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Eugene Vayda

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COMMENTARY: THE OREGON INITIATIVE: ETHICS AND PRIORITY SETTING

Eugene Vayda, M.D., F.R.C.P., F.A.C.P.†

CALLAHAN HAS GIVEN US a thoughtful analysis of the Oregon plan which proposes, by setting priorities, to substitute limited benefits for limited eligibility, but only for Medicaid recipients. He encapsulates the essential moral dilemma when he writes, "It could thus be said in the harshest construal of its meaning, that this is a targeted rationing program for the poor, setting limits for their care in a way that will not be borne by their more affluent fellow citizens; the poor, that is, are discriminated against by this plan and its context is that of a two tier economic society, now matched by a two-tier health care system." He asks whether the United States has accepted equal health care for all as a normative right and then concludes that the answer is "no", at least in practice, regardless of the rhetoric of public opinion. Given this political reality, he goes on to provide us with a detailed analysis of the Oregon plan.

He suggests that no firm conclusions will emerge from an analysis of the relative merits of "full eligibility and less coverage versus less eligibility and full coverage." He then proceeds ". . . from a consideration of the goals to that of the means designed to achieve them and problems of implementation." He feels that some needs are so preeminent that they "must 'trump' their way to the top of any priority list." This 'trumping', he feels, indeed I think he hopes, will compromise the entire priority setting procedure. However, here he misses the opportunity to comment on the unequal distribution of 'trump'. Most Americans have insurance or the money to buy additional 'trumps', whereas the poor and the uninsured may have to trade their health to obtain some 'trump'.

Callahan acknowledges the imperfections inherent in the priority setting process. He is uncertain of the success of that process and concludes that it will take a period of time to judge whether the

† Professor of Health Administration and Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada.

approach can pass the test of ethics. It would, he suggests, make sense to look at the process as a social experiment whose final test will be public acceptability. Yet, the social experiment will be a play within a play—a social experiment carried out on the poor for the edification of the larger, more affluent part of society. I would suggest that, as a minimum, informed consent is required.

Callahan concludes with a discussion of some of the problems of implementation. He suggests interest groups and special needs as staples of the American political process which will modify, or perhaps, even subvert the plan. Another related potential subversion may be the ad hoc reclassification of severe cases of conditions with low priorities. Here he argues for some flexibility, but feels that exceptions of any magnitude cannot be tolerated.

I read, or perhaps I would like to read, his discussion of the problems and the potential anguish of implementation with its "painful ragged edges" as a hope that, once adopted, the Oregon plan will self-destruct to be replaced by a program of universal insurance on equal terms for all.

I would now like to return to an issue raised earlier in the paper. Callahan identifies two "R" words, Rationing and Reality, as key concerns. He questions the ability to give everyone the advantage of unlimited medical progress at a reasonable price. Given the present system of uncritical adoption and dissemination of technology and its unequal distribution, the extension of benefits now available to the affluent to Medicaid recipients and the uninsured would certainly increase costs and require increased taxes. The reality of increased taxes, however, must be considered in the light of the fact that, at 12% of GNP and over \$2,000 per person per year, the United States already spends more than any other country for medical care. There is already enough money in the system to provide higher levels of care for every American than for the citizens of any other country. What is required is a commitment to equal distribution as well as a more rational assessment of the services now being provided or contemplated. Controls on dissemination and equality of distribution imply government taking an active hand in the health care system. Callahan points to "a deep distrust of government as the vehicle for a more effective and equitable system." He feels that, unlike Canada, the United States in practice has not accepted health care as a normative right or an intrinsic benefit, and certainly not accepted universal benefits as a politically palatable possibility.

Yet, the universal health insurance system has proven to be

Canada's most popular social program, and one that is supported by all three of its political parties. Provincial governments have fallen when they have attempted to reduce or otherwise tamper with the universal benefits. In 1985, over 60% of the electorate in Ontario voted for the two parties which included banning of extra charges by hospitals and physicians in their platforms. The measure was subsequently adopted.

Presently in Canada there is full coverage for all medical and acute-care hospital services; co-insurance, deductibles, and extra charges are now prohibited by law. Canada spends approximately 25% less than the United States, proportionally, on health care, yet it provides basic levels of care that are at least equal to the levels in the United States. Canada does provide fewer high technology services and it probably has longer waiting lists, but Canadian mortality and life expectancy outcomes are slightly better than those in the United States. Well over half of Canadians are satisfied with a system that spends 8.6% of GNP on health care, whereas only 10% of Americans feel the system of the United States, which spends 12% of GNP on health care, "works pretty well and needs only minor changes."

In essence, rationing in Canada is based on medical need and not on ability to pay. The dissemination of new technology is controlled—both as a cost saving measure and because Canada requires greater evidence of efficacy than the United States. This is not to suggest that the Canadian system is without conflict or problems. Yet, for the past 30 years, in the face of increasing economic pressure, the system has increased expenditures, added benefits, and is now firmly entrenched as a basic human service.

Obviously, one country's system cannot be totally transported to another. Canada and its provinces have demonstrated, however, that it is possible to enact and implement an equitable, popular, and affordable system of universal health insurance. If it spent as much on health care as the United States, I suspect Canada would be able to offer the services in place for more affluent Americans to all Canadians. A major source of the savings in Canada has been the reduction of administrative costs, mainly by the elimination of private insurance and the for-profit sector for those benefits included in the universal insurance program.

Why has government sponsored, tax supported universal insurance been possible in Canada but not in the United States? Robert Evans, Canada's leading health economist, has said of Canada, "There is a deep rooted suspicion of class based systems of any

kind. There are no private universities and virtually no private hospitals. Equality before the health care system is a political principle similar to equality before the law." Shortell and McNerney have attempted to explain the American stance. They wrote, "We are up against ourselves and our deeply held respect for autonomy and pluralism which take on added importance in view of the great diversity of our culture. Whatever we might like to believe about ourselves, we do not have as high a sense of responsibility for each other as do our British and Canadian neighbors."¹ Callahan calls up a tight fisted public that is mean spirited and stingy, and a deep distrust of government as additional factors. In a recent book, *CONTINENTAL DIVIDE*, Seymour Martin Lipset examined the values and institutions of the United States and Canada. Americans, he wrote, remain children of the successful revolution of 1776 and "America reflects the influence of its classically liberal, whig, individualistic, antistatist, populist ideological origins." Canada, on the other hand, ". . . can still be seen as group oriented, statist, deferential to authority—a socialist monarchy." Despite its individualism, the United States has the same police and fire protection and social security for all Americans. When it is essential, and when it can be done in no other way, government can, or perhaps must, be trusted.

The Oregon initiative is an attempt to inject government support and control into a major social problem. It fails because the social experiment it proposes will be limited to the least advantaged, to the least vocal sector of society, the poor. The initiative would be supportable only if it was extended to the entire population. In this context some states, notably Ohio, have taken a leadership role. They are, at least, discussing universal programs which will capture all the health care money already in the system—from premiums, employer and employee contributions, taxes, and out of pocket payments—and then use that money to finance full and equal benefits for all.

I fear that a strategy which settles for an unequal system in the hope that it will self-destruct and lead America or one of its states to a more equitable program may instead perpetuate or prolong the present two-tiered system. Like Callahan, I believe in setting limits, but I feel that the same limits must be set for all.

1. Shortell & McNerney, *Criteria and Guidelines for Reforming the U.S. Health Care System*, 323 *NEW ENG. J. MED.* 463 (1990).