Commentary by: L.R. Churchill

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COMMENTARY: FRAMING OREGON’S MEDICAID PROPOSAL

L. R. Churchill, Ph.D.†

PROFESSOR BUDETTI MAKES one point of singular importance, and he does so with great force and clarity. The Oregon plan will be most burdensome to AFDC adults and children, one of the most politically disenfranchised and medically vulnerable groups.

This political disenfranchisement means that current AFDC recipients have not participated in the prioritization of services and that they are the group most profoundly affected. Professor Budetti calls it “a scheme being imposed on the poor by the nonpoor”. If his characterization of the processes and procedures is accurate, he has an important point and I agree with him that it is a significant problem.

How much weight to give this problem — whether it is enough to scuttle the Oregon proposal entirely — depends on one’s reading of the larger context in which the Oregon plan is proposed and how seriously flawed the current system is perceived to be. And here I must demur at major portions of Budetti’s portrait of the virtues of current Medicaid policies and the vices of the Oregon plan. His discussion is marked by hyperbole and couched in idioms which tend to distort some of the salient background issues. Getting the background sorted out is, of course, essential to being clear on what is in the foreground. No text without a con-text. My response, therefore, is largely concerned with how the issues are framed.¹

Early in the essay Budetti acknowledges that, with the exception of the burdensome impact on AFDC populations, “everything else that has been said about this proposal is speculative.” I agree. The overall impact is hard to foresee. Yet Budetti writes entirely in the declarative mood. He claims that none of the stated objectives of

† Department of Social Medicine, The University of North Carolina at Chapel Hill.

the proposal will be achieved: a rational approach will not be established; medical inflation will not be curbed; no meaningful expansion of basic services will result. In other words, the entire proposal is presented as, at best, naive and mistaken, at worse, a piece of chicanery — legislative sophistry following upon moral sophistry. Moreover, Budetti's subtitle "Political Wolf in a Philosopher's Sheepskin", dispenses with subtlety altogether. It suggests politicians and philosophers in an unholy alliance, devouring, if not the poor, then at least their health resources to satiate their own rapacious appetites. This rather overdrawn carnivorous metaphor with which the essay begins, establishes a motif of hyperbole that mars the analysis and detracts from the merit of the argument.

The second, potentially misleading, framing issue is Budetti's reference to the Oregon plan as "the rationing proposal," or "the rationing scheme." Of interest here is the definite article. This phrasing suggests that the Oregon proposal is a plan to ration, hence, it is "the" rationing proposal, while other proposals currently in place or to be devised would avoid the dreaded specter of shortages, limitations, and rationing. This is a misleading implication, for all allocation schemes ration health care. Some economic theorists — who want to reserve 'rationing' for technical use — will take issue with this use of the term but concede the point. In the strict sense 'rationing' means denying goods and services to those who have money to buy them. For example, sugar, gas, meat and other commodities were rationed in the U.S. during World War II. The more inclusive and accurate definition of 'rationing' refers to the effect in all market economies which deny goods and services to those who cannot afford them.2 The first is sometimes called explicit rationing, rationing by an organized plan, while the second is frequently referred to as implicit rationing, de facto rationing, market rationing, or price rationing. It is important to note that we have largely failed to ration health care in an organized and explicit way in this country and because of that we are left with an implicit price rationing scheme. This is an ingenious system, and we should pause here to note one of its extraordinary moral aspects.

Allocation of resources by price is a rationing scheme we have easily accepted in health care because it fits our basic economic assumptions. But it is also a mode of allocation which largely absolves any particular persons from responsibility for the results.

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Since no one actually decides to exclude the poor (as it is their lack of money that excludes them, not our actions), no one is responsible and no one is to blame. Indeed, the genius of market-driven health care is that it orders the priorities of care by not ordering them, that is, by letting market forces determine allocation. This enables us to say, regarding the outcomes, that we are all innocent of ill will or prejudice against those who cannot compete. In the end, since no one is in charge, no one is responsible for the bad outcomes. The system did it. In this way of thinking, inequities and maldistribution are unfortunate, but not unfair. Efforts to compensate for those who cannot compete are then seen as acts of largesse, or philanthropy, options rather than obligations.\footnote{For a more complete exposition of this point see L. CHURCHILL, RATIONING HEALTH CARE IN AMERICA 14 (1987).}

The point here is that the Oregon rationing proposal is an explicit proposal substituted for a variety of implicit ones. It is not the rationing proposal but a rationing proposal, a substitution of rationing specific services for wholesale rationing of people, primarily by price, and secondarily by disease category, residence, age, eligibility standards, employment status, race, good looks, political contacts and a variety of other \emph{ad hoc} ways. Professor Budetti is, I am confident, more keenly aware of current rationing practices than most, but the language he has chosen blunts our awareness of these practices and tempts us to see the options as stark, black-and-white, either/or choices: the suspect, the Oregon plan, which will deny the poor, versus other plans which avoid the dreaded "R" phenomenon altogether. Rationing is not only a current practice, but an inevitable practice. No modern society has figured out how not to do it, for no modern society has been able to meet all the expressed health care needs of its citizenry. Many physicians, economists and ethicists are fond of talking about rationing as a specter which by economic tinkering, efficiency adjustments, or technological wizardry can be avoided. My contention is that the sooner we resolve to see our situation without blinders the better we will be able to cope with it. The substantive ethical question is not whether to ration, but how to ration. And here, on the "how" question (to follow Budetti's metaphor of predatory carnivores), legislators, philosophers, as well as doctors and lawyers — all of us — really do have something to chew on.

A third troubling aspect of Budetti's presentation is that it evokes the high egalitarian idealism of the Medicaid legislation, and
poses it as the alternative we should consider when we review the Oregon plan. Thus, an easily affirmable (but ideal) system is juxtaposed to a more modest but realistic one. This sort of rendering is one often encountered in ethical argument. A hypothetical choice, backed by a sophisticated, well-defended ideal is displayed against, and as a remedy for, some actual set of choices some concrete agents have made or propose to make.\(^4\) The problem is that the choice between the ideal and the actual is too easy. Most of us would choose the egalitarian, ideal system of mainstreaming the poor over the alternatives. But this choice has proved to date to be a non-choice. In our less-than-ideal world the movement appears to be in the opposite direction. Medicaid covers fewer and fewer of the indigent. The issue is better drawn if we compare the inadequacies of the current patchwork and underfunded Medicaid system with the Oregon proposal to limit depth of services in favor of broad equity. Both are flawed and both will be burdensome. Both will necessitate tragic choices. The luxury of an easy conscience will elude us, whatever system we choose. The signal virtue of the Oregon proposal is that it makes these flawed and tragic aspects of our choices more clear, whereas the current practices of cost- and burden-shifting through a multiplicity of players, none of whom are in charge, hides responsibility. A central concern, I believe, is how much tragedy we can tolerate before denial mechanisms take over and block the impetus for reform. But even if we can't face tragedy head-on, it may be better to remind ourselves that the choices are imperfect and that burdens which we do not acknowledge do not go away because we ignore them.

Professor Budetti may believe that the Oregon initiative will damage the chances for some more wholesale reform of health care nationally. If so, Budetti's comparisons will have the force he desires only if there is good reason to believe that the country is ready to fund more adequately the Medicaid program, and if it is clear that doing so is more beneficial to the poor than providing other publicly-sponsored goods and services, such as better housing, jobs, or nutrition. Short of that we are faced with a variety of "Would it be better?" scenarios, all of which I am willing to concede, but few or none of which are realistic. Would it be better if all Medicaid expenditures were subject to prioritization rather than just the AFDC allotment? I believe so. Would it be better if all

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\(^4\) Portraits of hypothetical, idealized scenarios of choice are abundant in the history of philosophy. Prominent modern versions include J. Rawls' "original position," frequently used to describe requisite conditions for choices about a just health care system.
medical and health care expenditures for all public and so-called "private" payers were prioritized? I am reasonably confident it would be. But short of these, does the Oregon proposal have some promise of moving in a better direction? I believe so. The Oregon plan will not be an ideal solution, but it may be an improvement. However, there is too little known, at present, about the proposal to make a judgment. For example, we do not know if Oregon will put any new money into its Medicaid program, or whether a basic floor of services will result from the prioritization process. While more wholesale, national reforms of the system are to be sought, smaller state-based changes may be beneficial in themselves, or could stimulate the national conscience. State and national reforms may not be mutually exclusive options. Changing our market-driven health care system of social Darwinism with small safety nets will not happen without some innovation in thinking. Inaction while awaiting more nearly ideal systems, holding out for better terms, may not serve the cause of greater equity and more cost-effective care in the long run. But, at least, it is an open question.

Also, while I share Professor Budetti's strong egalitarian sentiments, I do not share what I take to be his implicit status quo optimism about what medicine can do for us. He seems to assume that any reduction of services to Medicaid recipients would be harmful. Yet some of what is offered to us as "essential" and "needed" health care is really of little or no benefit, occasionally deleterious, to the poor and to the rest of us. To borrow Charles Taylor's phrase, health care seems to be for Americans a "hypergood," holding a superordinate, and disproportionate place in the plurality of goods. This hypergood becomes the only good in what Thomas Murray has aptly phrased the "rescue impulse" and Al Jonsen calls the "rescue imperative." Moreover, and interestingly, egalitarianism in the service of the rescue impulse sometimes obscures the larger issues. High technology and marginally effective interventions are sometimes used as instruments of restorative justice. People who are socially downtrodden, victims and losers in our great social lottery, are frequently compensated with medical rescues which are far

more intensive and expensive, and far less useful, than what they
were earlier denied.

It is a nice question whether the Oregon plan, if enacted, would
make us even more prone to compensatory rescue or toughen our
immunities to it. It would be a great gain if some of our rescue
energy at all levels were channeled into meaningful basic health
care and social services for the poor. The Oregon proposal should
be an occasion for raising that larger issue. So when Professor
Budetti expresses worry that the Oregon plan would "insulate polit-
icians" from visible responsibility, I share his concern. Accounta-
bility is essential. Yet I am also troubled by the numerous scenarios
in which politicians are not well enough insulated, and thereby vul-
nerable to individual pleas for rescue attempts that bankrupt health
and social services budgets for entire cities or counties.

Finally, let me return to the issue of sophistry, the kinder and
gentler reading of Professor Budetti's subtitle, emphasizing the
sheepskin motif rather than the wolf metaphor. The Sophists were
itinerate teachers who, in a perpetual lecture tour through the cities
of Ancient Greece, taught for a fee anyone who desired practical
skill in rhetoric and argument. Much of what we know of the Soph-
ists, such as Protagoras or Gorgias, is filtered through the bias of
Plato, who objected to the charging of money and to their apparent
lack of regard for the social or religious consequences of their teach-
ing. Bertrand Russell compares the Sophists to modern lawyers,
whom he viewed as prepared to argue any side of any opinion and
unconcerned with how their arguments might undermine moral tra-
ditions.8 This legacy of suspicion accounts for our sense of the term
'sophist' as a pejorative designation. Yet the charge of sophistry
can also be taken as a compliment. The notion of sophistry as spe-
cious reasoning we owe to Plato. Less aristocratic and conservative
views of the Sophists see them more favorably. Sophists were often
willing to disregard tradition to follow an argument wherever it led
them, and it frequently led them to skepticism about the established
ways of doing things. The Sophists can be seen as courageous in
that they pursued truth, even when it was not fashionable to do so.9
It is in this spirit that we might think of the Oregon proposal as a
piece of sophistry, that is, as an unorthodox approach, not necessar-
ily the best plan, but one marked by a healthy skepticism for the
accepted wisdom and enough courage to look at the issues squarely.

8. B. RUSSELL, A HISTORY OF WESTERN PHILOSOPHY 77-78 (1945).
9. Churchill & Cross, Moralist, Technician, Sophist, Teacher/Learner: Reflections on
the Ethicist in the Clinical Setting, 7 THEORETICAL MED. 6.
Courage and skepticism are not, to be sure, sufficient to merit our final commendation, but they are welcome changes.