ROBIN HOODS AND GOOD SAMARITANS: THE ROLE OF PATIENTS IN HEALTH CARE DISTRIBUTION

ABSTRACT. There are good reasons—both medical and moral—for wanting to redistribute health care resources, and American hospitals and physicians are already involved in the practice of redistribution. However, such redistribution compromises both patient autonomy and the fiduciary relationship essential to medicine. These important values would be most completely preserved by a system in which patients themselves would be the agents of redistribution, by sharing their medical resources. Consequently, we should see whether patients would be willing to share before we resort to surreptitiously redistributing their resources or denying medical care to some who want and need it. We should change our health care payments systems to allow patients to donate their medical benefits to those in need.

Key words: Allocation of resources, Altruism, Autonomy, Cost-shifting, Patient ethics.

I

Health care is already being distributed. It has always been scarce and it has always been distributed, sometimes by royal prerogative, sometimes by church edict, sometimes by governmental decree, often by the market. And physicians have always had some role in the distribution of health care resources—they have almost always decided how to distribute their own time among the cases assigned to them, if nothing else. In our society, of course, physicians have traditionally determined the distribution of a great deal more than their time. Physicians have acted as gatekeepers, deciding who received and who did not receive medical care. And after patients have been admitted into the medical system, physicians have made most of the decisions about what kind of treatments these patients did or did not get.

But very important changes in the physician’s role in health care distribution are now afoot. The changes currently drawing most attention are those driven by cost containment efforts. For example, hospitals, facing DRG reimbursement schedules and a variety of cost containment measures by private insurers, are trying to limit the physician’s role in distribution decisions within the hospital. Some form of these changes is probably inevitable: hospitals cannot contain their costs unless they can control the cost-generating decisions of the physicians who practice in them. There are, of course, many critical questions—economic, social, political, medical, and moral—about the form these attempts to control

physicians' distribution decisions should take. But I will try to ignore most of these questions.

Instead, I wish to begin by considering the position which advocates increasing, rather than limiting, the physician's role in health care distribution. Since medical goods, like all goods, are already being distributed — in our society, most commonly by the market — those who advocate an expanded role for the physician in distribution decisions do so because they are interested in redistributing medical goods and services. The physician, on this view, becomes an agent of health care redistribution.

Should we expand the physician's role in health care distribution in order to effect a redistribution of health care resources? When put this way, both the attractiveness and the unattractiveness of the proposals for doing so stand out more clearly. A brief examination of the pros and cons of the physician as health care redistributor will make clear the rationale for my own view: patients should be given a much larger role in health care distribution. Patients should be encouraged to share their medical resources with those in need. Strange as this idea may sound, sharing by patients is, I shall argue, more in keeping with central features of our medical ethics than other methods of redistribution.

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There is a medical as well as a moral reason for the desire to redistribute health care resources. The moral reason is clear enough: people are dying, and their health and lives are being needlessly ruined because of the present distribution of health care. The human cost of lack of access to health care, most often due to inability to pay, is evident (even if often ignored). And cost-containment measures, both public and private, will surely increase the number of Americans who lack access to the medical care they want and need.

The medical reason for redistribution of health care has, however, often been overlooked. It stems from the fundamental humanitarian purpose of medicine, which is to heal the sick. A concept of medical efficiency grows out of this purpose, and it amounts to getting health care resources to those who can best benefit from them. From this perspective, it is illness (or the threat of illness) and the ability to respond to available treatments, not the ability to pay, that calls for medical care. Those who are ill and able to respond are simply not always the same as those who are financially able to command medical resources. Therefore, so long as medical resources are distributed by the market, they will not be used with medical efficiency. This is the medical reason behind the impulse to reallocate health care resources.

To the extent that physicians and other health care professionals, hospitals and other health care institutions, are imbued with the fundamental purpose of their mission, we should expect them to feel some deep loyalty to medical efficiency, and thus some desire to redistribute health care resources whenever medical efficiency is not well served. Although this desire to redistribute is often obscured by the business of medicine, it is no more than faithfulness to one's medical calling.

Nor is the desire to redistribute an empty ideal: it is an important part of American medical practice. Both physicians and hospitals have in fact been acting as agents of redistribution for at least the past few decades. Hospitals, for example, have been cost-shifting — padding their charges to paying patients in order to offset the costs of treating non-paying patients. And many physicians have done the same. This method of redistribution has been a major source of health care for those unable to pay.

But there are also important objections, both moral and medical, to the whole project of redistributing health care resources. We can see these objections by noting that there are no "free-floating" resources to be distributed. All the resources are already distributed. They already belong to someone, and decisions (both private and public) have already been made about how much of those resources are to be devoted to health care. And for whom. Thus, to see either the physician or the hospital administrator as an agent of redistribution is to envision him in the role of a latter-day Robin Hood, taking resources from the rich (or medically rich — the well-insured) and giving them to the (medically) indigent.

However, like their earlier counterparts, latter day Robin Hoods can justify their redistributive efforts only by an appeal to some general theory of justice that would show that people are not really entitled to what they now own. Or else that they can not legitimately use what they own to purchase additional health care. And even if a theory of justice were able to show that redistribution of resources, especially health care resources, is in order, serious questions would remain about whether Robin Hoods (physicians and hospitals) are the appropriate agents to effect such a redistribution. Taxes and/or donations, for example, seem to be much more justifiable institutions of redistribution. These are formidable theoretical obstacles.

Backed partly by just these considerations, the government, insurance companies, and businesses are moving to halt the redistribution practices of physicians and hospital administrators who shift non-paying patients' costs to paying patients. And why shouldn't they stop it? After all, it's
their resources — or those of their members — that are being redistributed. It's one thing for my health insurance company to ask me (or my employer) if I want to purchase insurance, part of the cost of which will go to provide care for the medically indigent. Then my support would be above-board and voluntary. But it's quite another thing for a hospital or physician to over-charge patients who are covered by my insurance company, thus surreptitiously passing the cost of treating non-paying patients onto it and then onto me (in the form of higher premiums or less coverage for the same premium). Since it's my money that my insurance company is paying out, my insurance company, acting as my agent, has every right to try to halt this surreptitious redistribution of my resources by hospitals and physicians.

Third-party payers are doing precisely that. The government insurance companies, and employers are rapidly developing both the database and the methods necessary to eliminate this practice of subsidizing the health care of the poor by transferring its cost to paying patients. Soon hospitals and physicians who attempt to redistribute resources in this way will no longer be among the treatment options available to the insured (or their charges will not be fully covered by insurance — which will usually be more disastrous to such physicians and hospitals).

Thus, the methods by which physicians and hospitals have been acting as agents of redistribution will soon be very difficult, if not impossible, to practice. And the methods that hospitals and physicians would have to use in order to continue to redistribute resources seem even more open to ethical challenge. For, whereas formerly it was primarily financial resources that were being redistributed and channelled into paying for medical care for the poor, it seems likely that redistribution will increasingly be a redistribution of medical resources. And that is a much more serious matter.

Although I may have formerly paid too much — since my bill was padded to cover the cost of care for the poor — I received optimal medical treatment from my physicians and hospital. Money was being taken from me, but my health care remained intact. With the advent of “DRG-like” systems of payment and capitation, hospitals and physicians will be able to gather resources to redistribute only by treating paying patients at below the expected or average cost. Although this can sometimes be done without any compromise in the quality of care, there will also be a consistent incentive among would-be redistributors to cut costs by doing less for the paying patient — by not ordering an expensive set of laboratory tests, by cutting back on staff, by not using rehabilitation programs or trying to begin them sooner, by discharging patients from the hospital earlier, by withdrawing aggressive terminal care sooner, etc. Thus, if physicians and hospitals continue to redistribute resources, it will increasingly be medical care — and not just financial resources — that will be redistributed.

And how would this kind of redistribution of medical resources by physicians be other than surreptitious? Not only money, but the lives and health of people, hang in the balance of this sort of redistribution. Could we really expect totally candid conversations like the following? “We’re not completely sure what’s wrong with you, Mr. X. We could do another set of tests and your insurance would pay for them. But those tests are expensive and we don’t think we’d probably find out anything useful from them. So, we’ve decided to save them for some other patient where there’s a greater chance of learning something useful.” Or: “Although you could probably use another couple of days in the hospital and some physical therapy as well, Ms. Y, we’re going to discharge you with some instructions for exercises you can do at home. Because then we can use the hospital bed and physical therapy for someone who needs it worse than you and who, unlike you, doesn’t have insurance to pay for them.” To say nothing of: “We know that you can afford it and that you want us to prolong your life as long as possible, Mr. Z. Putting you on a ventilator would do that, but …”

Such conversations would be required by strict adherence to the canon of truthfulness to patients. But they would also cause great suffering and outrage on the part of patients. For this sort of redistribution would deprive patients of the right to use their legally acquired resources (money or insurance) to purchase the health care they want and need. Partly for this reason, such conversations will certainly not often take place. But even if they did take place, such redistribution efforts would take an enormous toll on the fiduciary relationship between doctor and patient and on the autonomy of the patient, as well.

Thus, there is also both a medical and a moral objection to physicians and hospitals playing the role of Robin Hoods. The medical objection is that redistribution strikes at the heart of the fiduciary relationship that is crucial to our conception of the practice of medicine. For a physician who is also an agent of redistribution cannot be trusted to be single-mindedly devoted to her patient’s well-being.

The moral objection to both the traditional and the current methods used by physicians and hospitals to redistribute resources is that they run afoul of the requirement of patient autonomy. Indeed, the basic moral objection of any scheme for redistributing resources by someone other than the person to whom they belong is that the autonomy of a person is
More specifically, we need to introduce the virtues of consideration of others and sharing into medical ethics. Indeed, an exercise of patient autonomy unrestrained by these virtues will guarantee that the autonomy of other patients — or prospective patients or future patients — will not get respected. For there simply are not and will not be sufficient health care resources to give everyone all they want and need. It is only through the virtues of consideration of others and sharing that the autonomy of one can be made compatible with like autonomy for all the rest.

In most areas in which we face scarce resources, we doubt that an optimal — or even a fair — distribution of these resources will result from all-out competition among egoistic claimants. So we encourage people to think about others. We want them to share. But we seem to think that patient ethics is anomalous: when it comes to patients and their consumption of medical resources, we forget about the virtue of sharing. Quite the contrary, we usually encourage patients to think only about what kind of future they want for themselves when making decisions about their treatments. We thus implicitly encourage patients to consume as much medical care as they want and can lay claim to, without consideration of others. But if, in areas outside of health care, we doubt that competition among egoistic consumers will result in an appropriate distribution of goods and services, we should be especially skeptical that it will do so within the realm of health care. If only because serious illnesses generally prevent people from competing effectively.

It is appropriate, of course, for competent patients to make decisions about their own treatments. That is the core of patient autonomy. However, treatment decisions very often have ramifications for the distribution of health care resources. Patients empowered to make treatment decisions are thus already acting as agents of distribution. They are already making decisions about the allocation of resources.

The only alternative to allowing patients to make decisions that affect the allocation of resources is to dramatically limit their autonomy by refusing to allow them to choose expensive options. We are, of course, moving rapidly in precisely this direction. Especially with poorer patients. And the imminent danger is that we will even further truncate the autonomy of patients — especially, again, of poor patients — by not even letting them know that there are efficacious but expensive treatments that are being denied them. “I’m sorry, there’s nothing more that we can do for you.” What they don’t know won’t hurt them. Perhaps. In any case, their not knowing certainly prevents them from getting angry with us.

It is my contention, then, that because the right to make treatment decisions involves ramifications for the allocation of health care resources,
patient's right to make her own treatment decisions involves the responsibility to make those decisions responsibly — i.e., in light of the consequences of those decisions on the resources available for the health care of others. Thus, so far from it being appropriate for patients to make exclusively self-regarding treatment decisions, patients have a responsibility to think of others when making these decisions. They have a responsibility to share.

Presenting a sick person with the possibility of sharing health care resources would be no easy task, and would require more candor and honesty with the patient than any form of redistribution by physicians. There would have to be great sensitivity and openness, and no trace of coercion or manipulation, in these discussions. However, if so conducted, such discussion would enhance rather than destroy the fiduciary relationship between physician and patient. For such discussion treats patients as full-fledged moral agents — i.e., as adults — while making it clear that the patient is free to choose not to share, that the very idea of sharing presupposes that the resources are the patient's, and that the physician or hospital will not surreptitiously redistribute those resources behind the patient's back.

If it is objected that it would be very hard for patients to decide to share their resources, I would agree. It would often be very hard. Indeed, it would mean that most of us will, sooner or later, have to face the fact that our lives simply are not worth the resources it would take to prolong them, relative to the value of other lives that could be saved with those resources. But that is the burden of autonomy. If we can not or are not willing to shoulder the responsibilities of such momentous decisions, we should admit that the defenders of paternalistic medicine have been right all along.

As things now stand, we often assume that even competent patients are self-centered and incapable of considering the needs of others. But patients, too, are capable of altruism and of sharing with others. Thus, if I am correct, patients may need to be reminded of the distinction between making an autonomous decision and making a self-centered, even selfish decision. We must not, under the guise of respect for autonomy, implicitly encourage patients to consider only what is best for themselves when making medical decisions. On the contrary, they should be encouraged to share.

So, patients need factual information. They need to be told how much different treatment options will cost, and they need to be given this information even if they have insurance to cover these costs. They should also be told about other demands for these resources. The prevailing assumption now seems to be that this information is not relevant or important to patients who will not have to pay these costs out of pocket. And this assumption shows, again, how deep is our belief that self-regarding considerations are the only considerations that are or should be relevant to a patient's medical decisions. But that assumption is not only false, it is dangerous — it is one factor creating the misallocation of health care resources that we now have before us.

Thus, if we are to combine patient autonomy with even an approximation of the morally and medically best use of health care resources, we must attempt to sensitize ourselves as patients to the health care needs of others. In other words, if we patients are to be allowed to make medical decisions, we need to learn to share in the humanitarian value of medical efficiency. We need to learn to want health care to go to those who can best benefit from it. And to recognize that they will not always be us.7

But I do not think that it will suffice to inform patients of the costs of their treatments and of the possibility of sharing their medical resources with others. For our present third-party payment system effectively precludes the possibility of any meaningful sharing of resources. Suppose a patient refuses on principle to use all the resources she can claim. As things now stand, her decision will not save anyone's life, improve anyone's health, or even get additional health care resources to anyone. Her decision will only save all taxpayers 1/2 cent on their taxes or the subscribers to her insurance company a dime on their policies. And these are clearly not sufficient incentives to forego maximal treatment for oneself.

Our third-party payment systems are simultaneously both the heroes and the villains of this situation: although they quite appropriately support patients who need more medical care then they could afford to purchase out of pocket, they also effectively discourage altruism and sharing by patients. In fact, by spreading the risk and by making the marginal cost of additional health care minimal, third-party payment systems effectively encourage increasingly lavish consumption of health care.

With present third-party payment plans, any one patient's decision about how much medical care (and hence medical resources) to consume will have minimal financial impact on anyone. Medical treatment decisions can, therefore, often be made without regard to cost. That might seem to be just as it should be. But demands that are both cost-free and cost-unconscious naturally escalate. And the aggregate of all patients making
rapidly escalating demands is threatening to bankrupt our health care system. The resultant soaring health care costs are already medically disenfranchising the poor and also the near poor who simply cannot afford the increased cost of health insurance.

We are, quite simply, in a condition of scarcity: health care resources are and will continue to be insufficient to meet the need. In such a condition, we can (1) force some to do without the medical care they want and need, (2) force patients to "share" by refusing to allocate more than a certain amount to the treatment of their cases, or (3) decide to share our medical resources. Those are, at bottom, the only three options. As I have argued, the third is the best option because it maximizes autonomy for all while moving toward a distribution of health care resources that is both medically and morally appropriate. If so, we need a system that will encourage, rather than discourage, decisions by patients to share.

I would propose, then, that we restructure our health care payment systems to allow patients to donate the medical resources they refuse to others in need. Patients with public or private insurance that would pay for either a more expensive or a less expensive form of treatment should, if they choose the latter, be allowed to donate the difference between the costs of the two to those whose health care needs will not otherwise be met.

Donations should be allowed to medical research, to foundations that provide medical care for specific kinds of patients, to programs providing health care for the medically indigent (either locally or elsewhere), perhaps even to a specific individual. Allowing patients to donate their medical resources would support decisions to share by making the allocative implications of their decision real and concrete to patients and by guaranteeing that a decision to share would make a very real difference to someone in need of health care services.

Providing patients the option to donate the health care benefits they refuse would require a basic shift in the way insurers, private and public, think about the benefits they pay. But, so far as I can see, it would not require basic changes in our health care system, and thus might be made palatable to both insurers and the health care industry. By discounting the amount that could be donated to allow for those who refuse aggressive treatment anyway, the option of donating would not necessarily even be more expensive for insurers.

It might be objected that this proposal is too ridiculous to try, on the grounds that it is obvious that there would be almost no patients willing to donate their health care benefits. But I think we would just have to try it to see whether significant numbers of donations would be forthcoming. Other hard times often create community. Serious illness might do the same. Sick people might better empathize with their fellow sufferers and thus care more for the needy than we, the healthy ones, seem able to.

Moreover, although the less expensive treatment will generally be slower, less pleasant, or less effective (otherwise it would be the treatment of choice), we should not automatically assume that refusing the more expensive treatment in order to share would even be experienced as a sacrifice. On the contrary, donating health care benefits might turn out to be like donating organs or volunteering to participate in medical research: it might make serious illness (and death) more meaningful by alleviating the feeling of uselessness that often comes from the incapacities of illness. In the eyes of many patients, the opportunity to give someone else the critical gift of life or health might serve to redeem one's own suffering and incapacity. Other-regarding decisions add meaning to life. Hence they are not necessarily self-denying, even when they appear so on the surface.

There are, of course, many different ways in which the health care payment system could be reorganized to encourage patients to share their health care resources. I have suggested a simple gift to a stranger in need, inviting the patient to choose to be a Good Samaritan. That plan has all the deep beauty of a gift based simply on need. But other plans could involve tax incentives, insurance policies with built-in donations, the opportunity to bank health care resources for the future use of family and friends, or even a voucher system to allow donations by those who are not (yet) ill. Each of these plans needs careful scrutiny for its medical, economic, and moral consequences, but it is obviously beyond the scope of this paper (and perhaps of this author, as well) to examine any of these proposals in detail. I hope only to have indicated why the idea of patients as agents of redistribution deserves such careful consideration.

In a day in which the dream of providing complete health care for everyone has died and in which cost containment has become the byword, we need to think about basic alternatives. For our present methods of distributing health care resources will increasingly exact an unconscionable toll of human misery. One basic alternative begins by recognizing that patients, in making decisions about "their own" treatment, are already acting as agents of distribution. And that redistribution by means of patient donations would better preserve both patient autonomy and the fiduciary relationship between patients and physicians than any other method of redistribution. So we should see if we could devise a moral and workable system to allow and even encourage patients to share health care
NOTE S

1 To say this is not, of course, to deny that prevention, diagnosis, rehabilitation, patient education, etc., are part of medicine. And certainly of health care. But we are discussing the role of physicians and (rightly or wrongly) physicians have always been seen as healing as the core of their mission. Although consideration of other features of health care would complicate the points I want to make, I don't think it would alter them in any essential way.

2 The ideal goal of medicine may well be to do everything possible for everyone who can benefit at all. And there may be, in health care practitioners, a tendency that drives economics with the tendency to continue to treat each patient until the marginal return equals zero. But it is important to recognize that the notion of medical efficiency is a concept of efficiency and it is capable of responding to scarcities of health care resources rather than limited resources, the desire to heal the sick and the resulting concept of medical efficiency implies that we should treat/prevent those who are sickest and best able to respond. The ethics of triage in non-military situations is an excellent example of medical efficiency in a microcosm involving acute shortages.

3 Thus, there is reason to fear the passing of health care distribution decisions from the hands of health care professionals to the hands of businessmen, for it is not to be expected that businessmen will be as deeply motivated by the goal of medicine or what I have been calling medical efficiency. This is so even if many physicians become primarily businessmen. Thus, for those who would redistribute health care resources to provide better treatment for the poor, there is also reason to seek to preserve and increase the role of health care professionals in distribution decisions. And this is so even if physicians have too often been oblivious to the effects of fee-for-service medicine on medical efficiency.

4 It would, of course, be an oversimplification to say that it is only financial, not medical, resources that are being redistributed. For as the cost of medical care to paying patients rises due to cost-shifting, these patients are led to purchase less of this commodity. They then receive less health care, as well as paying more for the care they receive. Moreover, cost-shifting increases the number of medically indigent people: every time insurance premiums are raised to pay for cost shifting, more people (as businesses) decide that they simply can no longer afford health insurance. However, the main point - that it has so far been primarily financial, rather than medical, resources that have been redistributed - remains valid as a first approximation.

5 It might be worth pointing out that the idea of sharing does not presuppose that those in need have no right to health care. On the contrary, if someone's right to treatment is being denied, that is an even stronger reason to share with him than that his health care needs are not all being met. Thus, the concept of sharing by patients is neutral on the issue of whether or not the recipient has a right to the care he needs. I do think there is, in affluent societies, a right to at least a decent minimum of health care. However, I would also insist that there can be no right to have all one's health care needs met and that, consequently, there would be a need to share medical resources even if all the valid claims of everyone were being met.

6 Obviously, these points can be adequately grounded only in a complete account of autonomy: Are the responsibilities and even obligations that rest on patients an expression or a limitation of their autonomy? Do irresponsible, even immoral choices fall within the realm of autonomy or do they fall beyond it? Must the autonomy of one patient be compatible with like autonomy for other patients? If the choices of one patient destroy or compromise the autonomy of others, can those choices still be considered autonomous, or do they fall into the category of privilege, license, or self-indulgence, instead? Etc. Fortunately, it is equally obvious that an analysis of autonomy cannot be undertaken here.

7 I would argue that the ethics of proxy decision making for incompetent patients will also need to be reworked in light of resource allocation issues. And that would involve learning not to demand too much for those we love. But that is the story for another occasion.

8 In the short run, there seems to be a fourth, rather attractive option, — we can expand the amount of our G.N.P. devoted to health care. But this is only a short run solution: the explosion of efficacious but costly medical technology means that we cannot long avoid the nasty dilemma of scarcity by providing everyone with all the health care he wants and needs. And it may not be a real option even in the short run: we seem to be collectively unwilling to sacrifice other goods — defense, education, non-medical welfare, consumer goods, etc. — to increased health care for more of us.

9 For additional arguments for the moral permissibility of donating one's health care benefit, and for a slightly more detailed explanation of a health care payment system that would permit such donations, see my article, "Donating Your Health Care Benefits," Hastings Center Report, in press.

10 A method like the following could be used to determine how much could be donated. Suppose that the difference between the average cost of aggressive treatment and more conservative care for a given disease or illness is $30,000, and that 2 out of every 10 patients with this disease now reject aggressive treatment. Given the option of donating health care benefits, suppose we find that 2 more out of the 10 elect the less expensive care, thus saving our health-care system an additional $60,000. Since we cannot tell which of the 4 would have refused the expensive treatment anyway, each would be permitted to donate $15,000. The remaining 6 out of 10 provide the patients on which to test new therapies and also the pool from which to draw new data about the changing costs of aggressive treatment. Thus, the amount of health care benefits that one would be permitted to donate could be continually revised in light of new information about costs and also revised estimates about the percentages of patients electing the less expensive forms of treatment.

11 I wish to thank Mary Read English for many helpful suggestions about this paper.