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HEALTH MATRIX

The Journal of Law-Medicine

INTRODUCTION TO THE CLEVELAND CONFERENCE ON BIOETHICS JUNE 3-5, 1990

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THE "OREGON PLAN"

THE STATE OF OREGON passed legislation in 1989 that will radically alter the use of public money for beneficiaries of Medicaid in that state. Medicaid is a federal program of generally comprehensive medical care for the poor, jointly funded by the federal government and each state, and managed by each state. The federal law gives to the states the right to determine their own standards of eligibility for Medicaid.

This legislation (the "Oregon Plan") would provide health care to all persons in Oregon who fall under the federal poverty level, but some medical services may not be covered. Medical care under Medicaid would be given priorities, and it is this point that constitutes the radical alteration of the use of public money under the Oregon Plan.

In Oregon, there are 300,000 persons living within the federal definition of poverty, of whom 166,000 qualify for the state's program. Money made available for the program effectively sets the limits of eligibility in the state.

Because the Oregon Plan does not include all of the generally

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comprehensive provisions of the federal program, the federal government must waive parts of the program before the Oregon Plan can be implemented. Waivers are presently under consideration by the federal government.

Prior to the 1989 law, the Oregon Legislature made a decision in 1987 not to fund certain organ transplantations for the Medicaid population. Funds not spent on organ transplantations were to be given instead to the prenatal care programs under Medicaid. In December of that year, two children affected by this decision (one with fatal kidney disease and another with fatal bone marrow disease) captured the attention of the national media.

THE CONFERENCE

The goal of the Cleveland Conference on Bioethics was to explore principles appropriate to govern access to health care in the United States. The conference was based upon a study of Oregon's unique approach to this issue in policy, legislation, and public funding.

The Conference was organized jointly by the Center for Biomedical Ethics of Case Western Reserve University School of Medicine, the I. H. Page Center of The Cleveland Clinic Foundation, and the Kaiser Permanente Medical Care Program. Funding and support were provided by philanthropic foundations, benefactors, and the organizing institutions.

Forty-five persons were invited to participate in the conference: men and women selected from the United States and Canada, representing the fields of public policy, medicine, health care administration, economics, journalism, government, theology, law, business, labor, ethics, and philanthropic foundations. The differing backgrounds, biases, and perspectives of the conferees illuminated the many issues in health care. Three persons were from Oregon; they brought to the Conference their personal knowledge of, and involvement with, that state's initiatives in medicine, government, and policy.

The structure of the Conference was built around original presentations from five of the conference participants, each analyzing the Oregon Plan from one of the following viewpoints: public policy, medicine, law, ethics, or health care administration. Drafts of these presentations were distributed to all conferees for review prior to the conference itself. Additionally, five other participants,

one for each of the five presentations, were asked to prepare a written response to each presentation.

A case study of the Oregon Plan¹ together with the presentations and responses provided the basis for discussions. Presenters and respondents gave verbal summaries of their work in plenary sessions with general discussion following. Small group discussions among the conferees considered one of the following issues:

*The values that should underpin the design of the United States' health care system;

*The priorities that characterize the Oregon Plan and the priorities that the U. S. health care system should emphasize;

*The components Oregon used to design and construct its program and the components that ought to be used to design and construct the U. S. health care system;

*The decision Oregon has made as to 1) who shall control access to health care and 2) the powers they shall have; and identify for the United States 1) who should control access to health care nationally and 2) the powers they should have; and

*How Oregon's proposed health care system's performance would be evaluated and adapted to meet its intended purposes and propose how the U S. Health care system's performance ought to be evaluated and adapted to meet its intended purpose.

The Conference was designed for persons of diverse backgrounds. Dialogue was vigorous and sometimes dissonant, but this was as it should have been in an atmosphere for creative discussion.

FINDINGS OF THE CONFERENCE

Health care and its costs are to be considered in the context of all services provided by government. Defense, education, transport, and environmental protection are also governmental services. Resources for their support are not unbounded, and the limits of national resources should mandate realistic policies in each area, including health care.

Priority ranking of health care services is legitimate. Priorities may be made age-specific, e.g., different for the elderly and children.

Minimum standards of health care should be defined and supported for all persons. These standards should reflect decisions in regard to: conditions of ill-health and their prevention, treatment, outcomes of treatment and care in terms of *longevity* and the *quality* of life, and health maintenance.

1. Golenski & Blum, The Oregon Medicaid Priority Setting Project (Mar. 30, 1989) (unpublished paper).

Minimum standards of health care, once established, should not be subject to reduction by budget-setting.

Decision making is, in the best sense, political. The voice of citizens — both poor and non-poor — and health care professionals should influence legislative action in the health care area.

Lack of public understanding is also an issue. Ignorance leads to unwise choices. Public expectations in health care should be built upon an appreciation of the limits of resources, limits of medical treatment, and the ratios of costs to benefits.

Data are needed on the effectiveness of end-of-life therapies. Limitations upon end-of-life choices impact the economy of health care, freeing resources to supply basic medical services to others, e.g., children, young adults, and mature adults.

Also at issue is whether, and to what extent, health care programs in the private sector should be allowed to exceed the scope of the governmental programs. There are different levels of health care in America, shaped by market forces and personal wealth. Radical change of this reality is an issue.

Objectives and accountability are needed. Health care standards should be subject to continued surveillance and evaluation. Evaluation and the measure of achievement should be paid for by government and be performed in the private sector; i.e., those paying for it should not be doing it.