

**THE ETHICS OF ACCESS TO HEALTH CARE: WHO WILL GET
CARED FOR, HOW WELL, AND AT WHOSE EXPENSE?**

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An apparent paradox pervades the American health-care system. On the whole, health in this country is more robust than it has ever been before. We have conquered many of the most dangerous infectious diseases, such as tuberculosis, diphtheria, smallpox, cholera, typhus, and polio, and have made powerful progress against many others. We have mastered scurvy, pellagra, iron deficiency anemia, and other nutritional diseases. We have brought a great many diseases, such as diabetes, under control, even though we haven't eliminated them. We have learned how to compensate for a wide variety of sensory and other deficiencies. We have reduced our exposure to mercury, lead, arsenic, chromium, and other heavy-metal poisons, and to asbestos, halocarbon solvents, and many other chemicals. We have substantially reduced our exposure to ionizing radiation. Since the turn of the century infant mortality has decreased remarkably, and life expectancy has increased just as remarkably. More people are living longer, healthier, more vigorous lives. Yet, there is tremendous disquiet over health care. There is a sense that many people can't afford or are being denied care, that a lot of the medical treatment being provided doesn't work, that costs have become exorbitant, and that marginal changes are becoming ever more painful.

Part of the problem is that even as we have conquered the classic threats, we have continued to expand our aspirations for health and wellbeing. Our definition of "health" has become liberalized to include mental, sexual, cosmetic, and other

problems that until recently were not the province of doctors. Many of the most central aspects of life -- the events of birthing and dying, certifications of sanity and fitness -- have become "medicalized." We have been broadening our apprehensions to include more chronic low-level toxic hazards, radiation, and stress, and such lifestyle vices as addictions to tobacco, alcohol, barbiturates, narcotics, caffeine, and rich foods. To our struggle against cancer and other traditional illnesses we have added concern about genetic, reproductive, developmental, immunological, behavioral, and other debilitations. We devotedly intend to help all infants get a vigorous start in life. And we strive to afford first-rate health protection to all citizens, and even noncitizens, throughout their lives. No civilization ever before has had these ambitions.

As is only too obvious to this audience, the financial price of these ambitions is enormous. Medical expenses continue to increase both as a proportion of individuals' budgets and as a proportion of the gross national product. This year we Americans are spending 11% of our GNP on health -- or about \$1,000,000,000 a day. Of the total health-care cost, about 40% goes to hospital charges. A large portion of hospital billings is accounted for by a small group of patients (in a well-known study by Zook and Moore, "on average, the high-cost 13% of patients consumed as many resources as the low-cost 87%") (Zook and Moore, 1980). Billpayers are concerned over doctors' pricy routine habits such

as elaborate laboratory testing and "physician-defensive" use of x-rays. Billpayers are concerned over such big-ticket items as organ transplants, artificial organs, and expensive diagnostic and therapeutic machinery. And billpayers are concerned about the draining expenses of chronic care, especially that involving hospitalization. Who pays? Of the American health-care dollar, private insurers pay about 29¢, the federal government 29¢, state and local governments 13¢, and consumers directly 29¢.

Altogether, third-party payers -- private insurance firms, government, charities, and industry -- finance 73% of the national bill (Gibson et al., 1984). Far from everyone is covered by insurance: at any given moment right now, about 25 million citizens completely lack health insurance. Because for most people insurance is coupled to employment, the job cutbacks of recent years have forced many previously insured people out of insurance pools (Rivlin, 1983). Our medical financing system has become an awkward hybrid of flawed private-sector and flawed public-sector programs, and the economic incentives operating on the medical industry are widely acknowledged to be perverse.

Although there is disagreement over whether health guarantees should be considered a birthright, virtually everyone agrees that health assurance is a strongly desirable goal for a generous, mutually supportive society. Health is held to be a very special, precious aspect of life. For present purposes I take it as given that society desires universal access to high quality health

care. In 1983 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research expressed what is probably the prevailing view. The Commission concluded, *inter alia*, that "society has an ethical obligation to ensure equitable access to health care for all"; that "the societal obligation is balanced by individual obligations"; that "equitable access to health care requires that all citizens be able to secure an adequate level of care without excessive burdens"; and that "the ultimate responsibility for ensuring that society's obligation is met, through a combination of public and private sector arrangements, rests with the Federal government" (U.S. President's Commission, 1983).

As to those cost burdens, in "the American way" we want to have it both ways. A review of fifteen national public opinion polls conducted between 1981 and 1984 concluded that "more than ever before, Americans want the problem of rising health-care costs addressed. However, they are unwilling to support the adoption of any solution that would produce a dramatic change in their own medical-care arrangements." But they are not ungenerous: "Even with 76% of the public seeing our escalating federal deficit as a threat to the economy, two out of three Americans still believe that federal spending for health care should be increased, and 59% favor some form of national health insurance, even if coupled with a tax increase to pay for it" (Blendon and Altman, 1984).

The problematic notion of equality. Much confusion is engendered by glib use of the revered notion, "equality." Equal according to need is not the same as equal according to desire, and neither is the same as equal according to merit.

"Need" itself is elusive. Medical requisites are a spectrum from core survival needs, through optional needs, to discretionary wants. Because even minimum needs differ among persons, to provide care equal according to need is to expend very different amounts of resources on different people. And which need is meant: equivalent service consumption ("three obstetrician consultations during pregnancy"), or equivalent health-status achievement goals ("optimal blood pressure for everyone")?

Nor is "desire" necessarily clear, even though it is reflected in the way people express their wants and spend their money. Desires range in seriousness from those backed by cash-on-the-counter to those that are merely unattainable wishes. Essentiality of the service and depletability of the medical resource may be relevant. There is nothing inequitable about the well-to-do's using health services -- unless it reduces other people's opportunities: competition for access to a facelift artist is one thing, but competition for the next available liver for transplantation is quite another.

Only recently has "merit" become an important consideration,

as the issue of self-responsibility for health has become prominent. Increasingly there is argument that illnesses caused or exacerbated by violation of "clean living" precepts do not deserved to be cared for at society's expense to the extent that other illnesses do. Courts and insurers now are beginning to take account of this factor. We are approaching the end of the no-fault health insurance era.

Thus, to call for "equality" or "equitable" treatment is merely to begin the discussion.

Three ethical strains. Overall, the combination of heightened medical capabilities with heightened societal aspirations -- in a time of financial stringency and acute public sensitivity to these issues -- is placing us in deeply tragic confrontations (Lowrance, 1985, pp.16-22). Three broad ethical challenges dominate the agenda: (1) ensuring basic medical access for the poor and near-poor; (2) coping with extraordinarily expensive marginal demands; and (3) generally protecting the environment and resources of the health commons. Let's survey them in turn.

Ensuring basic access. Access to medical care has two components: the existence of various care services, and the ability (financial and other) of clients to avail themselves of those services. Though they are imprecise, the aggregate

statistics on health status and access are not much disputed. Space doesn't allow reviewing them here. Quite simply: By most criteria the poor are less healthy than the nonpoor. Also there are racial, occupational, and other differentials. Poorer people's babies tend to be born underweight and to suffer higher mortality. The poor have less access to perinatal care, vaccination, and dental care. Blacks, especially black males, tend to have higher prevalence of hypertension and its consequences than other groups; in part this reflects reduced access to the medical system. Coal miners get black lung disease; the rest of us don't. Some difference is evident between poor and nonpoor, and between black and white, in rate of physician visits (even when adjusted for health status), in hospitalization rate and length of hospital stay, and in use of nursing homes. The physician-to-population ratio is much lower in rural and low income areas, although in recent years this has been improving. The most notable deprivations occur to the isolated rural poor. Many such differences have been described (Aday et al., 1980; Davis et al., 1981; Institute of Medicine, 1981; U.S. President's Commission, 1983). Perhaps the most egregious offense to the spirit of Hippocrates is that the very poor who depend on Medicaid to pay their bills often are denied medical service when they request it. The least-well-tended comprise the structurally underserved (those who by location, income, or education perennially lack access to care), and the marginally disestablished (those who are temporarily out of work, and those whose income is

enough to disqualify them from Medicaid but not enough to pay the bills). To cope with this challenge, most policy prescriptions -- Alain Enthoven's Consumer Choice Health Plan (Enthoven, 1980), or requirement that employers extend insurance coverage to discharged workers until they become reemployed, or liberalization of Medicaid eligibility -- urge guaranteeing at least a "decent minimum" of care. This will have implications both for the public purse and for the medical centers that provide charity care.

Coping with extraordinarily expensive demands. As has become clear with intensive care for very premature infants (Murray and Caplan, 1985), care during terminal illness, and costly high-technology diagnostic and therapeutic care, more and more we must ration both medical resources and living tissues (Aaron and Schwartz, 1984; Baily, 1984; Evans, 1983). Treatment of end-stage renal disease illustrates why commentators cry "crisis": over 12% of the entire Medicare budget is spent on just 0.25% of the Medicare population for renal dialysis and transplantation (Eggers, 1984). As the Baby Fae, Barney Clark, and other dramas have emphasized, many such procedures are coming along. The ethical dimensions become starkly evident if one tries to devise guidelines for making choices about life-extending technologies. Consider, for example, Robert Veatch's criteria (Veatch, 1980, p.158):

-- The relative social usefulness of individuals or members of a class, their willingness to pay for life-extending

technologies, and the dollar value of their future production ought to be irrelevant to policy choices regarding alternative life-extending technologies.

- Any other aggregating methods of determining which life-extending technologies deserve priority should be used cautiously, if at all.
- The younger the individual, the greater should be the priority of life-extending technologies.
- Medical conditions that produce the greatest suffering should be given priority.
- The needs of the generally least well off at times may have to be placed ahead of those who may die relatively early because of a medical problem.
- A medical condition that is seen as involuntary, which originated through causes outside the control of the individual, should get priority over conditions which have resulted from voluntary choice of health-risky behavior and life-style.

Any such list will be disputed. But we already follow criteria of this kind (if not content) implicitly, and we can no longer put off making them explicit. This deliberate confrontation of deeply important but nearly irresolvable life issues is, in the classic sense, "tragic."

Protecting the environment and resources of the health commons. Costliness per se does not make for ethical complaint.

A decision or action becomes of ethical concern when it influences the actions of others, denies freedoms or resources to others, or requires others to pay costs not their own. The problems outlined above are of ethical concern to the extent that they allow one person's actions to deprive others of care (drawing from a pool of constrained resources), or to subject others to risk (refusal to submit to vaccination, thus encouraging spread of an infectious disease). Typical ethical goals are those Paul Menzel endorsed in his book Medical Costs, Moral Choices: "maximum human welfare, justice as distributional equality, and individual autonomy or consent" (Menzel, 1983).

The connection, then, between efficacy and ethics has to do with maximizing the benefits of health resources. Medical practices vary widely, for reasons not understood, and the efficacy and cost-effectiveness of many of them simply have not been proven (Eddy, 1984; Wennberg, 1984). In the long run, access to some rather low-cost procedures -- vaccinations; screening for high blood pressure, glaucoma, breast cancer; dental prophylaxis -- can spare large measures of grief, disability, and expense. Moreover, medicine is only one contributor to health.

[To be completed: Health promotion and prevention...; evaluation and reflexivity...; cost-containment measures (PSROs, HSAs, HMOs, DRGs...; health goals....]

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