Donating Your Health Care Benefits
by John Hardwig

To encourage altruistic behavior, we need to develop programs in which patients can offer to others the costs of medical care they have a right to claim.

We have devised a health care system that effectively discourages sharing of medical resources. In concentrating on responding to the needs of self-regarding health care consumers, the responsibilities of patients to share scarce resources has been neglected. We need to change both our theory of medical ethics and our health care system to encourage rather than discourage decisions to share resources, a thesis I will develop with particular reference to decisions by competent patients who have terminal illnesses but whose deaths may or may not be imminent. Although sharing is by no means a virtue for them alone, decisions by the terminally ill provide an illuminating context in which to consider sharing medical resources.

In most dimensions of life, we encourage altruistic behavior. We want people to consider the welfare and wellbeing of others when they

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make choices. But the virtue of sharing disappears when we talk about health care. The patient is encouraged to act exclusively for his or her own benefit: it is considered appropriate to claim all the health care one can.

The ethic that encourages this behavior stems partly from a laudable attempt to assert an affluent society's obligation to meet the health care needs of its members, regardless of their ability to pay. But it also results from the less laudable habit of viewing ethics as a discipline that floats serenely above the unhappy reality of economics: "How can you place a monetary value on the life of a human being? If we are worth more than any amount of money, surely we should consume health care services without regard to cost."

This ethic is supported by our religious conception of the sanctity of human life and our Western ideology, which claims that the way to die is courageously, fighting death every step of the way. Of course, a competent adult has a moral and legal right to refuse medical treatment. But we still feel that the only morally appropriate reasons for not wanting medical care are self-centered ones.

Clearly, refusing treatment because of cost is sometimes tragic, the result of injustice. But it is equally clear that, given the cost of medical care today, we cannot all have all the medical care we want. We can now spend $500,000 or more on heroic measures to extend the life of a dying patient. And it will soon be possible—technically, if not economically—to spend that kind of money on an increasingly broad spectrum of dying patients. But we cannot afford for many of us to die that way, not even if we trim the fat and inefficiency from our health care system—not even if we were willing to make dramatic cuts in our spending for defense, education, nonmedical welfare, public works, and personal consumption.

By pouring money into expensive and often only partly successful heroic measures for a few people at the expense of more commonplace measures for more people, we add a little time of seriously impoverished quality to some lives instead of saving many other lives that could last longer and be of much higher quality. Thus, a terminally ill patient who is considering what treatment to request ought to be encouraged to calculate the costs of the alternatives in making his or her choice.

This would not be incompatible with our deeply held commitments to the autonomy and the dignity of the individual, or even the sanctity of human life. Whenever there are not enough resources to give all individuals everything they want or need, it is more in keeping with the autonomy and the dignity of all individuals and with the sanctity of all lives if some choose to share their health care resources than if some are forced to share or if some are deprived due to inability to pay, barriers to access, or the fact that the victims of our rationing are out of sight and out of mind.

But what is the practical result of refusing aggressive treatment if I want it? Will I then save any lives, contribute to anyone's health, or even share the available medical resources? Not under the present system. We need to develop programs under which patients can donate the costs of the medical care they have a right to claim to others in need.

Providing this alternative would require a basic change in the way insurers (public and private) think about the benefits they pay. Data are or will soon be available to allow us to predict the average costs of maximal, aggressive therapy versus minimal, palliative care for any given patient. This information could be used to allow the patient to donate the difference between the two. The donations could be made either by competent adult patients with terminal illnesses or as parts of advance directives. (Perhaps even "health care donor" cards would be appropriate.) To make the gift as tangible to the donor as possible, donations should be allowed to specific medical research programs, to programs providing specific kinds of medical care, or even to specific individuals.

Would such a program be palatable to third-party payers and the medical establishment? To offset the additional costs third-party payers would incur from donations by those who would have refused aggressive treatment anyway, all individuals could be permitted to donate a portion—adjustable with experience—of the health care costs they have saved. Since donations could be made only for medical treatment, the health care industry as a whole would not suffer (though certain individuals, medical specialties, and corporations might). It thus seems that such a program could be made to work within our present health care system.

Of course, a program of this sort could be abused. It would be crucial that such donations not be used to replace existing health care funding, for that would defraud the donor. There could also be real tragedies if anyone, especially the poor or those society finds unattractive or worthless, were pressured to donate their health care benefits. Safeguards would have to be designed to limit such abuses. But if it is morally permissible and even admirable to refuse aggressive terminal care out of an ethic of sharing, then we should be able to design a program to allow such sharing that would likewise be morally sound.

Realistically, how many Americans are going to forgo aggressive medical treatment in order to share resources? Wouldn't this represent an extreme and unreasonable self-sacrifice that very few would be willing to make?

On one level, the answer depends on how we perceive our society. It might turn out that the "bad times" of serious illness would call forth a community of suffering with more willingness to sacrifice for others than we, the healthy ones, are able to muster. Or it might not. We would have to try to find out.

On a deeper level, if I am ill and debilitated and the prognosis is bad, the life I sacrifice will often be short and of low quality. Such life may not be an unmitigated good. The end of my life may be a good deal more meaningful to me (and to my family, as well) if I can make a gift of life or health to someone else. Here, as in other dimensions of life, those who act out of regard for others may not see their actions as a sacrifice. Like a self-centered life, a self-centered death may turn out to be neither moral nor meaningful.