

5-1-1993

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Recommended Citation

Barnet, Robert J. (1993) "[Book Review of] *Rationing America's Medical Care: The Oregon Plan and Beyond*, Strosbert, Martin, et al editors," *The Linacre Quarterly*: Vol. 60: No. 2, Article 14.

Available at: <http://epublications.marquette.edu/lnq/vol60/iss2/14>

expectations that science can solve all and desperation when faced with devastating disease such as AIDS tend to nourish the acceptance of such activities.

— Robert J. Barnett M.D., M.A.

Rationing America's Medical Care: The Oregon Plan and Beyond

Strosbert, Martin, et al editors

The Brookings Institute, Washington, D.C. 1992, 229 pp. \$12.95 (Paper)

The Oregon Health Care Proposal has generated praise, criticism and controversy. The dialogue concerning it has served to move the discussion about American health care from emphasis on broad guidelines, platitudes and promises to specific pragmatic and ethical considerations.

This volume consists of the proceedings of a conference held at the Brookings Institute in May of 1992. It is comprised of a total of 18 papers of varying length by both proponents and critics of the Oregon proposal for health care. The authors include philosophers, economists, policy makers and physicians.

This is a valuable book that reviews the details of the current American health care crisis in a specific regional setting. The majority of the papers are excellent. Some are outstanding, especially the discussions of philosopher Robert Veatch, Director of the Kennedy Institute, Sara Rosenbaum, a lawyer from the Children's Health Division of The Children's Defense Fund and Robert Baker of the Department of Philosophy, Union College. The comments of John La Puma, physician and ethicist, from the Center of Clinical Ethics in Park Ridge, Illinois are both incisive and insightful.

There are some basic questions that can be posed about the Oregon proposal. Is it workable? Will it solve the problem? Is it fair? I will conclude that the Proceedings do not provide a convincing argument that the scheme is practicable, nor prove that the proposal will solve the problem, nor that it is just.

It would be helpful, first, to review the details of the Oregon proposal since they are often not fully understood. The intent of the Oregon plan is clear and laudable. The goal was to deal with the need for access to health care and for those in the State of Oregon who are currently uninsured and simultaneously address rising health care costs.

There are several components to the proposal:

1. It would extend **eligibility** for Medicaid to all persons who fall below the federal poverty income level (\$928 per month for a family of three in 1991). (Currently in Oregon the eligibility limit is **50%** of the federal level.)
2. A public process would define a basic health care package. After a series of community forums a list of 709 paired medical conditions were ranked by a publicly appointed Health Services Commission according to clinical effectiveness and social importance. Quality-of-life measurements were incorporated. A total of 587 were accepted. Those excluded were generally either self limited (viral sore throat) or instances in which treatment was either ineffective or futile (aggressive treatment for end stage cancer or AIDS).
3. It would mandate by 1995 universal employer health care coverage of all employees and dependents with a benefit package at least equal to that provided for the Medicaid group.
4. It would establish an insurance pool for the "uninsurable."
5. It would establish a "liability shield" to protect physicians when they do not provide services that were excluded from the "covered" list.

It is primarily the first two aspects that have evoked controversy. The proposal would add 120,000 people to the 231,000 currently on the Medicaid rolls. Although additional federal funding was requested the plan would basically reallocate the resources to a larger group on the basis of disease. There was opposition from anti-abortion groups, groups representing the disabled

and the Oregon Catholic Conference as well as from vice-president Al Gore.

There are several aspects of the process (#2 above) involved in the development of priorities that are of concern. Less than two thousand people participated in the local forums. Of these a majority had some connection with health care. After the priority list was submitted to the appointed Health Care Commission it was "massaged" on the basis of intuition with "quality of life" judgments being a major consideration.

Part of the defense of the Oregon plan has been to claim that it is only intended as a step towards a national program. This has not always been clearly articulated, perhaps out of political expediency, by the proponents of the plan. It would be helpful if the debate openly included that aspect.

As part of the implementation the physician must be both patient advocate and "consider" the needs of society. I see this as an untenable and dangerous situation. It is one thing for physicians to give input into policy decisions but it is another to make rationing choices at the bedside. It is true and appropriate that we make clinical decisions on the basis of burden and benefit for the **individual patient**. It is another thing to decide whether the available resources should be assigned to one patient rather than another.

As proposed, the plan would not require simply a waiver of current Medicaid rules, as some press reports have suggested, but would require additional funds (at least \$18 million) to implement the program. (It is not that it may not be appropriate to infuse more funds, but the necessity of doing so should be stated up front.) Yet, even the present Medicaid funding plus the \$18 million would not provide basic health care access to those below the poverty level, not to mention those above the poverty level who have inadequate funds to meet the ever rising health care costs.

Although there are favorable aspects from the physician's standpoint, such as improved reimbursement and greater emphasis on preventative medicine, there are obvious problems from a medical practice standpoint. It is unclear, even after the detailed discussion in the papers, how some diagnostic categories and practice situations would be handled. Mrs. Johnson comes in one day for treatment of her tuberculosis (approved). The next week she returns with a common cold or even a "nonfatal" viral pneumonia (not covered). (As far as I know the **treatment** of any **fatal** condition is an oxymoron. It is only when treatment has failed that we can know that the condition is lethal!) In addition, the influence of coexisting conditions, an important clinical concern, is not considered.

How "creative diagnostic labeling" and other methods of manipulating or "gaming the system" would be controlled is unclear. It is very easy to diagnose a "covered condition" rather than an "excluded" one. There is another pragmatic aspect. There appears to be no effective mechanism included that would control total provider fees or at least utilization. There is the intent to utilize "managed care" and prepaid health plans to maintain cost control. Unless these approaches involve non-profit, staff model HMOs, that outcome may not be realized.

Robert Veatch, although claiming that the "experiment" is not only worth trying but "morally imperative" presents first "three surmountable worries." Veatch argues that there is a need to ration and that we in fact do already, that attempting to quantify medical decisions is acceptable and that the argument of limiting the rationing of care to the poor can be circumvented if those in the debate "are morally engaged simultaneously in efforts to expand the application to a universal system of insurance."

His "worries" are paired with three more serious "concerns" or conditions. First he wants assurance that **cost effective** basic care is not equated with what is of higher moral priority. On the specifics of this point he is obscure but the consideration about cost setting priorities is well taken. His second concern speaks to the use of a simple utilitarian or net benefit calculus in determining whether the plan is just. Since this is integral to the proposal I do not see how this objection can be defeated. His third concern is about "the inability to differentiate within condition-treatment pairs." By this he means that one individual may benefit much more from a specific treatment than another and the value may vary considerably. This underlines my concern about the emphasis on **what** is delivered rather than by **whom** and to **whom**. Although Veatch argues for the plan his strong ethical caveats would seem to require an alternative solution.

The final essay by Robert Baker drives to the most central issue and supports the Oregon proposal because it recognizes openly and unequivocally that there are limits to the health care that can be provided by any modern society. Baker lauds the Oregon plan because it involves "open, visible, explicit, direct rationing." Baker draws on the experiences of the British National Health Service and

its failures. What Baker does not adequately develop is the fact that Britain spends, in terms of GNP, only about half of what we currently spend in the United States. A comparison with the Canadian system, in which about 2/3 of what the United States is spent and universal coverage is provided, would be more appropriate.

The Oregon proposal according to Baker will provide "basic health insurance coverage for everyone below the poverty level." What it would in fact do is to provide treatment for a limited number of **conditions or diagnostic categories** for those eligible. The program would increase dramatically the number of those who would be **entitled** to care. This move would effectively exclude from care a large number of those currently covered. Those excluded would primarily be the poor, children and elderly. Unfortunately, the proposal is "cost driven" and deals only with a small segment of health care.

Catholic Social Teachings argue strongly for a "preferential option for the poor." Does this plan make the worst off better? What it seems to do is to primarily redistribute the available resources plus a little more. It takes from some of the poorest and gives to some, not all, of the not quite so poor. Some have argued that the proposal is more communitarian. However, it is primarily the poor, those least able, who are asked to abandon their individual gain for the common good.

There is an alternative approach that would appear to be worth considering. There is a presumption that primary care is most important. The excessive number of specialists encourages the use of high tech, more esoteric, care and diagnostic studies. From a practical standpoint it would be most appropriate, as a first step, to fund services provided by certain specified health care deliverers including those in family practice, pediatrics and nurse practitioners. I am suggesting that it is **who** delivers the care, not **what** is delivered that would be the most appropriate focus for rationing decisions. This would encourage a much needed shift to primary care. This would have to be part of a larger reform that addresses the issues other than costs. Among those issues are rampant entrepreneurship, overemphasis on technology and specialization, high administrative costs, the high cost of medical education, and the need for portability of insurance. Such reform can only be accomplished at the national level.

This volume is valuable, not only for discussing the merits of the Oregon plan from rather disparate perspectives, but for laying out some of the basic issues. What is perhaps most important is that careful reading of the statements of the thoughtful and concerned participants in this symposium lead to the conclusion that the Oregon Proposal may only delay the implementation of what is really needed (and what is acknowledged as the goal of the Oregon proponents): a comprehensive, coherent **national** health policy that ensures meaningful access to basic health care for everyone in the United States.

— Robert J. Barnett M.D., M.A.
