2 Allocation on the Social Scale

Usually, the scarcity that necessitates allocation decisions between individual patients is the result of background decisions on a wider scale to limit the resource. These decisions Calabresi and Bobbit (1978, 19) call "first-order determinations." For example, in the case discussed in Section 1.3, a decision by the hospital officials resulted in only five doses of the drug being available. If the officials had stocked ten doses instead, no dilemma of allocation would have arisen on this occasion, although a situation might arise at another time in which eleven demands for the medication would be received. A judgment about how much of a resource to make available determines, as a consequence, how frequently individual allocation decisions will arise and how acute they will be.

Options for the first-order decision in the early days of kidney dialysis included:

1. not developing the resource at all, thus achieving equality by denying it to everybody
2. not using the resource until it was available in sufficient quantity to meet the total need
3. making enough of the resource available to meet only part of the need, and meeting as much of the need as possible while additional quantities of the resource were being developed.
The first option would have led to considerable loss of life, as would the second, since it would have meant that a number of patients who could have benefited would have been denied this life-saving resource during the period of further development. Another problem with the second option is that refinements and improvements in the technology normally made on the basis of early, limited use would either not have been available at all or would have required replacing a full complement of the technology. The third option was the one chosen in the case of renal dialysis, as well as with most other developing resources (e.g., the artificial heart). Once the technology was fully developed, Congress obviated further allocation decisions (at least for the present) by establishing a federal program to finance dialysis for all patients in need of it.

In general, three distinct but interrelated issues arise at this social level:

1. access to health care services
2. the structure of health care organizations, including the dramatic increase in involvement of for-profit agencies in the health care "industry"
3. the issue of costs in health care.

2.1 Access to Health Care Services

When someone suffers from a disease condition against which medical science is powerless, the situation is tragic and disturbing. However, even more disturbing, albeit in a different way, is someone suffering from a disease condition for which the resources exist to relieve the suffering, and yet the person lacks access to these resources that could help him.

An especially dramatic example of this is the incident portrayed by Edward Albee in the one-act play *The Death of Bessie Smith*, the account of a renowned blues singer who collapsed on the street just outside a Memphis hospital and was denied life-saving treatment because she was black and the hospital was "for whites only." The injustice of such a blatant and deliberate denial of access is obvious.

This incident would not likely occur today anywhere in the United States. Courts have firmly upheld the requirement that any hospital maintaining an emergency department must render aid to anyone presenting with a condition that requires urgent attention, regardless of race or ability to pay.

Interesting to note is that no corresponding duty applies to those who supply other basic life needs. If someone starves to death on the steps of a bakery or dies of exposure next to a hotel, the baker or hotel operator does not face legal liability. An important part of the reason for this difference in accountability stems from the difference in the acknowledged role of the providers. Baking and hotel management are not professions with a self-declared dedication to service. In contrast, an inherent goal in the enterprise of medicine is the attempt to meet *all* medical needs. Thus there is still reason for concern and careful examination of the circumstances
when any remediable medical need goes unmet for lack of access to the appropriate services. Even if this is not the result of deliberate acts of injustice, it still constitutes a tragedy within society. How can such situations be avoided? Who is responsible for correcting it? In particular, in the attempt to close any gaps of access to services, what is the responsibility of the individual physician, health care institutions, and the government?

The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research sets forth the following as an “ethical standard” against which the justice of existing structures and programs should be measured: “Access for all to an adequate level of care without the imposition of excessive burdens” (President’s Commission 1983a, 1).

2.1.1. The Current Situation In the United States at present, the extent to which gaps in access to medical care exist is far from obvious. For example, the President’s Commission (1983a, 67) reports that

the number of physician visits per year, whether in response to perceived illness or for health maintenance reasons, is a key indicator of access to care. During the past few decades the increased use of services by traditionally underserved groups, especially the poor and racial and ethnic minorities, has been dramatic. Aggregate data, unadjusted for differences in need, show a substantial narrowing of the disparities in physician visits among population groups over the past 15 years. The poor now pay on average as many visits to physicians per year as the nonpoor. Blacks, on average visit the physician at rates comparable to whites.

When the data are adjusted to consider differences in health status, however, these patterns change. Once visits are adjusted by perceived health status, the poor make fewer visits to a physician each year than the nonpoor, and blacks visit a doctor less frequently than whites of comparable health status.

One member of the Commission filed a dissenting statement to this report that questioned the significance of these data:

This “adjustment” is capable of various interpretations, one of which might be that it is meaningless and another that there are fewer hypochondriacs among the poor and blacks. It certainly cannot mean that the poor and the blacks are denied equitable opportunities to visit a doctor. (President’s Commission 1983a, 201)

There were other indications of unmet medical needs reported by the Commission. The physician visits made by patients with insurance coverage average 154% the number made by those without it (or, to put the point in reverse, the visits made by those without coverage average only 65% of all with coverage); and the hospital days for those with insurance averages 191% the number for those without insurance coverage (and thus the days for those without coverage average only 52% of those with coverage) (President’s Commission 1983a, 101–102).

4. A summary of the recommendations from this report is included in Appendix 11.3.
The site of physician interactions also shows variance. A person with an income of less than $5,000 per year is twice as likely as one whose annual income is over $15,000 to have last seen a doctor in a hospital emergency room or out-patient department instead of a private office. Blacks are 2-1/2 times as likely as whites to have last encountered a physician in a hospital clinic setting. (p. 75)

Significant differences are also found in the severity of illness at the point of initial treatment:

Data from the National Cancer Institute reveal that white patients have a higher percentage of their cancers diagnosed at an early stage than black patients do. Furthermore, "paying" patients have their cancers diagnosed in an earlier stage more often and have better survival rates than indigent "nonpaying" patients. Women who are considered to be at a higher risk of cervical cancer (particularly poor, black women aged 45–64 living in nonmetropolitan areas) are less likely than other women to have had a Papanicolaou (Pap) test to screen for that disease.

A study of 5000 patients hospitalized for a variety of conditions found marked differences in the severity of illness at admission among those publicly and privately insured. In another study, patients insured under private plans were more likely to be hospitalized in earlier stages of their condition than those publicly insured. Public beneficiaries diagnosed as having appendicitis, for example, were twice as likely as those covered by commercial insurance to have their disease be at an advanced stage when they were admitted to a hospital. A similar study compared the severity at hospital admission of 21 medical or surgical conditions that require hospitalization at the earliest possible stage; it found that publicly insured patients were more likely than privately insured patients to be admitted with conditions in advanced stages. (President’s Commission 1983a, 74—footnotes omitted)

In discussing the relationship between payment sources and health care, it is useful to know the size of the various payment groups (Table 5-1).

<table>
<thead>
<tr>
<th>Table 5-1</th>
<th>Health Care Coverage by Type, 1980</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number, in millions</td>
</tr>
<tr>
<td>Private</td>
<td>161.2</td>
</tr>
<tr>
<td>Medicare</td>
<td>21.7</td>
</tr>
<tr>
<td>Medicaid</td>
<td>15.2</td>
</tr>
<tr>
<td>Medicare and Medicaid</td>
<td>6.1</td>
</tr>
<tr>
<td>VA, CHAMPUS</td>
<td>5.3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>231.0</strong></td>
</tr>
</tbody>
</table>

*President’s Commission (1983a, 91).*
While the interpretation of these data is subject to considerable dispute, it does underscore the importance of access to health care services. Of special concern are the 21.5 million Americans who lack any form of assistance in paying the rising costs of health care. These are the people most likely to have pressing medical needs go unmet due to lack of access to the health care system.

2.1.2 What Is the Goal? In addressing the access issue, however, questions arise. First, what exactly is the goal sought? Paul Starr (President’s Commission 1983b) distinguishes between

1. availability of services
2. nonexclusionary policies and conduct
3. access to services
4. use of services
5. results of services.

He illustrates the differences between the first and third items in this passage:

The right to postal service is a right of availability, not of access: The government guarantees to transmit mail in and out of communities, but not that you will have enough money to send letters. Insofar as there is a right of access to the U.S. mail, it is a right of communities rather than individuals. (The government does, however, guarantee to deliver your mail if somebody else has paid the postage.) On the other hand, local government typically provides fire protection regardless of your ability to pay, in part because of the risk to others. Some aspects of medical care, such as the control of contagious diseases, have long been considered like fire protection; providing access to those who cannot afford services has been understood as a matter of community welfare. Other aspects of medical care have been treated more like the postal service: Government has been willing to acknowledge a right of availability, but not necessarily of access. (This seems to have been the premise of the Hill-Burton hospital construction program.) (President’s Commission 1983b, 7)

It is an enormous puzzle to decide which of these five goals should be addressed in trying to promote more adequate health services.

A. Availability The easiest of the items to address, this is quite remote from the concerns with which we began. Governmental programs such as the Hill-Burton act can be used to subsidize construction of hospitals and other health care facilities. Capitation subsidies to medical schools can increase the supply of practitioners. However, if those in need are barred from using resources and/or lack the means of access to them, no benefit is derived from their mere presence.

B. Nonexclusion Exclusionary policies are illustrated by the Bessie Smith case described earlier. Blatant forms of exclusion can be addressed by law and social policy, but more subtle forms of discrimination may remain, and these are much more difficult to root out.
Furthermore, there are other forms of selection that are less obviously unjust. Must VA hospitals admit any citizen, or is it appropriate for them to limit their services to veterans? Could a sectarian hospital be established specifically to serve the medical needs of a particular group (e.g., Jehovah’s Witnesses) and then justly serve members of the founding group exclusively? Can a hospital justly treat only certain diseases or offer exclusive types of care?

C. Access There are three primary barriers to access to services:

1. money to pay the costs of treatment
2. time to submit to treatment
3. transportation to the site of treatment.

These barriers are more difficult to overcome than barriers to availability or exclusionary policies, as shown by the struggles over the last several decades to devise a social policy for financing health services for those in need. Furthermore, eliminating these barriers may not achieve the ultimate goal, as shown by the next point.

D. Use Correlation studies show that even if availability and means of access are fully equalized, the rate of use varies from one population to another. Many initially assume this to be unjust until the rate of use is equalized. Indeed, if you look at Section 2.1.1, you will note that most of the indicators of unmet needs cited by the President’s Commission deal with use. To some extent this reaction to discrepancies of use makes sense: the differences in rate of use might, in part, reflect subtle exclusionary conduct within the institutions. However, the differences reflect, in part, health beliefs and attitudes of the subculture in question. Perhaps these beliefs and attitudes have been influenced by past practices of discrimination and lack of access to health services. However, insistence on eradicating these defining beliefs as the price for achieving some ideal goal of justice violates the integrity of the cultural subgroup.

E. Results Since it is the importance of health needs that prompts concern with justice, it seems natural to set a standard in terms of states of health as the goal to be sought. The problem is that even if all barriers to availability and access to health care resources are removed—and indeed, even if use were equalized—perfect health for the population as a whole would not necessarily result. Health care does not directly produce health in the same way that bestowing money produces wealth. Individual, cultural, and perhaps genetic differences lead to different outcomes from the same level of services.

Should society insist on equality of access even though it does not effect equal result? If so, what are we trying to equalize?
2.1.3 Level of Services  Furthermore, it is impossible to provide availability, access, and/or use to meet all needs. The cost of attempting to achieve this level of services would be prohibitive. Daniel Wikler calls this the "bottomless pit" problem and points out its three aspects:

First, some patients use (or could use with benefits) health care of practically unlimited cost. Even these expenditures would not, in some cases, be enough to restore such patients to the average health status of the rest of the community. Second, even if these needy individuals are left untreated (to some extent), medical resources likely will continue to be concentrated on a relatively small number of patients. Finally, the health benefits achieved by these expenditures are not always great. There is nothing in the nature of disease or medical care that guarantees a proportionality of expense and benefit. Chronic diseases are so called, after all, because they go on and on regardless of medical intervention. (President's Commission 1983b, 120)

Notice the goal presupposed by Wikler: "to restore such patients to the average health status of the rest of the community." This goal, set in terms of results, raises two problems.

1. Why should we rest content with achieving the "average health status of the rest of the community?" Why not, instead, try to bring everyone up to the highest possible level of health, or at the very least, why not aim at one or two standard deviations above the mean rather than merely aiming at the mean? These are questions of justice and need to be addressed in a public debate focusing on principles of justice. (Parallel questions arise for goals set in terms of availability, access, or use.)

2. Talk of specifying a certain level of overall health status suggests that there are clear-cut ways to measure this. Complexities and uncertainties in measurement pose theoretical difficulties for stating goals, over and above the ethical difficulties mentioned in item 1.

a. Measures traditionally used to determine result include personal perceptions of illness, number of sick days in a given period (i.e., days of work or school missed due to illness or days spent in bed), and gross health measures such as infant mortality, etc. All these pose great theoretical difficulties.

b. If availability is the goal, the level sought would be specified in terms of ratios of hospital beds, professionals, etc., to population. These benchmarks are often derived from current average rates of use, but these may be distorted by existing vagaries of access, and thus their soundness as indicators of ideal goals is questionable.

c. Specifications of levels of services in terms of access could focus on 1) barriers to be addressed, or 2) the range of services to be made available, or 3) the procedure to be employed in deciding in each
particular case what services to make available. The choice among these, as well as issues about specifying the content of each, poses theoretical problems.

d. Use measures raise theoretical difficulties when attempts are made to correlate them with need.

Pellegrino and Thomassma (1981, 242) offer the following priorities under a general goal of access:

[1] Primary health care, and specifically its first-contact component, seems the minimal health care claim a citizen may make on a society of our kind. It takes precedence over other forms of care because of its universality and its intensely human dimensions, and because it is the critical point of first entry into the entire system of health care. It is fundamentally a form of personal security, and one of the benefits which ought to follow on the formation of society. Following this would be [2] access to treatments which can effect a radical cure or prevent occurrence of a disease entirely. Next would come [3] the care and containment of established serious diseases for which no radical cure is available; then [4] the more expensive, highly complex procedures of dubious or unproven benefit; and last, [5] treatment for disorders with minimal disability, which, though distressing, are not incapacitating and need only symptomatic treatment or self-care.

A nation must determine how far down this list it will go, given its resources and the expectations its form of society engenders. Whether health is preferred to other human services will depend largely on how far down the list of health priorities one wants to go. Since sanitation, housing, nutrition, and environmental safety contribute to health, they might well take precedence over health care items lowest on the list. In fact, they might take precedence over primary care as well.

As stated earlier, the President’s Commission proposes a standard of "an adequate level of care." After examining several ways in which this notion might be defined (President’s Commission 1983a, 35–42), the Commission leaves the definition to be worked out through the political process:

The Commission cites these alternatives as examples of possible initial approaches to approximating an adequate level of health care that should be available to all Americans. There are both theoretical and practical differences between these approaches, yet each has something to offer, separately and together. For the purpose of health policy formulation, general theories as well as ordinary views of equity do not determine a unique solution to defining adequate care but rather set some broad limits within which that definition should fall. It is reasonable for a society to turn to fair, democratic political procedures to make a choice among just alternatives. Given the great imprecision in the notion of adequate health care, however, it is especially important that the procedures used to define that level be—and be perceived to be—fair. (President’s Commission 1983a, 42)
2.1.4 How to . . . ? The most difficult question is how to achieve the goal once it has been defined. An extensive variety of approaches is available. Each must be examined, not only to measure its probable effectiveness and efficiency in achieving the goal, but for its impact on other values. One's sense of the magnitude of the problem (based upon interpretation of the data in Section 2.1.1) dictates the sense of urgency with which one approaches this issue and there are a number of approaches possible.

A. Laissez Faire This would allow existing forces to continue to act without any added interference by government or other influences, in hopes that the conscience, compassion, and standards of professionals and the responsibility of institutions will lead to changes that correct existing deficiencies in availability, access, and/or use of health services.

B. Moral Suasion A more active approach would be to strengthen these inherent tendencies through moral suasion. One means to accomplish this is to call the attention of professionals to these issues and corresponding professional responsibilities (as is being done in these pages). Another is to enunciate professional responsibilities in the form of codes of professional ethics (as the ACP Ethics Manual does, as you will see shortly). Public opinion may have impact here through general public discussion of these issues.

C. Private Subsidies There are mechanisms in the private sector that could provide for expanded access, etc. Private charities could provide for the needs of those whose access, etc., to health care is deficient. Charitable organizations currently play a vital (if small) role here, but a greater initiative would require a radical expansion of their present efforts.

Cost shifting by professionals and health care institutions is a mechanism for subsidizing care for patients who cannot pay. This amounts to a (privately levied) "sick tax." (Public and private hospitals have used this mechanism for years as a way of providing care for indigent patients.)

D. Government Subsidies Local, state, and federal governments could work within the existing system to "fill in the gaps" of access, etc. This has been the dominant thrust of most past governmental action in this country, from the Hill-Burton program to increase availability of hospitals to Medicare and Medicaid programs which pay (at least in part) for access to services for certain groups. One key problem with this approach is that it rarely occurs without regulation of the system receiving the subsidies.

5. Another approach, not discussed at length here, is to attempt to remove existing external influences on the present system. Among the many practical and theoretical problems that attend this option is the thorny task of sorting out which elements count as "external interferences" and which have been internalized into the system. For example, are licensure and associated restrictions against practice by unqualified healers an external interference?
E. Government Manipulation  Government could deliberately contribute forces of its own to work within the system to move it in the desired direction. This can take a number of forms: The "carrot-and-stick" approach follows naturally from government subsidization of elements of the system. The next step is to tie these funds to certain regulations, as has been done from the beginning with the Medicare and Medicaid programs. This linkage is seen even more explicitly in the program of prospective funding in terms of diagnosis-related groups (DRGs). Admittedly, one can avoid the impact of these regulations by not taking advantage of the subsidies to which they are attached. (However, it may not be possible thereby to return entirely to the status quo ante, because other means of providing for this population, such as charity support or volunteer assistance, may have dried up with the onset of government subsidy programs.)

Direct regulation would not be escapable in the same way. By the same token, government may not have strong basis for influence if its edicts are not tied to reimbursement or some other state function. The forms of direct regulation include

1. bureaucratic regulation
2. court rulings
3. statutory law.

F. Nationalization of the Health Care System  In this, the most radical approach, the government would assume full responsibility for health care delivery. Health care institutions would be run by the government and health care professionals would become employees of the state. Patients would become, in effect, wards of the state.

The President’s Commission (1983a, 4) asserts the following on the role of government in this effort:

When equity occurs through the operation of private forces, there is no need for government involvement, but 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. Private health care providers and insurers, charitable bodies, and local and state governments all have roles to play in the health care system in the United States. Yet the Federal government has the ultimate responsibility for seeing that health care is available to all when the market, private charity, and government efforts at the state and local level are insufficient in achieving equity.

This approach favors government subsidies to fill the gaps after the private sector has done all it can to provide full access to health care services.

The individual practitioner also has some responsibilities here. The ACP Ethics Manual addresses these in the following comments:

Like any other good citizen, the physician should strive for the well-being of the community and of society. He should work toward ensuring the availability of adequate medical care for all individuals and should support community health endeavors.
In addition, the physician has the following special obligations:

1. To be aware of the availability and accessibility of health services to the people of the area in which he practices and to participate in reasonable efforts to correct defects in such availability and accessibility. [ACP 1984a (Manual), 18–19; 1984b (Annals), 135–136]

The physician may be technically free to select his patients to the exclusion of those who cannot pay, but as a professional he has a moral obligation to contribute some of his services to the neglected and underprivileged and to give good medical care to all his patients irrespective of their ability to pay.

When care is free, every effort must be made to preserve the dignity and self-respect of the patient. The indigent patient should receive equal care and be treated with the same respect and thoughtful concern as the patient who can pay for services. [ACP 1984a (Manual), 8–9; 1984b (Annals), 132]

We agree with these statements and add that physicians have a responsibility to take a leadership role in the public debate proposed by the President’s Commission. A professional understanding of needs and priorities is an essential ingredient in policy formulation. If this viewpoint is not forcefully represented, less acceptable values may prevail (see Blendon and Altman 1984).

Decisions about location and form of practice ought to be influenced by considerations of medical need and not wholly by personal preferences. But frequently the problem is a combination of “How can you keep them down on the farm . . .?” and “Make hay while the sun shines.” Physicians must balance considerations of medical need with their own and their family’s needs, e.g., to

1. earn enough to pay back medical school debts (This is likely to be especially urgent in an atmosphere of impending dramatic changes in cost and financing of medical education. Since it may become impossible to meet these obligations in the future, it seems urgent to medical school graduates to recoup educational expenses as rapidly as possible.)

2. provide access to cultural opportunities for themselves and their families

3. provide for the style of life to which they have become accustomed.

Medical school and residency faculties can significantly influence the choice of practice location by helping students achieve a workable match between these needs and their desire to serve. On the other hand, faculty can train students away from a choice of practice in an area of unmet needs by creating an aura around academic medicine as the only respectable form of practice. One mechanism by which this is done is the disparagement of the “LMD” (local MD). Given the sneer with which these initials are usually spoken, it is hardly surprising that students and residents do not aspire to the title.
2.2 The Monetarization of Medicine

Any effort to close existing gaps in access to or use of health care services will undoubtedly take money, which brings us to the role of money in medicine.

Although expressed in cynical terms, the following statement by sociologist Erving Goffman captures the traditional view of money in the profession of medicine:

There is a double sense in which a [professional] fee is not a price. Traditionally a fee is anything other than what the service is worth. When services are performed whose worth to the client at the time is very great, the server is ideally supposed to restrict himself to a fee determined by tradition—presumably what the server needs to keep himself in decent circumstances while he devotes his life to his calling. On the other hand, when very minor services are performed, the server feels obliged either to forego charging altogether or to charge a relatively large flat fee, thus preventing his time from being trifled with or his contribution (and ultimately himself) from being measured by a scale that can approach zero. When he performs major services for very poor clients, the server may feel that charging no fee is more dignified (and safer) than a reduced fee. The server thus avoids dancing to the client's tune, or even bargaining, and is able to show that he is motivated by a disinterested involvement in his work. And since his work is the tinkering kind, which has to do with nicely closed and nicely real physical systems, it is precisely the kind of work in which disinterested involvement is possible: a repair or construction job that is good is also one that the server can identify with; this adds a basis of autonomous interest to the job itself. Presumably the server's remaining motivation is to help mankind as such. (Goffman 1961, 326–327—footnotes omitted)

Compare the foregoing to the following statement, which contains many of the same elements expressed in different terms:

Most doctors are basically honest and conscientious individuals who began their professional careers motivated more by scientific interest and idealistic goals than by profit motives. Most doctors come to realize early in their careers that they will not become rich practicing medicine. They may hope to achieve a better-than-average income, but it is the intangible rewards of practice, closely associated in doctors' minds with humanitarian achievement and the striving toward a goal of ideal service to their patients, that brought most physicians into medicine in the first place, and, ultimately, that keeps them there. (Nourse and Marks 1963, 59)

Factors on both sides of the physician-patient relationship contribute to this attitude of downplaying its financial components. For physicians, professional standards reinforce their predisposition to concern themselves less with the money to be gained from their practice than with 1) the intrinsic fascination of the technical task itself (what Nourse and Marks call "scientific interest" and Goffman calls "disinterested involvement in his work" or "tinkering"), and 2) a concern to help people who are in need (what Goffman calls a motivation "to help
mankind as such’’ and Nourse and Marks describe as ‘‘a goal of ideal service to their patients’’).

On the patient’s part, there are two key considerations that subordinate attention to finances: 1) There is a generally shared recognition that the ‘‘commodity’’ being dealt with is beyond price; i.e., it would be improper to assign a monetary value to one’s life or health. 2) Furthermore, the relationship itself is more a personal relationship than a commercial transaction; i.e., it is so intimate and deals with matters so momentous that it goes beyond matters appropriate for contractual negotiations and bargaining and requires instead trust. Goffman acknowledges these elements:

The server’s attachment to his conception of himself as a disinterested expert, and his readiness to relate to persons on the basis of it, is a kind of secular vow of chastity and is at the root of the wonderful use that clients make of him. In him they find someone who does not have the usual personal, ideological, or contractual reasons for helping them; yet he is someone who will take an intense temporary interest in them, from their own point of view, and in terms of their own best interests. As one student of human affairs suggests:

As defined in this culture, the expert is one who derives his income and status, one or both, from the use of unusually exact or adequate information about his particular field, in the service of others. This ‘‘use in the service of’’ is fixed in our industrial-commercial social order. The expert does not trade in the implements or impediments of his field; he is not a ‘‘merchant,’’ a ‘‘collector,’’ a ‘‘connoisseur,’’ or a ‘‘fancier,’’ for these use their skill primarily in their own interest. [Harry Stack Sullivan, ‘‘The Psychiatric Interview,’’ Psychiatry, XIV (1951), p. 365.]

It therefore pays the client to trust in those for whom he does not have the usual guarantees of trust. (Goffman 1961, 327–328)

Notice that these points have all been made with reference to motivations. This indicates that at issue here are character judgments rather than either judgments of moral obligation or evaluative judgments. Yet the other two forms of judgment are lurking in the background. The corresponding judgment of moral obligation is tacitly assumed: it goes without saying that it would be morally wrong for a physician to act in a way that serves no purpose beyond increasing his or her personal income, e.g., to recommend and carry out a medical procedure that does not serve the best interests of the patient. Evaluative judgments are incorporated into the central character judgment: what is questionable about a ‘‘profit motive’’ orientation is the value one assigns to money relative to interest in medical science and the welfare of one’s patients.

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6. To refresh your memory about the distinctions between these three kinds of judgments, see Chapter 2, Section 2.1.
The point is that an excessive concern for money is unseemly in a professional, just as it would be, for example, in parents whose dominant thought throughout the years of child raising was how the child would provide for them in their declining years. Another example of this might be "stage parents," who put their children through audition after audition in hopes of income and/or vicarious glory for themselves. These are the wrong reasons to have children: one ought to care about them for themselves, not merely for the benefits they might bring. This is true even if the motive never affects action: in the case of parents, even if it does not influence the career guidance they give to their child; in the case of physicians, even if it never prompts them to do a single lucrative but unnecessary procedure.

But, of course, there is the added danger that it will affect action, especially in borderline cases. When faced with the decision, for example, whether to order an additional diagnostic test to confirm a diagnosis, a physician with profits uppermost in mind may be influenced to do the procedure since her income will thereby be enhanced, whereas a physician whose dominant interest is the welfare of the patient might refrain from inflicting this added risk. And precisely because medical decisions are so much a matter of judgment, it is exceedingly difficult for observers to know to what extent this factor has influenced choice.

Two important implications follow:

1. An ongoing discipline of examination of one's motives is an important element in the moral life. Along with reviewing the rights and wrongs of past actions, one should honestly face the pattern of motives that prompt action and examine them in terms of ethical and professional character ideals.

2. One must avoid, not merely the fact of impropriety, but also its appearance, since observers may assume the worst if any basis for a conflict of interest exists. The only check against being misled by a conflict of interest is the interior influence of professional standards and personal ethical discipline, which by its interiority is invisible to the observer. "Man judges by outward appearances. . . . ." (I Samuel 16:7).

This latter element addresses what is most disturbing about the incursion of for-profit corporations into the health care field. The check of professional standards is lacking, and thus the danger is increased that individual ethical standards will be subordinated to the profit motive.

2.2.1 What's a Nice Profession Like You . . . ? Arnold Relman forcefully sets out the dangers here (and also offers a partial solution) in an influential essay entitled, "The New Medical-Industrial Complex":

What I will call the "new medical-industrial complex" is a large and growing network of private corporations engaged in the business of supplying health-care services to the patient for a profit—services heretofore provided by nonprofit institutions or individual practitioners.
Can we really leave health care to the marketplace? Even if we believe in the free market as an efficient and equitable mechanism for the distribution of most goods and services, there are many reasons to be worried about the industrialization of health care.

1. In the first place, health care is different from most of the commodities bought and sold in the marketplace. Most people consider it, to some degree at least, a basic right of all citizens. It is a public rather than a private good, and in recognition of this fact, a large fraction of the cost of medical research and medical care in this country is being subsidized by public funds.

2. A second feature of the medical-care market is that most consumers (i.e., patients) are not "consumers" in the Adam Smith sense at all. As Kingman Brewster recently observed, health insurance converts patients from consumers to claimants, who want medical care virtually without concern for price.

3. There are other unique features of the medical marketplace, not the least of which is the heavy, often total, dependence of the consumer (patient) on the advice and judgment of the physician.

All these special characteristics of the medical market conspire to produce an anomalous situation when private business enters the scene. A private corporation in the health-care business uses technology often developed at public expense, and it sells services that most Americans regard as their basic right—services that are heavily subsidized by public funds, largely allocated through the decisions of physicians rather than consumers, and almost entirely paid for through third-party insurance. The possibilities for abuse and for distortion of social purposes in such a market are obvious.

It seems to me that the key to the problem of overuse is in the hands of the medical profession. With the consent of their patients, physicians act in their behalf, deciding which services are needed and which are not, in effect serving as trustees. The best kind of regulation of the health-care marketplace should therefore come from the informed judgments of physicians working in the interests of their patients. In other words, physicians should supply the discipline that is provided in commercial markets by the informed choices of prudent consumers, who shop for the goods and services that they want, at the prices that they are willing to pay.

But if physicians are to represent their patients' interests in the new medical marketplace, they should have no economic conflict of interest and therefore no pecuniary association with the medical-industrial complex. (Relman 1980, 963, 966–967)
There is no doubt that the involvement of for-profit corporations in the health field is a mushrooming phenomenon. As one author estimates (using a somewhat wider definition of "medical-industrial complex" than Relman employs):

As of early 1983 listed corporations already owned approximately 11 percent of the nation's 5,900 community hospitals. They also had possession of 66 percent of nursing homes and chronic care facilities.

... of the $317 billion spent on health care in 1982, fully $118 billion turned up as corporate revenues for the companies of the Medical-Industrial Complex. (Wohl 1984, 19)

2.2.2 Implications for the Future  Starr (1982, 428–439), Ginzberg (1984), and others point out that the influence of the corporate invasion of the health services "industry" has extended far beyond the for-profit institutions, and certainly beyond the selected institutions that Relman singles out in his essay. A "marketing mentality" and new concepts of institutional structures have emerged in all health care institutions.

Paul Starr (1982, 428) insists that "medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century." He explains that

the change goes beyond the increased penetration of profit-making firms directly into medical services. By the growth of corporate medicine, I refer also to changes in the organization and behavior of nonprofit hospitals and a general movement throughout the health care industry toward higher levels of integrated control. Five separate dimensions need to be distinguished:

1. Change in type of ownership and control: the shift from nonprofit and governmental organizations to for-profit companies in health care
2. Horizontal integration: the decline of freestanding institutions and rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations
3. Diversification and corporate restructuring: the shift from single-unit organizations operating in one market to "polycorporate" and conglomerate enterprises, often organized under holding companies, sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets
4. Vertical integration: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs
5. Industry concentration: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole. (Starr 1982, 429)
2.2.3 Exercise: Professional Responsibilities

INSTRUCTIONS: Look over the statements below. Step 1. Discard those with which you disagree entirely. Step 2. Go back over those remaining, two by two, and decide 1) whether the two statements are consistent and, if so 2) whether each statement adds something important to the other. If the answer to either of these questions is "No," discard one of the statements. Continue in this way until you have assembled a set of statements describing a complete, consistent, and acceptable policy to deal with financial conflicts of interest in medical practice. (You may add statements of your own or amend some of these.) Step 3. Look up the source of the statements you chose (given at the end of the chapter, p. 250) and see whether you chose from a single policy source or you assembled your view from a mixture of sources.

1. If physicians are truly not to have conflicting financial interests as they deliver their services, they should not be in the position of charging fees for services.

2. The physician should avoid any business arrangement that might, because of personal gain, influence his decisions in patient care. Activities of physicians relating to the business aspects of his own or his group's practice should be guided by the principle that such activities be intended for the reasonable support of that practice and for the effective provision of quality care for patients. Similarly, activities relating to the provision and maintenance of research and educational endeavors of his group or institution should be guided by the same principle.

3. For a physician to own shares in a drug company or in a hospital in which he practices does not constitute unethical behavior of itself, but it does make him vulnerable to the accusation that his actions are influenced by such ownership. The safest course is to avoid any such potentially compromising situations.

4. The guiding principle of the medical profession is to serve humanity. Financial gain should be a secondary consideration. Therefore personal financial interest should never override patient welfare in decision making.

5. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationship among individuals, by name, who are treating him.

6. In any conflict which might develop between the physician's financial interest and his responsibilities to a patient, the patient's welfare must be the guiding consideration.

7. So long as the care of patients is not compromised, there is no objection on ethical grounds to a physician being engaged in any proper business unrelated to his medical practice.
8. If physicians are to represent their patients’ interests in the new medical marketplace, they should have no economic conflict of interest and therefore no pecuniary association with the medical-industrial complex.

9. Critics . . . will probably point out that even without any investment in health-care businesses, physicians in private fee-for-service practice already have a conflict of interest in the sense that they benefit from providing services that they themselves prescribe. That may be true, but the conflict is visible to all and therefore open to control. Patients understand fee-for-service and most are willing to assume that their doctor’s professional training protects them from exploitation. Furthermore, those who distrust their physicians or dislike the fee-for-service system have other alternatives: another physician, a prepayment plan, or a salaried group.

10. Groups of consumers shopping for health care packages should be informed in advance about restrictions on seeking care from providers outside health care panels.

2.2.4 Physician Payment Systems  Another element of the financial aspect of health care is the system by which physicians are paid. Review the following description of possible methods of payment; you then will be asked to reflect upon this issue.

The possible ways of paying doctors for medical care are fee-for-service, salary, capitation, and case payment. None are linked inextricably to any way of organizing a country’s medical services. National health insurance systems and national health services can be found using each of the payment methods, but national health services tend to use the more predictable device of salary and to avoid fee-for-service. . . .

Fee-for-service is payment for each medical procedure. Under “service benefits” or “direct payment” methods, the third party—i.e., the sick fund or the health service—pays the doctor directly, and the patient usually pays him nothing. Under “cash benefits” or “reimbursement” methods, the patient pays the doctor and subsequently regains all or most of the fee from the third party.

Capitation is a fixed annual payment for each person on a list regularly assigned to a doctor. The physician gives all necessary care to the members on the list who come to him. Even if a person never visits him, the doctor automatically collects the capitation fee; even if a person has many medical problems, the doctor usually can collect no more than the capitation fee. Patients usually pay nothing to the doctor.

Salary is a fixed amount of money scaled according to the rank of the job and paid according to the amount of time the doctor gives. Patients usually pay the doctor nothing. Some arrangements allow the doctor to collect fees from the third party, in addition to the salary given for basic care.
Case payments are fixed sums given the doctor for giving a patient all necessary care. They differ from capitation fees, which are paid for persons on a list regardless of illness. Case payments differ from fee-for-service in that payments are not itemized by procedure and totaled. The few case payment systems use the service benefits principle: the third party pays the doctor, and the patient pays nothing. (Glaser 1970, 25)

2.2.5 Exercise: Payment Systems

A. Your Reaction

1. How do you want to be paid?
2. Is case payment acceptable to you? Why or why not?
3. Who should control how you are paid?
   a. the hospital
   b. the government
   c. the insurance company
   d. your spouse
   e. other (specify): ____________________________
4. Is the fee-for-service structure of payment so important to you that you are willing to avoid participation in any form of prepayment plan?

B. General Analysis  It cannot be denied that the problems pointed out by critics of the existing fee-for-service, cost-reimbursement system of payment are genuine cause for concern. They include

1. high cost
2. overreliance on technology and technique
3. gaps in access, etc., to services not covered by some form of assured care (especially with third-party reimbursement that obscures out-of-pocket expenses)
4. failure to meet the perceived needs of patients, i.e., electrochemical reductionism vs. care and sensitivity.

What must be questioned, however, is whether these problems are the ineluctable result of irresistible forces inherent in the payment system. Instead they may result 1) from exploitation of the system by practitioners who do not abide by professional standards of behavior (the "black hats") and/or 2) from forces in the society independent of the medical payment system. These possibilities are usually not considered when alternative payment systems are examined. It is assumed that these new systems will be operated wholly by "white hats" and in a vacuum of external forces. But, of course, that is unlikely to happen.
As a corrective, look at the alternatives in a realistic light: assume a mixture of white and black hats, much like you would find in today’s medical community (in any relative proportion that you choose to postulate). Then, on the basis of this assumption, answer the following questions for each of the payment systems described in Section 2.2.4.

1. If one intended to “game” the system, what would be the strategy to follow? How do the possible forms of exploitation vary from system to system?

2. Project the likely consequences of the typical forms of abuse of the system. Are there significant differences in these from one system to another?

3. Look back at the four problems listed earlier (and other parallel problems that come to mind). For each system, consider whether each problem is likely to be:
   a. removed entirely and impossible to recur
   b. relieved somewhat but not removed entirely
   c. unchanged
   d. exacerbated somewhat
   e. exacerbated greatly.

4. Describe the impact within the system of the social forces behind these problems (e.g., the general lack of deep concern for the underprivileged, fascination with technology and technique, unrealistic patient expectations of what medicine can accomplish).
   a. How does this differ from one system to another?
   b. Are there safeguards in the system to minimize the negative impact of these forces? If so, what are they?

5. What would it be like to be a “white hat” under each system? What changes (if any) in professional standards would each require? What changes (if any) would each make in the nature of the physician-patient relationship? (For example, what practical truth is there to the adage: “He who pays the piper calls the tune”? What differences might institutional forms of payment make to one’s loyalty to patients?)

6. What incentives would you need to continue to be a white hat?

2.3 Cost Control

The monetarization of medicine, in turn, may exacerbate the problem of rising costs, which brings us to the issue of cost control.
2.3.1 The Problem

The good news is that modern medicine can work miracles. The bad news is that it is very expensive and that many health expenditures do not seem to yield benefits worth their cost. Medical expenditures in the United States (in 1982 dollars) rose from $503 per capita in 1950 to $776 in 1965 (the last pre-medicare, pre-medicaid year) and to $1,365 in 1981, 10.5 percent of gross national product.

... Hospital care expenditures alone showed even more dramatic increases, rising from $153 per capita in 1950, to $257 in 1965, and to $563 in 1981. (Aaron and Schwartz 1984, 3, 139)

Of course, it is difficult to tell how much is too much to spend for health care. A comparison of worldwide figures may shed some light:

... The available data indicate striking differences in the levels of current total public expenditures on health for capital and operating purposes, with average figures of $2.60 per capita per year in the poorest countries (1.1 per cent of the gross national product), $19 in middle-income developing countries (1.2 per cent of the gross national product), and $469 in industrialized countries (4.4 per cent of the gross national product). The combined public and private health expenditures in the United States and several northern European countries are close to $1,000 per capita per year—more than 100 times the level in the poorest group of countries. At the other extreme, a few of the poorest countries—Bangladesh, Ethiopia, Indonesia, and Zaire—have annual public expenditures on health of only $1 per capita. (Evans et al. 1981, 1122)

There are other figures of interest: total health expenditures in western European countries were much higher than ours—in West Germany, 12.8% of the gross national product (GNP) in 1978; in Sweden in the same year, 11.3% of the GNP. In contrast, Great Britain's expenditures totaled only 5.4% of the GNP in 1978 and were actually reduced slightly to 5.3% of the GNP by 1980—at which time the U.S. expenditures were 9.4% of a much higher GNP.

These differences among developed countries do not appear to have a direct effect on overall health status. Indeed,

... crude indicators of health status put Britain abreast or slightly ahead of the United States. Life expectancy at birth for men was 70.2 years in Britain in 1979 and 69.9 years in the United States; British baby girls born in 1979 could expect to live 76.2 years, and their American counterparts about 1 year more. During the first year of life babies born in 1979 died at the rate of 12.9 per thousand in Britain and 13.1 per thousand in the United States. (Aaron and Schwartz 1984, 12)

It is also difficult to ascertain the relative contribution of various elements of the health care system to the cost differentials and increases. Physicians' income is often cited as a factor, yet this accounts for less that 20% of the total health care cost. Hospital costs have increased far faster than other components and now
comprise more than 46% of the total national health care expenditures, but this in itself is made up of many elements. "Big-ticket" technologies are a dramatic focus of attention, but their role is disputed. Moloney and Rogers (1979, 1414) argue:

If the annual operating costs of the nation's four most widely heralded large technologies (CT scanning, electronic fetal monitoring, coronary by-pass, and renal dialysis) were reduced by half—a dramatic rationing—the net savings to the nation would equal less than 1 per cent of last year's bill for health care.

These authors claim that a much more significant contributor to health care costs are "low-cost services such as laboratory tests and x-rays rather than a shift to the use of big, expensive technologies for diagnosis or treatment."

2.3.2 Comparison with British Health Care System An illuminating study of issues in cost containment is the comparison of the U.S. and British health care systems by Aaron and Schwartz (1984). They compared rates of use and costs for 11 medical services:

1. bone marrow transplantation
2. cancer chemotherapy
3. CT scanners
4. coronary artery surgery
5. diagnostic x-rays
6. hemodialysis
7. hemophilia treatment
8. hip replacement
9. radiotherapy
10. total parenteral nutrition
11. intensive care beds.

They summarize their conclusions as follows:

The British, on a per capita basis, buy less than Americans of many of the technological procedures discussed in this part of the book. They provide the same volume of care only for radiotherapy, bone marrow transplantation, and the treatment of hemophilia. At the other end of the spectrum lies coronary artery surgery; the British do only 10 percent as many procedures per capita as Americans. In a few instances, such as cancer chemotherapy, differences in clinical judgment may possibly explain all the differences between the number of patients cared for in Britain and in the United States. But in the case of such procedures as coronary artery surgery and CT scans, resource limits have led the British to sacrifice some medically beneficial information or treatment. The political process implicitly concluded that the benefits were worth less than the value of alternative objects of public expenditure.
The British would have had to spend an additional $1.030 billion around 1980 to have provided full care [i.e., the same level as the U.S.], and a total of $2.395 billion if intensive care is included. These amounts may seem modest by American standards or compared with the range of improvements that could be achieved. But it represents roughly an 8 percent increase over British hospital expenditures in 1980, 18 percent if intensive care is included. In a system that has managed annual growth in real outlays of only 1.5 percent a year, however, such increases would require a major change in the priority attached to health care. It is precisely such a change that neither Labour nor Conservative governments since 1975 have been prepared to make.

The most striking aspect of these comparisons is that the pattern of rationing evident in Britain is so uneven: Britain provides some services in negligible quantities and some at nearly the same levels as found in the much less constrained U.S. system. (Aaron and Schwartz 1984, 74–76)

This rationing is accomplished in Britain by a combination of several mechanisms. First, the central government sets an overall health services budget annually—usually increased little in real dollars over the previous year. This is allocated among individual hospitals and other health care institutions through a series of bureaucracies at the national and regional levels.

Second, within the hospital, allocations are usually made by the senior consultants, a group of physicians who work exclusively in one institution and are salaried by it. Capital expenditures, allocations of beds by clinical services, and similar decisions are explicitly regulated by these consultants. "Nominally, there are no limits on the physician’s ability to command pharmaceutical supplies. But in fact, financial stress results in sharp real restraints on the physician’s nominal clinical freedom." (Aaron and Schwartz 1984, 55). For example,

in one large teaching hospital, we learned, the clinical interests of a consultant led to a steady growth in his expenditures on TPN [total parenteral nutrition]. As others began to prescribe it, rising costs pushed the hospital pharmacy over its budget. To make room for the TPN, the chief pharmacist cut back on maintenance, staff, and other services. Eventually the medical staff imposed a limit on TPN service. . . . In the end, the staff decided to allow a maximum of six adult patients at a time to receive TPN. (Aaron and Schwartz 1984, 55)

Finally, the primary care physician serves as gatekeeper in the rationing process. Older patients in renal failure are not referred for kidney dialysis. Instead, they are told that "nothing more can be done." If any are bold enough to seek out a dialysis center on their own (and remarkably few do so), they are likely to be accepted for treatment, in spite of a general agreement not to provide dialysis for patients over age 55 or so. (Aaron and Schwartz believe this form of rationing would not likely succeed in the United States. Patients would not accept the gatekeeper’s denial of access to advanced care without protest.)
2.3.3 Professional Responsibilities  Physicians have not failed to show concern for the issue of cost increases. As one indication of professional interest, the index for the latter half of 1984 (volume 311) of the New England Journal of Medicine contained 28 articles under the heading "Cost."

The central question here is what the role of the physician should be in the attempt to control health care costs. Should these decisions be made by others in the society, or should the responsibility for making them be the physician's?

A. Dr. Jekyll and Citizen Hyde  The ACP Ethics Manual proposes a dual role for physicians: as citizens, a zeal for holding down health care costs, but as physicians, an equally forceful zeal for providing every beneficial resource for patients.

Patient Advocacy and Conflicting Interests

Under the covenant of personal medical care the physician is ordinarily the advocate and the champion of his patient, upholding the patient's interests above all others. All too frequently, however, the physician is forced to serve conflicting interests. For example, . . . he may at one moment serve society in the painful but necessary task of allocating limited resources, and in the next moment, quite properly, reverse his role and function as the patient's advocate under these circumstances. The patient's welfare must always be the physician's prime concern, but no one can avoid these moral dilemmas. In such cases the physician must act with sensitivity and without duplicity making it clear to the patient and understanding it himself when other interests are being served and to what extent secrecy and trust have been infringed. [ACP 1984a (Manual), 13; 1984b (Annals), 134]

Obligations of the Physician to Society

Like any other good citizen, the physician should strive for the well-being of the community and of society. He should work toward ensuring the availability of adequate medical care for all individuals and should support community health endeavors. In particular, he should seek to use all health-related resources in a technically appropriate and effective manner and to husband limited resources. . . .

In addition, the physician has [the] following special obligations:

4. To be aware of the limitations of health services resources, such as material and personnel, and to participate with others in exercising restraint in the expenditure of these resources.
5. To be aware of the costs of care and to provide care in the most efficient manner. [ACP 1984a (Manual), 18–19; 1984b (Annals), 135–136]

Resource Allocation

The physician has a particular responsibility to his patient in a world of increasingly limited financial resources. The guiding principle must be that the
physician should concentrate his energy and attention on providing the patient with the best possible medical care within the context of practicing humanistic, scientific, efficient medicine. In the event that external pressures resulting from limited institutional resources prevent the physician from providing optimal care, he must decide whether it is appropriate to advise the patient of the nature of the situation. In the final analysis, no external factors should interfere with the dedication of the physician to provide optimal care for his patient. [ACP 1984a (Manual), 31; 1984b (Annals), 266]

The puzzling question is whether the roles of citizen and physician can be kept separate in the way this position requires. Can Citizen Hyde become Dr. Jekyll without the inappropriate attitudes of the former role infecting the latter? For example, can a physician who spends the morning forcefully endorsing cost-containment goals abandon this attitude in the afternoon upon encountering a patient who is obviously abusing himself and the health care system? Can the principle of loyalty to one's patients be fully honored unless one does shed these attitudes entirely?

B. Patron Saint Some commentators feel that these two roles cannot be combined appropriately. Thus they put the entire emphasis on the side of Dr. Jekyll and patient advocacy, leaving it to others to serve as Mr. Hyde:

Physicians can help control costs by choosing the most economical ways to deliver optimal care to their patients. They can use the least expensive setting, ambulatory or inpatient, in which first-class care can be given. They can eliminate redundant or useless diagnostic procedures ordered because of habit, deficient knowledge, personal financial gain, or the practice of "defensive medicine" to avoid malpractice judgments.

However, it is society, not the individual practitioner, that must make the decision to limit the availability of effective but expensive types of medical care. . . . If society decides to ration health care, political leaders must accept responsibility. David Owen, who is both a political leader in Britain and a physician, believes that "it is right for doctors to demand that politicians openly acknowledge the limitations within which medical practice has to operate." I agree and would add that doctors are entitled to lobby vigorously in the political arena for the resources needed for high-quality health care. (Levinsky 1984, 1575)

C. Dancing (as gracefully as possible) to Another's Tune The following commentator agrees with the substance of much of the previous position, although his attitude is quite different. He suggests that a process of external limitations on resources could work fairly smoothly.

A major concern is whether attempts to control the use of health-care resources will affect the health of the population. Opinions differ concerning this question, and no one knows the answer with certainty. Some health experts contend that it is possible to cut expenditures substantially without seriously affecting health. They claim that some care—say, 10 per cent—is actually harmful to patients, that they
would be better off without it. It is not difficult to believe that another 10 per cent has a relatively low yield even though there may be a slight benefit. Thus, if cuts were concentrated on the 20 per cent that had a negative or low yield, the overall effect on health would be small. But that is a big “if.” Two major problems stand in the way of such an outcome. First, much of medical practice lacks a firm, quantified, scientific base; therefore no one can be certain just which care should be cut. Second, even as clinical experience and systematic research reveal which hospital admissions, operations, x-ray procedures, prescriptions, and the like can be forgone without harm (or even possible benefit) to patients, there is no guarantee that medical practice will be modified accordingly. Media hype, irrational patient preferences, distorting insurance coverage, and perverse incentives for health care professionals and institutions may result in a pattern of care that is far different from the ideal.

What needs to be done? First, the nation’s practitioners, hospitals, and academic medical centers must launch a major effort to identify the benefits that patients receive from the various components of the $400 billion that is spent annually for health care. Second, experts on health-care policy need to continue to press for reforms in organization and finance that will lead patients to want, and health professionals to deliver, more cost-effective care.

... For physicians to have to face these trade-offs explicitly every day is to assign to them an unreasonable and undesirable burden. The commitment of the individual physician to the individual patient is one of the most valuable features of American medical care. It would therefore be a great mistake to turn each physician into an explicit maximizer of the social-benefit/social-cost ratio in his or her daily practice.

... Health-plan managers, hospital administrators, insurance-company executives, and governmental officials will ... make difficult decisions about the allocation of scarce resources. This shift in the locus of decision making will inevitably reduce the power of practicing physicians. To the extent that these decisions set the constraints within which individual practitioners function, however, there will be less need for them to ration care to their patients explicitly. (Fuchs 1984, 1573)

D. Professional Discretion Other commentators maintain that the most satisfactory locus of decision in limiting resources is in the framework of clinical decision making:

These new medical techniques require a shift in standard medical practice. Instead of stopping treatments when all benefits cease to exist, physicians must stop treatments when marginal benefits are equal to marginal costs. But where lies the point at which marginal costs equal marginal benefits? And who is to make this ethical decision—the patient, the doctor, some third-party payer? And how

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7. It is hoped that this new decision locus will not be less pertinent to patients’ needs.—Authors
do we as a society decide that we cannot afford a medical treatment that may marginally benefit someone?

... One answer is that third-party payers can write rules and regulations concerning what they will and will not pay for and can prohibit their clients from buying services that are not allowed under the private or public insurance systems. This is essentially how the British have kept health-care spending at half the American level.

Such a procedure works, but it works clumsily, since no set of rules can be adjusted to the nuances of individual medical problems. It will be far better if American doctors begin to build up a social ethic and behavioral practices that help them decide when medicine is bad medicine—not simply because it has absolutely no payoff or because it hurts the patient—but also because the costs are not justified by the marginal benefits. To do this we are going to have to develop and disseminate better information on the cost effectiveness of alternative medical techniques for treating different ailments. Some small fraction of what we now spend on health care could be better spent to determine the limits of health-care expenditures under different circumstances.

The medical profession now has professional norms concerning what constitutes bad medical practice. Those norms have to be expanded to include cases in which high costs are not justified by minor expected benefits. If such norms are developed and then legally defended against malpractice suits, it just may be possible to build up a system of doctor-imposed cost controls that will be much more flexible than any system of cost controls imposed by third-party payers could be. But if the medical profession fails to do this, sooner or later the United States will move to a system of third-party controls. Something will have to be done. (Thurow 1984, 1569, 1571)

Intriguing to consider is whether a limitation imposed by third parties would be more palatable to the public than one imposed by physicians. The responsible agent may have to bear a significant brunt of criticism, for in a field as inexact as medicine, attempts to limit treatments are bound to have negative outcomes in some cases.

Hiding from the public the rationing effects of these decisions would clearly be dishonest. Calabresi and Bobbit (1978) indicate that it is not uncommon to shield the implications of what they call "tragic choices" from conscious awareness, because people find it intolerable to admit that they are willing to put a price on human life. This is another conflict of fundamental values, similar to the question of whether to inform a patient of a diagnosis of terminal illness. Here the question is whether to impose an unpleasant awareness upon the society as a whole. It must be decided whether peace of mind is worth the price of self-deception and/or dishonesty toward others. It will be difficult to reach a social consensus on the issues of justice involved in these choices, but it would be self-defeating to assume, before making any attempt at an explicit social consensus, that one is impossible.
2.3.4 Exercise: Cost-Control Measures  Continue the exploration of realistic assumptions begun in Section 2.2.5. Consider various cost-containment approaches, answering the following questions about each:

1. What are the possibilities for exploiting the system?
2. What are the likely consequences of exploitation?
3. What safeguards against abuse are inherent in the system?
4. What tendencies are inherent in the system that would sacrifice other values (e.g., justice, compassion, professionalism) in pursuit of cost control?
5. What cost-control strategy do you find most satisfactory overall? Why?
6. Test Case: The Self-Insured Patient. Nowadays most patients either have third-party sources of payment (at least for hospital expenses), or it is obvious that they will become a "write-off." Occasionally, however, a patient makes a serious commitment to pay the costs of his care from his own pocket.
   a. Do you find yourself more conscious of cost in choosing diagnostic tests, etc., for this sort of patient than with insured patients?
   b. If so, reflect on the differences. There are three possibilities:
      1) The level of care this patient receives is substandard, and that which others receive is quality care.
      2) The differences between these patients make no difference to the quality of their care.
      3) The level of care this patient receives is optimal, and other patients are really overtreated.
   c. Which is most often the case, in your judgment?
   d. Could the treatment received by the self-insured patient serve as a model for cost-appropriate medicine? If not, perhaps it could serve as a negative example, i.e., as a limit that cost-control measures should not be allowed to reach.

2.3.5 DRGs, PPOs, and Other Alphabetical Mysteries* Social forces have already set in motion programs to attempt to control costs. These have given rise to a confusing variety of acronyms, as well as to more serious frustrations in clinical decision making. And yet the public appears not to recognize the negative consequences of rationing health care. A typical reaction is an article that appeared in Scripps-Howard Newspapers on the first anniversary of the implementation of DRGs, concluding:

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8. PPO: Preferred-provider organization.
The year-old federal program that tells hospitals how much they can charge Medicare patients for specific treatments is credited with curbing hospital costs after a 17-year-long climb. . . . With surprising unanimity, federal and hospital officials agree the new payments formula is dramatically changing the way hospitals care for their patients. (Kirkman 1984)

Claims made in the article are cited below (with the article’s explanations) and are followed by questions not examined in the article (or in much of the other public reaction to health care cost containment):

1. ITEM: “Hospital prices this year have risen only 4.8 percent, compared with 12 percent last year and 19 percent annual increases in the late 1970s.”

2. ITEM: “The average hospital stay has declined from 9.5 days a year ago to 7.5 days.”

Explanation: “Hospitals no longer are admitting patients early and keeping them a couple of extra days to fatten the hospitals’ Medicare payments.”

Question: a) To what extent was a desire “to fatten the hospitals’ Medicare payments” an influence in admission and discharge decisions in the past? b) What should a physician do with regard to patients for whom complications make it medically advisable to keep them in the hospital longer than the standard formula allows?

Explanation: “If a hospital unnecessarily delays a patient’s care for one day, it now costs the hospital $500 to $600 the hospital no longer can recover.”

Question: What should a physician do if he or she judges that the patient’s medical condition dictates postponing the next diagnostic test until tomorrow, although this will delay the patient’s care one day and thereby cost the hospital $500 to $600 that the hospital no longer can recover?

Explanation: “The old hospital game of admitting patients on Friday to fill up the hospital with paying customers is a thing of the past.”

Question: a) To what extent was the desire “to fill up the hospital with paying customers” an influence in admission and discharge decisions in the past?” b) What should a physician do if he judges that this patient is too sick to be cared for adequately at home over the weekend, but the surgical team cannot be assembled until Monday [especially given recent staff cutbacks (see item 3)]?

Explanation: “We’re bringing patients into the hospital now on the day they’re due for surgery, not the night before.”
**Question:** This necessitates leaving preparations for surgery to the patient. a) Are patients willing and able to accept this responsibility (e.g., to avoid taking anything by mouth after midnight, to give oneself an enema, to initiate presurgical antibiotics and other medicines)? b) If a patient forgets or misunderstands these instructions and harm results, should the hospital be immune from liability for damages?

**Explanation:** "Our doctors are getting patients in and out of the hospital more quickly."

**Question:** This requires cutting corners on the "margin of safety": discharging patients at a stage when the odds of their escaping complications are (e.g.) 80% instead of the past practice of waiting until a stage at which the odds reached (e.g.) 95%. Is the cost savings worth this added risk?

3. **ITEM:** "Hospitals have laid off tens of thousands of employees, the first time staffs have been cut since World War II. . . . Most hospitals are reducing their staffs by attrition, but there have been some big layoffs at some hospitals, mostly nurse's aides, lab technicians, dietary workers, and maintenance workers."

**Question:** Can the quality of care be maintained at a satisfactory level with the reduced staff? Is the cost savings worth this added risk and inconvenience?

4. **ITEM:** "[H]ospital medical committees are providing cost data to their physicians so doctors can see whether they're making or losing money for the hospital. Physicians who are chronic money losers are given 'little talks' by the committees and advised to mend their expensive ways."

**Question:** How should a physician respond to such a "little talk"? If the physician is convinced that she has developed a pattern of practice that is in the best interests of her patients, to what degree should the physician be willing to modify (compromise?) this to "make money for the hospital"?

5. **ITEM:** In some hospitals, "doctor's requisition forms for X-rays and tests now show doctors how much each procedure costs."

**Question:** To what extent should the cost of a test be a factor in the physician's choice?

6. **ITEM:** Some hospitals "no longer admit patients with minor illnesses and injuries who would have been hospitalized in the past. Instead, the hospital treats these patients in the emergency room or out-patient clinics."
**Question:** a) Is this shift medically advisable? b) Are people willing to accept the added risk of complications that results from this policy? Should physicians and hospitals be immune from liability for harm that results from this policy? c) Are people willing to assume the added burden of care for family members that results from this policy? (For example, "He must have absolute bed rest for 48 hours. He cannot even get up to go to the bathroom. Elevate his leg at a 45° angle. Check his blood pressure every hour, day and night. If you note any change in mental status, call an ambulance immediately!")
d) Whose responsibility is it to decide whether the patient can safely be cared for outside the institution—the hospital, the family, the patient, the physician?

It is not clear how PPOs ensure that the physician bent on financially exploiting the system will not continue to do so. This sort of arrangement depends on cost shifting plus an expanded market as strategies for success, from the provider’s point of view. There are no additional assurances or guidelines to ensure upholding quality of care. It may be tempting to bring about cost savings by lowering quality of care. The ideal, of course, is to do away with unnecessary interventions and to keep beneficial ones. But to say this amounts to no more than advising the inquiring investor to "buy low and sell high." There is the danger in all these systems that the individual will be sacrificed for the sake of controlling cost. The show of concern for the welfare of the individual patient may be no more than a facade. One test of these systems will be their response to expensive rescue strategies. A certain number of these may be undertaken for symbolic purposes, or they may be avoided as "not worth the cost."

### 3 Reviewing Your Expectations

These questions are thorny and complex. Issues of justice, professional standards, and social expectations are woven together. Medicine’s importance is demonstrated by the zeal with which people attempt to ensure ready access to health-care services for themselves and those they care about.

Ultimately, your position on these issues will depend on your fundamental principles, values, and expectations. Go back to Chapter 1 and review the sets of expectations you enunciated, starting with the exercise in Section 1.1.

Consider the following questions.

1. Have your expectations altered as a result of working through this material? Note any changes.
2. Do you see possibilities you did not recognize before for frustration of expectations in medical practice? If so, think of ways to avoid these difficulties.

3. Do your expectations enable you to set priorities among the elements considered in this chapter?
   a. If so, what position do they lead you to?
   b. Are you satisfied with this position, or will you alter your expectations?

4. In light of your expectations from your professional life and changing definitions of what is medically important in our society, do you see a need to participate in political activity? If so, what sort of group would you find most appropriate and comfortable to work within?
   a. American Medical Association
   b. medical specialty organization
   c. voluntary organization of health care providers
   d. church group
   e. political party

Discuss the pros and cons of each of these groups as instruments to achieve your goals. Do you plan to discuss these issues on an ongoing basis as part of a group that has patients among its members, or will you keep these discussions “within the circle” of the profession?

By thinking these questions through, you can develop a coherent, comprehensive, and personally acceptable basis for confronting these issues, and for the decisions you are likely to face in your medical practice.

Sources of Items in Exercise, Section 2.2.3

2. ACP 1984a (Manual), 21; 1984b (Annals), 137: “Commercialization of Medicine and Other Conflicts of Interest.”
4. A paraphrase of a sentence in Current Opinions-1984, Section 4.04: “Health Facility Ownership by Physician” (pp. 14–15); the section is quoted in full in Chapter 3, Section 3.3.3. [NOTE: This statement is criticized by Relman (1980, 967–968).]
5. American Hospital Association (1972): “Patient’s Bill of Rights.” A similar provision is contained in the statement “Health Facility Ownership by Physician” in Current Opinions-1984, which is quoted in Chapter 3, Section 3.3.3.
6. Cf. Current Opinions–1984, Section 4.04: “Health Facility Ownership by Physician” (quoted in Chapter 3, Section 3.3.3.) Cf. “In the case of personal conflicts the moral edict is clear. The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient. Collusion with nursing homes, pharmacists, or colleagues for personal financial gain is morally reprehensible” [ACP 1984a (Manual), 14; 1984b (Annals), 134: “Personal Conflicts of Interest”].


10. Authors’ construction—but it sounds much like desirable insurance company policy.

References


Further Reading


 Enthoven AC: Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care. Addison-Wesley, Reading MA, 1980.


 2.03 Allocation of Health Resources
 2.08 Costs
 2.16 Unnecessary Services
 2.17 Worthless Services
 4.04 Health Facility Ownership by Physician

 6.00 OPINIONS ON FEES AND CHARGES
 8.00 OPINIONS ON PRACTICE MATTERS


Advertising by Medical Professionals (Havighurst CC)

Aging and the Aged

I. Theories of Aging and Anti-aging Techniques (Harflick L)

II. Social Implications in Aging (Neugarten BL)

III. Ethical Implications in Aging (Christiansen D)

IV. Health Care and Research in the Aged (Young EWD)

Decision Making, Medical (Murphy EA)

Drug Industry and Medicine (Coulter HL)

Food Policy (Henriot PJ)

Health Care

I. Health-Care System (Lee PR, Emmott C)

II. Humanization and Dehumanization of Health Care (Howard J)

III. Right to Health-Care Services (Jonsen AR)

IV. Theories of Justice and Health Care (Branson R)

Health Insurance (Riesenfeld SA)

Health Policy

I. Evolution of Health Policy (Strickland SP)

II. Health Policy in International Perspective (Anderson O)

Hospitals (Williams KJ)

Justice (Feinberg J)

Kidney Dialysis and Transplantation (Fox RC, Swazey JP)

Life—I. Value of Life (Singer P)

Rationing of Medical Treatment (Childress JF)

Social Medicine (Silver GA)

Technology—III. Technology Assessment (Walters L)


See especially Chapter XII: "Costs and Allocation of Scarce Resources."


