

November 1986

## Moral Considerations in Rationing Health Care

Robert J. Barnet

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

---

### Recommended Citation

Barnet, Robert J. (1986) "Moral Considerations in Rationing Health Care," *The Linacre Quarterly*: Vol. 53 : No. 4 , Article 10.  
Available at: <http://epublications.marquette.edu/lnq/vol53/iss4/10>

# Moral Considerations in Rationing Health Care

Robert J. Barnet, M.D.

*Doctor Barnet, a Reno, Nevada physician, gave this talk in February, 1986 at a conference at Notre Dame University.*

Must we ration health care?

If we ration health care, how will we do it?

Will some be deprived of health or life if we ration?

Are there alternatives to rationing?

I will not give final answers to these questions, but rather will present a perspective for dealing with a moral dilemma which I see as remaining paramount over at least the next five to ten years. The answers to these questions will significantly affect, on a day to day basis, the entire health care profession, all those seeking medical care, and the entire social and economic structure of our country.

The answers to the questions posed involve fundamental concerns that go beyond the questions themselves and will vary depending upon:

First, how we evaluate our resources and needs; second, the understanding that individual physicians and health care professionals have their own moral responsibilities; third, society's understanding of its obligations under the concept of justice, and fourth, our understanding of the nature and meaning of life.

The title of this article presumes that there may be limits and that it may be necessary to ration health care. By implication then, we must consider the possibility that certain medical interventions, such as organ transplantation, including organs such as artificial hearts, may not be available to everyone. This recognition of "limits" arises from the perception that either financial resources are not available or that resources such as transplant organs, either natural or artificial, may be in limited supply. However, these limits may apply not just to the unusual and esoteric but to much of what we consider standard medical care.

There are some that would argue that the very topic is one that is inappropriate to discuss. They would argue that, whether it is organ transplantation, food supply or energy, our society has the capability of unlimited expansion both in terms of resources and in technical expertise. They would argue further that, rather than discussing limits and allocations even as a stopgap, we should be directing our efforts at solving

the resource and technical problems and should not be wasting our time lamenting a "gloom and doom" philosophy.

Arthur Caplan<sup>1</sup> of the Hastings Center has pointed out some of the hard economic facts of the cost of medicine today. Our average expenditure per individual person in the United States is \$1,500 per year. In terms of gross national product, while England spends 6% and the rest of Europe and Japan spend between 7% and 10%, we spend somewhere between 11% and 12% on health care. Our total cost for neonatology is in the range of 2 billion dollars a year. We spend in excess of 2.3 billion dollars for renal dialysis for some 72,000 patients. The current expenditure for coronary bypass surgery is estimated to be between 1.5 and 2 billion dollars per year. If we implant 30,000 artificial hearts, a number which has been projected, we can anticipate a cost of 4 to 6 billion dollars a year. Heart transplants at Stanford University run approximately \$150,000 per patient. It has been estimated that kidney transplants cost in the range of \$35,000 for initial transplant and medical costs on an annual basis of \$5,000 to \$15,000 per year. Caplan does agree that we currently limit access by financial ability and methods such as the D.R.G.'s<sup>2</sup>. Yet he argues that there is no case for rationing at the present time considering our total national resources. His position is that we have a moral obligation to provide those procedures which are shown to be efficacious and desired by competent patients as long as they do not adversely distort existing services. Caplan's main emphasis is directed at neither rationing nor allocating, but at examining efficacy and eliminating inappropriate and unproven interventions.

### A Challenge by Fuchs

In contrast, the economist Victor R. Fuchs<sup>3</sup>, from Stanford University, in the *New England Journal of Medicine*, December 13, 1984, challenges the appropriateness of even the discussion about rationing medical care stating,

Although we hear this warning with increasing frequency, taken literally, the statement is sheer nonsense. It is nonsense because the United States has always rationed medical care, just as every nation always has and always will ration care. No nation is wealthy enough to supply all the care that is technically feasible and desirable; no nation can provide 'presidential medicine' for all of its citizens. Moreover medical care is hardly unique in this respect. The United States 'rations' automobiles, houses, restaurant meals - all the goods and services that make up our standard of living.

There are some similarities between Caplan's position and Fuchs's, but there is also a fundamental difference. Fuchs's position is that health care is in limited supply, has been in the past and has, in effect, been rationed. Caplan's position is that although there is waste, inefficiency and

\* D.R.G. - Diagnostic Related Groups: A system in which a hospital is reimbursed at a set fee for a particular illness. This differs from the traditional method of cost reimbursement.

inappropriate use of resources, at least in terms of financial expenditure, there is not a shortage. Caplan's solution is that we provide what is appropriate and that we need not and should not ration. There is a fundamental difference between these two positions. Who is correct, Caplan or Fuchs?

Let me for a moment turn to energy. When we look at what happened in the panic following 1973 over limited energy resources and review where we are today, it is apparent that we continue to function as a society without discernible recognition of significant limits. In health care, as with energy, the prevalence of such an attitude is understandable. No real lines have been drawn.

It is important that we critically examine the premise that we can continue to expand and deplete our resources at current rates. Although it may not be possible to precisely define what they are, there are clearly limits, both in health care resources and in energy. If we examine atomic energy and consider the thermal reactors which are our major source of atomic energy in this country, we should realize that there is only enough uranium worldwide to last 30 years. Even the most optimistic estimates for the fast breeder reactors guarantee an energy supply at our current level of usage of little more than 300 years, even if major technical and environmental problems can be resolved. Our renewable energy reserves including solar, wind and tidal are without question finite and can meet only a limited portion of our current level of usage. We have not arrived at suitable answers to our energy policy questions even in terms of our own Western society, and yet it has been estimated that if the Third World or "under-developed" countries were brought up to the energy expenditures which the United Nations has deemed appropriate, the total reserves of energy supply in the world today would be enough to last the entire world less than two weeks. In health care, as in energy, we cannot approach the problem of resources isolated from the remainder of the world. Nor is it moral to consider the question of organ transplantation or other comparable medical interventions in a way which does not consider that every member of society has the right of equal access to a reasonable level of health care. If we accept that right and recognize the reality of limits, we have a dilemma.

### **Out-of-Reach Pricing**

While we are spending billions for renal dialysis and bypass surgery, we are, at the same time, pricing out of reach reasonable access to hospitalization for a significant segment of our population. Many retired individuals are no longer able to afford the Medicare hospital deductible which increased to \$492 the first of January, 1986. This amount alone exceeds the average \$478 monthly pension check of social security recipients. This does not include the deductible and 20% co-insurance paid to physicians nor the cost of medication which often runs \$50 to \$100 a month. At the same time that these financial constraints limit access for

transplantation for a select and limited number of individuals. We hear presidential pleas for organ donors, and a recently enacted New York law anticipates special treatment for a small number of individuals by requiring hospitals to request organ donations or be fined. Similar laws have been enacted in other states including Oregon and California and are being considered elsewhere. These events presume that organ harvest and transplant as practiced today are morally acceptable, economically feasible, and should be expanded. Other contradictions in public policy exist in our continuation of special favorable financial treatment for the tobacco industry at the same time that we issue warnings on the use of cigarettes. An example of the double-thinking taking place is a concern voiced in England this past summer over a new seat belt law which would add, as a requirement, seat belts in the *back seat* as well as in the front. The concern about extending this life-saving measure was described as arising from "the gruesome results" of front seat belt legislation which has resulted in an unacceptable decrease in organs available for transplant. Strange irony.

Current public policies and the priorities implicit in their implementation require that we deal more and more with the hard decisions and the dilemmas involving the allocation of limited resources. Decisions on the continuation or discontinuation of treatment are being made increasingly on pragmatic grounds. For pragmatic read "cost benefit" if you wish; and this benefit typically refers to "society's benefit". I am uncomfortable with the decision in which "quality of life" or "meaning of life" is the determinate for public policy. "Quality of life" necessarily involves a great deal of subjectivity, and because of the subjectivity, is a very dangerous way to approach medical decision-making.

If we look at the subject of organ transplantation from the perspective of potential donors, our unmet needs, and the possible need for rationing, it is apparent that there is a wide gap between the "20,000 potential donors" and the 2,500 who actually received organs in 1982. A proclaimed goal of medicine is to narrow that gap. In discussing this dilemma and the "psychological and ethical implications of organ retrieval", a group from Case Western Reserve in Cleveland, in the Aug. 1, 1985 issue of the *New England Journal of Medicine*,<sup>3</sup> made a statement which should cause us again to examine carefully our ready acceptance of current policy on organ procurement. The authors stated: "Thus although cadaver organ donors are declared dead, they hardly resemble patients who have died from cardiopulmonary arrest. In fact, they remind us in many ways of living patients."

The morality of organ retrieval is an issue which cannot be separated from the question of rationing of health care. If we approach the question of resources in health care with the idea that we will produce whatever products are necessary to meet the seemingly insatiable societal and professional demand for all medical care, there is a danger that we deny both a limit on resources and man's mortality - a danger that we will deny that man is more than a physical body with parts to be repaired or

replaced. There is a danger when we define our terms - whether life, death, or health - to accomplish the end of what is best for society, not what is right. That there is a limit on resources, that there are some absolutes and that man is mortal and has a special nature are the real reality.

### Recognition of Realities

Society must recognize these realities and deal then with the question of a reasonable level of allocation of financial and other resources to health care. This must be done in the context of both what is moral and what man is. It *ideally* could best be done by informed and responsible individual choice and by neither state engineered acts nor professional edict. That choice seems not possible today. It should still involve professional input, but increasing governmental implementation may be necessary and inevitable. Society and the profession, however, must not *adjudicate* their roles.

It is appropriate to first ask what is a reasonable amount and not confuse it with the question about what the amount is which we are willing to spend. Our efforts to determine a reasonable amount may require a reorientation of our individual, professional and societal priorities. An individual has the right to make a decision on personal health care expenditure on the basis of his own personal resources and priorities. We must, however, consider such expenditures on a societal basis in the context of how it will effect other individuals, and ask the question whether it will deprive other members of society access to even reasonable health care. There can be no question but that we have an obligation to provide for the common good and that includes medical care. Pope John XXIII in *Pacem in Terris*<sup>4</sup> discussing the rights of man declares that "Every man has the right to life, to bodily integrity, and the means which are suitable for the development of life; ... primarily food, clothing, shelter, rest, medical care and finally the necessary social services." The American Catholic Bishops, in their pastoral letter *Health and Health Care*<sup>5</sup>, have reaffirmed that right in the words: "... access to that health care which is necessary and suitable for the proper development of life ... for all people."

We should also look within the profession concerning the allocation of our efforts and resources to individual procedures. As a cardiologist, I can only deplore the continued over-utilization of expensive, invasive and noninvasive cardiological studies, including bypass surgery and, more recently, angioplasty. Physicians' decisions are a major, but not the only, determinant of health care costs. Patient expectations, medical legal concerns, media manipulation and non-physician entrepreneurship strongly influence these decisions. It needs to be emphasized that a major problem in the past 20 years is that the majority of input on policy was made by the physicians and other members of the scientific community, influenced by their own typically altruistic concerns as they approached the challenge as dedicated scientists. The role of personal financial gain and self-serving vested interests cannot, unfortunately, be excluded

completely from the decision-making process. It is now becoming an even more frightening situation in that, although there has been at least some lip service for a broader input, and some blunting of the major impact of the profession and scientific community, much of this change has been brought about by the increasing influence of investor-owned, entrepreneur-oriented forces.

Decision-making for the individual health care professional dealing with the individual patient, and decision-making for society in the context of allocation of resources, necessarily involve two separate and distinct perspectives. The first level of decision-making involves individual physicians and their patients. It is the physician's role, when dealing with an individual patient, to do what is best for that patient. The individual patient and his course of therapy should be considered on the basis of his or her medical status and the resources available. Our role as individual moral health care professionals should be to emphasize, in the context of our best scientific judgment, what is the best choice of treatment available for that patient. At times, that may include the patient choosing, at other times, not choosing to accept such things as a heart surgery, renal dialysis, ventilator support, or even hospitalization. Because something *can* be done does not mean it *must* be done.

### **Decision-Making and Possible Conflict**

The second level of decision-making is a societal one. It is different, distinct and may involve conflict with the physician's decision. Here we do not deal with the choices of medical options available for an individual patient, but rather with the question of distributive justice and the allocation of resources. Society has an obligation to do everything possible to provide an appropriate level of food, housing, education, transportation and health care to all members of society. The free market has not and will not guarantee this. Some type of societal involvement is necessary. Resources should be allocated on the basis of what is available after a review of all the social and economic needs of all members of society. This inherently involves a reality, and that reality is a recognition that limits exist. Our decisions on allocation should be based upon a free and open discussion in which the decision is made not by vested interests, not by government, not by the profession, not by the profit motivated, but by all of society.

There is a tendency in a scientific community to take a position that increasing material and technical advances must be made and should be available to all. Although some argue that there should be a "voucher system" in which one might choose (particularly if one had the expertise to accumulate more than average wealth) to spend those available resources in whatever manner one wished. I will not argue the individual's right to choose those options, but it should be clear that the very fact that society provides those options may divert resources from other needs which are not being met. For this reason, it is very difficult to justify a society in

which extremely expensive and unusual medical procedures of unproven clinical efficacy continue to be funded in the name of scientific progress and improved quality of life, while a major segment of our society, not to mention the rest of the world, lacks even basic needs. There is no valid argument, for example, on the basis of either discernable scientific progress or improved quality of life which morally justifies the current artificial heart program. That we do this at the same time we reduce prenatal care, limit access of significant numbers to adequate health care, food and shelter, is morally unacceptable.

I would now like to shift from the subject of whether there are limits and the question of how we should allocate or ration. I would like to return to our fourth question and ask again if there is any alternative to rationing. I would like to examine two important and related issues - the meaning of life and a recognition of man's morality.

There is a Mexican word, "comida" which is normally translated as "food". I know of no other language in which a word has the meaning that "comida" does to the Mexican peasants. The German "mahlzeit" touches on the concept as does the Hawaiian word "nohona", but both in different ways and both are incomplete when compared to "comida". "Mahlzeit" alludes to the conviviality of mealtime as reflected in the sign on the wall of the kitchen of my home: "Sit long, talk much"; "nohona" refers to the meaning of life", Comida says both, but more.

### **Meaning of Comida**

"Comida" is a vernacular expression which refers to all the activities and interactions of individuals among themselves, with their environment and all that allows them to generate, obtain and assimilate the material elements that they need to in their daily life. It includes the land, the conversation, the growing, the harvest, the breaking of bread at home and in liturgy, the sense of community, and in the medieval sense, the idea of commons. "Comida" means nourishment for all aspects of man's life - physical, social and spiritual. I do not mean by my call for the recognition and realization of the value of the concept of "comida" that it is something which we should only internalize. What is needed is for the profession and society to begin a dialogue dealing with the integration of both the concept of limits and "comida" into our professional and social structures.

In dealing with the question of resources and rationing, it is important to recognize that it is easy for us as members of a scientific community to impose our values on the rest of society as well as the world, and to operate as if our goals are common to all society. This may create both a false reality and an injustice. If the continued exhaustion of our resources is not an injustice for our contemporaries, it will certainly create an injustice for our children and grandchildren. Whether in health care or in energy, to operate on the basis of unlimited resources first of all may alienate us from the opportunity to experience "comida" and deprive future generations of the

opportunity to know it. If there are limits, then a society in which the concept of "comida" is central is an alternative, perhaps the only viable one. The values of a scientific community and the health care profession may not be the values which most people would choose for themselves. Have we structured our society so that people often choose what we wish? We have approached this question of allocation with the premise that it is possible that adequate resources are available and that technology can solve all problems. We have not questioned whether the premise of the current system is appropriate, or on balance, even beneficial. It is not an acceptable tenet that technology can solve all problems, nor is it acceptable that available resources are unlimited, or that current resources could be adequately re-allocated. What is most called for is the challenge of re-thinking and re-defining the role of health care. What is happening with increasing frequency is not greater freedom and greater access to health care, but less freedom, less opportunity for responsibility, less access and more entrapment of both the profession and society. More and more, every day life is medicalized and commercialized by such movements as alternatives and holistic health. We have fragmented our lives and replaced a sense of power of self with power of those all-pervasive external forces. We have replaced wisdom with technology, social ties and obligations with fees, and meaningful friendships with professional control. We have been made "health consumers" and haven't awakened to the fact that health (a modern construct) is not something which can be consumed. "Comida" and the value of life have been replaced by entrapment, institutionalization and, in particular, in the Christian context, a slavery wherein the freedom which comes when we recognize our mortality has been taken from us. Our society has made it both rationally and morally acceptable to desire not only endless accumulation of commodities, but a life span without end.

### Enumeration of Choices

What choices do we have?

1) We can continue the illusion that there are no limits either to our resources nor to our technical expertise and that we can provide any desirable medical benefit which each individual patient or each individual physician expects or requires. Into this formula we can also plug a continuation of our expanding entrepreneur-for-profit philosophy and include profit for everyone.

2) We can agree to ration and design a system which will choose *who* will be the recipient. We might make this choice on youth having a greater right or we might argue for those who would contribute the most to society. We might argue that our greatest efforts should be directed at those with the most serious disease because we have a higher obligation to save life rather than to relieve distress or prevent illness. Whatever rationing system we choose must necessarily involve subjective judgments and priorities or random choice.

3) We can recognize limits and begin to deal with priorities and allocation by a) allocating our health care resources with priorities for select *illnesses* or special procedures and methods of treatment, and b) re-examining the priorities of our *total society expenditure* and drawing up an allocation system which will recognize some type of priority among the various governmental and private programs.

Unless there is a significant decrease in health care costs in either of these methods of allocation, health care would continue to be assigned no more than its current level of funding or there would be a requirement that we diminish allocation to such things as defense, space and/or social programs. With either decision on allocation, it is probable that rationing as Fuchs suggests would still continue.

If we continue a system of rationing, it should be one which recognizes justice, autonomy, and beneficence. It should 1) allow equal access; 2) assure patient autonomy; and 3) allow the health care professional to function in a beneficent manner.

The current DRG system shifts the question from the traditional Hippocratic subjective assessment of the patient's good to what is an imposed external and allegedly objective assessment of the patient's good. Such a decision has its origins in the greater good (utility) of society. But the system is inherently adversarial, rations through limited access, and thwarts both patient and physician autonomy. Access is not limited but is not equal. "Profit centers" increasingly determine availability. How well the hospital and physician "play the game" manipulates access. They are the origin of the individual physicians' and patients' potential dissatisfaction and the moral dilemma under DRGs. It arises from the reality that control of access involves not only limitations but also inequity, and recognition that our resources do not meet the expectations of our society.

It is essential that the integrity of the traditional covenant between patient and physician be preserved. The relationship of the physician to his individual patient is one in which the physician is obliged to make his decision independent of external forces and to provide the best possible care for each patient within the limits of good clinical judgment. It is a challenge, but necessary for the socially conscious physician to suspend his judgment on social policies as he deals with individual patients. Central to the physician's approach must be a concentration on a patient who is fully informed of the risks and benefits involved in the decision and a requirement that a paternalistic attitude based on the physician's own sense of values is not substituted (because of the powerful relationship that the physician has) for the values and priorities of the patient. This combination of adequate allocation with rationing which equal access, patient autonomy and retention of beneficent professional actions is most desirable, but may not be possible.

4) The fourth alternative involves a re-thinking and re-definition of health, illness, and even death, and the role of the health professions in

each of these. The fourth alternative recognizes limits and is a concept which should be integrated into a discussion of our policies on priorities and allocation.

### Central American History

The Aztecs in Central America lived in a stoneage neolithic culture until the time of the coming of Cortez. When the Spanish first arrived, a Franciscan monk went to members of the Aztec community and collected from various individuals versions of some of their most important pleadings, prayers and sayings. For the Aztec, God was someone in Whom all found consciousness. That is what His name means. It also means "in whose juice all of us grow". Related to their recognition of the importance of nature and God is the fact that one-third of Aztec words have as their root, words which are flowers. This life-giving relationship between the Aztecs and their God and a recognition of the need for nourishment and the life cycle of flowers is central to the understanding of this primitive but perhaps once universal attitude about life. This Aztec poem is directed at their God and says:

Oh only so short a while, you have loaned us to each other.  
Because we take form in your act of drawing us, and we take life in your painting us.  
And we breathe in your singing us, but only for a short while you have loaned us to each other.  
Because, even a drawing cut into crystalline obsidian fades  
And even the green feathers, the crown feathers, of the beautiful Quetzal bird,  
lose their color.  
And even the sounds of the waterfall die out in the dry season.  
So we too,  
Because for only a short while, you have loaned us to each other.

The fourth alternative involves a return to man's traditional ability to recognize his mortality and abandon his obsession for health as a goal in itself and as a substitute for happiness. It rejects technology as our god; it involves recognizing limits and re-ordering priorities in which "comida" rather than *commodity*, in which *Homo sapiens* rather than *Homo economicus*, would be the focus. The choice is ours as a people, as a society. It is our duty as a profession and society to begin a dialogue.

### REFERENCES

1. Caplan, Arthur, Remarks at Oxford University, July, 1985.
2. Fuchs, Victor R. "The Rationing of Medical Care", *New England Journal of Medicine*, Vol. 311, No. 21, Dec. 13, 1984; p. 15, 72-73.
3. Youngner, Stuart J., et. al, "Psychosocial and Ethical Implications of Organ Retrieval". *New England Journal of Medicine*, Vol. 313, No. 5, Aug. 1, 1985; p. 321-323.
4. John XXIII, Pope, *Pacem in Terris*. Part I (II). American Press. New York, 1963.
5. American Catholic Bishops, "Health and Health Care", Pastoral Letter, November, 1981.