an unfortunate "unholy trinity" in many countries between the healthy, the wealthy, and the finance ministers whose efforts to push payments from government to the private sector largely work against equity in healthcare.

A remarkably positive phenomenon in the past decade is the increasing trend of consulting with ethicists on creating programs that meet ethical as well as economic and health criteria. Such consultations have taken place in a number of Western countries, and in particular by the State of Oregon in its famous plan.

A remarkable book recently appeared, Benchmarks of Fairness for Healthcare Reforms, jointly authored by a philosopher, an eco-

9. H.J. Aaron, "Competition in the Financing and Delivery of Healthcare: Why, When and How?" in *Governments and Health Systems*, D. Chinitz and J. Cohen eds. (Chicustee, UK: John Wiley and Sons, 1998).

nomist, and a sociologist.[10] Although written with the specific intent of comparing the various health plan proposals that came before Congress, the concepts are applicable to other countries as well.

President Clinton, with the naive enthusiasm with which he began his first term in office, appointed the Task Force on National Health Reform, to which an advisory ethics working group was attached. They proposed fourteen ethical principles on which they felt the reform plan should be based. In their description of these principles, Brock and Daniels, two prominent philosopher-ethicists, pointed out that they were not pulled out of thin air or matched to a specific plan for healthcare reform. They stated that these principles "are deeply anchored in the moral traditions we share as a nation, reflecting our long-standing commitment to equality, justice, liberty, and community."[11]

The Fourteen Principles

1. Fundamental Importance

Healthcare is of fundamental moral importance because it protects our opportunities to pursue goals, reduces our pain and suffering, prevents premature loss of life, and gives us the information we need to plan our lives.

2. Universal Access

Everyone must have access to healthcare services without financial or other barriers. This point obviously represents a revolution in American thinking. Even in countries with reasonable national programs, there are often attempts by treasury officials to erode this principle by excessive out-of-pocket payments. Aliens and foreign workers are often excluded from this universality.

3. Comprehensive Benefits

The healthcare system should meet the full range of healthcare needs. Ideally, the program should cover primary, preventive, chronic, and long-term care, as well as acute, home, and hospital care and treatment for mental and physical illness. Obviously, not every possible service can be provided, but when there must be

10. N. Daniels, D.W. Light, R.L. Caplan, *Benchmarks of Fairness for Health Care Reform* (New York: Oxford University Press, 1996).
11. D. Brock, N. Daniels, "Ethical Foundation of the Clinton Administration's Proposed Health Care System," *JAMA* 271 (1994): 1189-96.

limitations, they should be placed on the least important benefits relative to their costs.

4. Equal Benefits

Healthcare services should only reflect differences in healthcare needs and not other individual or group differences. The drafters of the reform plan were emphatically opposed to a two-tier healthcare system and clearly indicated that whereas in other realms of societal endeavor two tiers might be acceptable, healthcare is too important to basic human functioning.

5. Fair Burdens

The costs and burdens of meeting healthcare needs should be spread across society by a progressive tax, with payments scaled according to ability to pay.

6. Generational Solidarity

The system should respond to needs at each stage of life, with benefits and burdens fairly shared across generations.

7. Wise Allocation

Society must wisely balance what it spends on health with other priorities such as education, housing, and defense. It will therefore have to set limits on the amount to be spent on healthcare, as well as prudently allocate resources within the healthcare budget itself. Unfortunately, in too many countries military expenditures often greatly exceed those on health.

8. Effective Treatment

Since funds will always be limited, it is a medical as well as ethical responsibility to spend only on services whose effectiveness has been proven (evidence based medicine) and to avoid spending on ineffective or doubtful services, whether diagnostic or therapeutic. This clause also mandates spending on research, particularly outcomes research.

9. Quality Care

This clause mandates creation of systems of quality assurance in all aspects of the system.

10. Efficient Management

The system should be simply organized and easy for patients and professionals to use and should minimize administrative costs. For a country such as the US, which spends such an enormous percentage of its healthcare resources on administration, this recommendation is of paramount ethical consideration.

11. Individual Choice

In the true spirit of American individualism, the authors of the reform plan proposed that the healthcare system permit maximum freedom of choice among providers, plans, and treatments. Other Western countries have traditionally placed lesser emphasis on such freedom of choice. In the US, managed care plans are increasingly restricting options, precipitating considerable displeasure among patients as well as among physicians.

12. Personal Responsibility

The healthcare system should help citizens take responsibility for protecting and promoting their own health and that of their families. This is meant to include the provision for education, counseling, and treatment to encourage healthy behavior patterns.

13. Professional Integrity

The system must respect the clinical judgment of health professionals and protect the professional-patient relationship while ensuring that the professionals fulfill their responsibilities to their patients.

14. Fair Procedures

To protect these principles and values, fair and open democratic procedures should exist for making decisions and resolving disputes.

These fourteen principles are to no small degree utopian, almost like the World Health Organization's definition of health or of human rights. One principle is often in conflict with another and fulfillment of the entire list clearly could "break the bank," but they provide a vision for goals toward which to strive. Without a vision we are doomed to retrogress.

When President Clinton presented his plan to Congress he listed only six principles: security, savings, simplicity, responsibility, choice, and quality. Perhaps he thought that fourteen was too many ethical principles for Congress to handle. Of course, even these six did not make it.

The British Secretary of State for Health defined seven principles for the National Health Service: fairness, efficiency, effectiveness, responsiveness, integration, and accountability. The Swedish government, characteristically practical and wise, simplified the list to three: human dignity, which means that we treat all humans equally; solidarity, which means that we have to pay particular attention to the needs of the weak and vulnerable; and efficiency, which means that in the absence of other overriding considerations we should spend our money in ways that give the greatest return for the money.

Interestingly, the Israeli National Health Insurance legislation also describes three principles – justice, mutual assistance, and equality – which are, in essence, very similar to the Swedish list aside from the omission of efficiency.

The principles are relatively easy to define and it is even easier to pay them lip service, but their practical actualization is much more difficult. Nevertheless, they must be our lodestar when we evaluate the effects of each proposed change or reform if we are to preserve our ethical equipoise in the face of the enormous economic pressures and those of special interest groups.

Several decades before the establishment of the State of Israel, its Jewish community created a healthcare system whose key principle, in keeping with classic Jewish tradition – even if expressed in the language of socialism – was mutual assistance. After the establishment of the State, even before the National Health Insurance Law went into effect, Israel's healthcare system was impressive, particularly considering the economic burdens it faced as a result of military pressures and immigrant absorption. The system was the envy of many countries, in spite of its problems.

The National Health Insurance Law was intended to improve the system even further. It was supposed to increase equity by providing for a comprehensive and uniform basket of minimum health services for all, enhancing patients' ability to move freely between sick funds (*kuppot holim*), and reducing the sick funds' ability to discriminate against the sick and elderly. The law gave

Israel a unique opportunity to improve and render more efficient an already quite outstanding healthcare system.

Unfortunately, today one hears an increasing number of voices calling for changes that may seriously damage the equity of the system. Healthcare is not the proper arena for the application of Milton Friedman's economic philosophy or Margaret Thatcher's form of government. The Israeli healthcare system has a structural, human, and ethical foundation that can be an example for the world.

While it is clear that access to healthcare services cannot eliminate the large inequalities in mortality, morbidity, and other healthcare outcomes, it is critical that the leaders in medicine and those who set the religious and ethical tone in society join forces to advocate on behalf of those who are relatively powerless – the poor, the aged, the disabled. Those who are aware of and sensitive to the health burdens that these unfortunate individuals bear in addition to the suffering caused by poverty and social deprivation must represent them in public forums, in the media, and in government circles. These unfortunate individuals are engaged in a battle for their lives against the "unholy trinity" of the healthy, the wealthy, and the finance ministry.

We have a holy obligation in Israel to create a society characterized by social justice as expressed by our prophets and sages. We have a mission to be an *or la-goyim*, a light unto the nations. I am convinced that in the field of healthcare this is indeed possible. The challenge is for all of us.

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