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DISTRIBUTIVE JUSTICE AND HEALTH CARE

George P. Smith, II[*]

I.

TECHNOLOGY AND MORTALITY

Termed "technologically driven [and] death-denying,"[1] the American health care system will persist at this level—testing and expanding the frontiers of medical science—so long as individuals continue to insist in their desire to attain a degree of immortality for as long a time as is humanly possible.[2] At the end-stage of life, marginal improvements will, assuredly, continue to be charted even though they may have been seen—by the patient—as worthless from a qualitative standard of reference; and, from a societal point of view, extraordinarily expensive.[3] Yet, until medical science accepts the inevitableness of mortality, the medical technology costs associated with prolonging life will never be contained.[4] Thus, the challenge of contemporary health care distribution is to structure a framework for normative decision making whereby the goal of distributive justice[5] is achieved equitably for as many citizens as possible.

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1. GEORGE J. ANNAS, STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS 211 (1993).

2. *Id.* at 214.

3. *Id. See generally* DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS (1990).

4. ANNAS, *supra* note 1, at 216.

5. "When applied to basic health care, the theory [of distributive justice] provides that everyone - the poor, the rich, the young and the old have an unqualified right to health care." GEORGE P. SMITH, II, HUMAN RIGHTS AND

The Modern Focus

A lead article in the January 15, 2002, issue of *The Wall Street Journal* frames the issue and presents the dilemma of distributive justice in contemporary health care administration. The title of the article is, "Some Doctors Say They May Stop Seeing Medicare Patients After Cuts." The article, itself, investigates the anticipated consequences of the federal government's recent decision to cut Medicare reimbursements to physicians by 5.4%.[6] This decision affects greater than an estimated ninety percent of physicians currently treating Medicare patients.[7]

In response to heavy medical treatment demands for health care of an aging population, combined with costly new advances in medical technology, a congressional formula approved in 1997 was designed to control costs, reducing Medicare reimbursement amounts to physicians.[8] The formula's effectiveness is diminished because of the current economic slowdown.[9] This factor, along with increased Medicare reimbursements, has caused the federal government to cut reimbursement fees to physicians by 5.4%.[10]

A member of the Board of Trustees of the American Medical Association acknowledged that, "[p]hysicians are getting to a point where they cannot afford to accept new Medicare patients."[11] Evaluated by any standard of distributive justice, this move by the Centers for Medicare and Medicaid Services—the federal agency that administers the Medicare program—will be catastrophic for the elderly.[12]

Conflicts in Distribution

Because of rising health care costs during the past fifteen years, societal concern has focused on whether the world's health care resources are

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BIOMEDICINE 176 (2000).

6. Barbara Martinez, Some Doctors Say They May Stop Seeing Medicare Patients After Cuts, WALL ST. J., Jan. 15, 2002, at B1.

7. *Id.*

8. *Id.*

9. *Id.* The total cost of all Medicare reimbursements was $244 billion, an increase of fifty-one percent since 1993. *Id.*

10. *Id.*

11. *Id.*

12. Id. See also Washington in Brief, Medicare Rates Won't Meet Costs, HMOs Say, WASH. POST, Jan. 18, 2002, at A4.

being distributed fairly and wisely. More and more, contemporary medicine demands of its practitioners—particularly those in America—that the principle of justice be made a distinct factor in the decision making process.[13] Increasing governmental pressures continue to stress: (1) the need to follow cost control policies, (2) eliminate waste and inefficiency and, as noted, (3) implement the principle of distributive justice in patient care. As a consequence of these three competing policy concerns, more and more, patient interests become secondary to healthcare delivery.[14] The central conflict for physician-gatekeepers, thus, is to assure and maintain a patient-centered ethic in their professional work while, at the same time, from a *macro* economic standard, safeguard their responsibility to preserve society's resources.[15] Ancillary to this conflict is the harsh reality that implementing distributive justice at the patient bedside, without any real societal consensus on how it is defined and practiced most often means that an arbitrary process is put in place. This process depends upon—to a very large extent—the individual value system of the person assigning worth to the medical intervention or procedure put in issue.[16]

In considering applications of distributive justice, then, physicians are required to evaluate this operative principle at two levels: the statistical patient or the identifiable patient.[17] The more direct example of statistical applications of distributive justice is seen within the process of establishing guidelines for utilization review. Another example is found in the work of capital budget committees. Although decisions made under utilization and budget reviews affect, assuredly, real people, it is considered more appropriate and—indeed—safer by physicians to not only consider and evaluate their rationing decisions prospectively rather

13. William S. Andereck, *Money, Medicine, and Morals*, *in* THE HEALTH CARE PROFESSIONAL AS FRIEND AND HEALER: BUILDING ON THE WORK OF EDMUND D. PELLEGRINO 233 at 235 (David C. Thomasma & Judith L. Kissell eds., 2000).

14. *Id.* at 236. *See generally* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987).

15. Andereck, *supra* note 13, at 236.

16. *See also* MARY R. ANDERLIK, THE ETHICS OF MANAGED CARE: A PRAGMATIC APPROACH 125 (2001) (Physicians want power, resources, and freedom, in part to preserve life . . . and in part to advance medical knowledge through research.)

17. Andereck, *supra* note 13, at 236.

than be forced to evaluate issues of this nature at the bedsides of their patients.[18] Alternatively, when the particular financial resources of each patient are factored into their identifiable medical treatment profile, the second and unstable level of distributive justice is seen in bold relief.[19]

II.

GATEKEEPING ISSUES

As observed, physicians are—of necessity—the primary gatekeepers to the health care distribution industry; for they are responsible for not only limiting or, as the case may be facilitating, medical tests but for treatments as well as consultations and—most importantly—initial admissions to the health care institutions themselves.[20] There are three traditional gatekeeping roles for physicians: (1) the *defacto* role, which recognizes a responsibility to practice medicine which is both beneficial and effective for the patient; (2) negative gatekeeping which operates under a prepayment system and, in turn, requires a physician to limit, within the rules of the system, the use of health care services; (3) or positive gatekeeping, where the physician encourages patient use of the health care system for either personal or corporate profit.[21]

Allocating and Rationing Health Care

Regardless of which of these three roles are assumed by the gatekeepers, primary issues of allocation and rationing are central to all of them; for, health care involves a competition for limited resources and therefore—at one level or an other—forces a cost-benefit approach, which balances reasonable individual needs against the availability of medical resources.[22] In the face of ever-mounting distribution costs, it is

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18. *Id.*

19. *Id.* at 237.

20. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping,* 2 J. CONTEMP. HEALTH L. & POL'Y 23 (1986).

21. *Id.* at 26-29. *See also* ANDERLICK, *supra* note 16, at 158-59. *See generally* Edmund D. Pellegrino, *Patient Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship,* 10 J. CONTEMP. HEALTH L. & POL'Y 47 (1994).

22. *See* Daniel Callahan, *What is a Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits,* 8 J. CONTEMP. HEALTH L. &

the elderly, in specific, who become major players in the health care drama for which they are cast in alternating roles as victims and as villains.[23] While the health care system helps to prolong their lives, it also allocates more and more dollars into geriatric spending.[24] The ethical issue implicit here involves the fair distribution of public resources among the different age groups.[25]

Allocations

The allocation of health care resources "involves a societal determination of what resources should be devoted to a particular program."[26] Perhaps the best examples of age-based allocation schemes are to be found in the experiences in other countries, where cost containment initiatives result in indirect limits on care for the elderly.[27] Utilizing cost containment initiatives or following a cost-benefit approach to distributing health care resources is, however, neither practical nor sound ethically, because either policy seeks to reduce or convert all health benefits to dollar amounts. In turn, both seek, awkwardly, to convert what might be considered quality of life benefits into hard, uncompromising economic terms.[28]

One method proposed as a solution to this inequality of the cost-benefit analysis seeks to evaluate the quality-adjusted life years (QALYs) produced for each available health care dollar.[29] The goal of this resource allocation strategy is to maximize the most QALYs for each available health care dollar.[30] There is a central weakness to this method, however, because considering the limited remaining life years of the elderly—individually and as a group—and calculating their QALYs is highly problematic. Thus, for example, a group of elderly individuals needing a

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POL'Y 1 (1992).

23. *See* HARRY R. MOODY, ETHICS IN AN AGING SOCIETY 4 (1992).

24. *Id.*

25. *See id.* at 5.

26. George P. Smith, II, *Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly,* 8 FLA. J. L. & PUB. POL'Y 1, 9 (1996).

27. MOODY, *supra* note 23, at 197.

28. John McKie, Helga Kuhse, Jeff Richardson & Peter Singer, *Allocating Healthcare by QALYs: The Relevance of Age,* 5 CAMB. Q. HEALTHCARE ETHICS 534 (1996).

29. *See id.*

30. *See id.* at 535.

surgical procedure will not fare as well using the QALY approach as a younger group of patients—this being rather obvious inasmuch as the older patients in the group have fewer remaining years to live.[31]

Rationing

Health care rationing is the fair distribution of limited resources by limiting the availability of various programs and services.[32] A central concern with rationing, or in other words the planned distribution of limited resources, is devising a system that is fair and equitable.[33] In the current American health care system, the ability-to-pay is used as an implicit rationing device; yet, a lack of consensus in values and norms prevents the development of a specific method to achieve the ends of rationing health care services.[34] "Thus, the debate is no longer whether health care should be rationed, but rather, how to ration it equitably."[35]

Health care decisions, in the control of third-party payers, have distorted the ability to make real choices.[36] Cost containment issues in geriatric health care have also changed the role of physicians, and forced them, as seen, to become reluctant medical gatekeepers.[37] Inherent in health care decisions is the conflict between saving costs and obtaining quality health care.[38] In essence, "rationing has come to represent discrimination in access to health care services on the basis of socio-

31. *Id. See also* ANDERLIK, *supra* note 16 at 55.

32. *See* Smith, *supra* note 26, at 10-11 (relating rationing to health care needs).

33. Dorothy C. Rasinski-Gregory & Miriam Piven Cotler, *The Elderly and Health Care Reform: Needs, Concerns, Responsibilities and Obligations,* 22 W. ST. U. L. REV. 65, 83 (1993).

34. *See id.* at 83-86 (noting the possibility of many different criteria such as age, disease and entitlement).

35. Smith, *supra* note 26, at 17.

36. *See* MOODY, *supra* note 23, at 39.

37. *See generally* Pellegrino, *supra* note 20; *see also* Edmund D. Pellegrino, *The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic,* 24 J. MED. & PHIL. 243 (1999).

38. *See* Joanne Lynn, *Ethical Issues: Equitable Distribution and Decision Making, in* LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY 17 (1985); *See also* Edmund D. Pellegrino, *Metaphors, Managed Care and Morality,* 3 J. CRIT. CARE NUTRITION 40 (1995).

economic status."[39]

Rationing must be viewed as more than limiting care, for it is a means of providing care where resources are managed and preserved.[40] Rationing is also access control, which is dependent on the medical good, the patient's values, and the needs of society itself.[41] Here, justice involves a constant balancing between the good of the individual and the needs and goods of society.[42]

Aged-based Concerns

The moral and social costs of age-based rationing are indisputably very high, as "the elderly would receive less than their economic due as a return on their prior investment to society.[43] Indeed, the harshest criticism against rationing is seen in the misperception that health care will be withheld or withdrawn based solely on economic decisions.[44]

Rationing health care to the elderly is based traditionally upon a cost-benefit analysis that views the elderly as poor investments per health care dollar, or as a use of scarce resources with limited returns.[45] The basic argument advanced here is that other segments of the population have more of a potential return on the investment of health care dollars than the elderly.[46] Rationing does not mean necessarily the withholding of *all* medical care. Instead, expensive treatments should be abandoned when the chances of positive, rehabilitative results are minimal.[47] Thus, the primary negative implication for age-based rationing is the demeaning

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39. Smith, *supra* note 26, at 11.

40. *See* David C. Thomasma, *The Ethical Challenge of Providing Healthcare for the Elderly,* 4 CAMB. Q. HEALTHCARE ETHICS 144, 152 (1995).

41. *See id.* at 155 (noting that the physician and patient must negotiate the good to be accomplished).

42. See id.

43. Rasincki-Gregory & Cotler, *supra* note 33, at 90.

44. Thomasma, *supra* note 40, at 149.

45. Andrew H. Smith & John Rother, *Older Americans and The Rationing of Health Care,* 140 U. PA. L. REV. 1847 (1992).

46. *See id.* at 1853.

47. *See id.* at 1850; *see also* George P. Smith, II, *Triage: Endgame Realities,* J. CONTEMP. HEALTH L. & POL'Y 143, 149 (1986) (suggesting that love and humaneness serve as guides to determine when treatment cease—this, tested against the ability of the patient to engage in or sustain human relationships).

notion of placing a monetary value on an elderly person's life.[48]

Chronological age alone, as the determinative factor, fails as a practical approach in making health care decisions because of the great divergence between theory and practice.[49] Instead, other variables, such as quality of life and health factors, are as equally important in determining treatment for the elderly.[50] The utilitarian view of health care advocates balancing many different factors such as public and private benefits, predicted cost savings, risks involved and necessary trade-offs.[51] In contrast, others argue a functional approach to rationing where the functional status of the person takes precedence over any utilitarian balancing.[52] No doubt, the best gatekeeping ethic is to be found in the inherent physician-patient relationship—a relationship based on mutual trust and access to health care information which then allows treatment to be consistent with a patient's preferences or recovery potential.[53] The major factor in addressing health care rationing should not be age. Rather, the course of a patient's treatment should be dependent solely upon his individual medical condition[54] and shaped always by the goal of humane, loving care which reduces human suffering, enhances the common good, as well as safeguards the dignity of the human spirit especially in end-game situations.[55]

III.

STRUCTURING A DECISIONAL FRAMEWORK

Establishing fair procedures for the distribution of health care resources is a crucial goal for contemporary society to set and, hopefully, to achieve. Accordingly, fairness is to be defined and shaped by four conditions: (1) public accessibility to "limit-setting decisions" and their

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48. *See* Smith, *supra* note 26, at 14.

49. *See* MOODY, *supra* note 23, at 190.

50. *See id.* at 189.

51. *See* Tom L. Beachamp & James F. Childress, Principles of Biomedical Ethics, 47-55 (4th ed. 1994).

52. *See* Thomasma, *supra* note 40, at 157.

53. *See* Rasinski-Gregory & Cotler, *supra* note 33, at 91.

54. *See* Smith & Rother, *supra* note 45, at 1856-57.

55. *See* George P. Smith, II, *Stop in the Name of Love!* 19 ANGLO-AMERICAN L. REV. 55 (1990).

policies and rationales; (2) clarity in policy rationales which explain how "value for money" is met in distributing health care resources within a society where there are reasonable resource constraints on the resources themselves; (3) a framework for principled decision making which provides a means for resolution of disputes; and (4) a regulatory process which not only assures public access to the initial "limit-setting decisions" but also provides an equitable mechanism for challenging the reasonableness of contested health care distribution decisions.[56]

Restoring Trust

Sadly, as a direct consequence of the multiple and conflicting roles a physician is cast in or forced to choose between, because of either the particular managed care program he is practicing under or the professional ethic he espouses, medicine is no longer being seen as caring for people. Rather, the politics of economic self-interest compromise—if not extinguish—the sacred trust patients once placed in their physicians. Stated otherwise, the system promotes the use of expensive, invasive and at-risk treatments and places little effort in patient care.[57] It has been suggested that a new ethic needs to be recognized and embraced by physicians—one that shifts from using medicine if it might assist to one that promotes use only when it will.[58]

Balancing Needs

The ineluctable conclusion to be drawn from this analysis is that in formulating health care policies for the elderly, the principle of distributive justice demands decisions such as allocating and rationing health care be made fairly within the political process. It demands, further, that broad grants of discretion (which in turn often promote managerial indecision) to administrative decisionmakers in the HMOs who, themselves, have varying systems of values, and to bedside medical

56. ANDERLICK, *supra* note 16, at 134.

57. George Lundberg, Severed Trust: Why American Medicine Hasn't Been Fixed (2001); *see also* George J. Annas, Some Choices: Law, Medicine and the Market, ch. 4 (1998).

58. ANDERLICK, *supra* note 16, at 5. *See* Marian Gray Secundy & Rodger L. Jackson, *Engendering Trust in a Pluralistic Society*, *in* THE HEALTH CARE PROFESSIONAL AS FRIEND AND HEALER: BUILDING ON THE WORK OF EDMUND D. PELLEGRINO 65 (David C. Thomasma & Judith Lee Kissell eds., 2000).

gatekeepers as well, be limited. It is only by and through deliberate debate within a democracy[59] that assumptions about aging, the value of life for the aged and intergenerational responsibilities of assisting them in their care can be set, tested or—as the case may be—rejected.

No matter within what policy forum this debate occurs—local, state, or national—a fundamental balancing test will, of necessity, be employed; one that weighs, in an equitable and reasonable manner, individual needs with larger societal standards of economic efficiency.[60] By seeking to integrate moral and ethical reasoning with quantitative or economic "formulations of needs and resources,"[61] the opportunities for a stronger and more contemporary standard of distributive justice will be both enhanced and stabilized.

The penultimate moral issue seen in this debate is not—rather surprisingly—whether too much or too little treatment is offered; but rather how to seek an optimum level of reasonable or appropriate treatment based on the medical condition of each patient.[62] Failing to meet resolutely the inherent difficulty of allocative decisions here foredooms the total decisionmaking process to a continued state of lethargy where inaction becomes the tragic hallmark of the distribution of health care for the elderly.

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59. *See* George P. Smith, II, *Judicial Decisionmaking in the Age of Biotechnology,* 13 NOTRE DAME J. L., ETHICS & PUB. POL'Y, 93, 102-03 (where the author recognizes the inherent weakness of deliberative democracy—namely, the lack of interest and sophistication by the citizenry to engage the issues).

60. ANDERLIK, *supra* note 16, at 130.

61. Smith, *supra* note 26, at 22.

62. *Id. See generally* George P. Smith, II, Monograph, THE ELDERLY AND HEALTH CARE RATIONING (2000).