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# WHAT IS A REASONABLE DEMAND ON HEALTH CARE RESOURCES? DESIGNING A BASIC PACKAGE OF BENEFITS

*Daniel Callahan\**

Understood most broadly, the fundamental crisis in the American health care system comes down to a simple dilemma: Americans need to spend less money on health care in order to control costs and spend more money to insure those not presently covered. The United States has a health care system which regularly generates excessive costs, continually outrunning the general rate of inflation in the economy as a whole. In fact, for well over a decade, health care costs in this country have increased at twice the rate of general inflation. This has put enormous pressure on both the federal government's entitlement program and private employers' insurance policies on behalf of their employees. Yet, despite spending more money on health care, less equity is provided in the process. Up to thirty-seven million people are estimated to have no health insurance and tens of millions more have inadequate health insurance coverage. The only way to remedy this problem is to spend more money to provide coverage to the uninsured. The dilemma is then a complex one: how is the United States supposed to hold down health care costs while simultaneously increasing equity?

One result of this dilemma has been a national debate that usually focuses on the issues separately rather than together. There is a great deal of interest in methods of cost containment. For example, a number of experiments have been carried out over the years, including HMOs, DRGs, competition, and managed care. At the same time, a number of proposals have been introduced for national health insurance. However, few of these proposals make any direct reference to the control of costs; it is simply ignored as a problem.

The idea of a "basic package" of health care benefits is an attractive one for a number of reasons. If Americans could come to some consensus on

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\* Director, The Hastings Center, Briarcliff Manor, New York. This Article is adapted from a lecture delivered on March 27, 1991 at the Columbus School of Law, The Catholic University of America, as part of the Brendan Brown Lecture Series. The lecture series honors Dr. Brendan Brown, the sixth dean of the Columbus School of Law (1942-54).

what a decent minimum of health care for all citizens entails, there might be a basis for some form of universal health insurance and overall health care costs might drop. If it could be determined what health care everyone needs, in addition to finding some limits to that fundamental level of need, then there might be an ideal solution to the general dilemma: a plan that combines a basic minimum of care with some means of controlling the cost of the care provided.

In any event, if that is a desirable goal, it is necessary to inquire why it has been so hard to achieve. Despite a great deal of talk over the years, there has never been any real progress made toward defining a plausible and affordable package of basic health care benefits. Though various standards have been proposed—including provisions for a “minimum level of adequate care,” “medically necessary” care, or a “decent minimum of care”—none have managed to make themselves fully coherent internally or to strike a responsive political chord. For instance, Congress stated in the 1965 Medicaid legislation that the goal of the program was to provide “medically necessary” care to the indigent; it neither defined what that concept meant nor, in the years after, made any effort to define it.<sup>1</sup> The net result is that the program itself is enormously erratic, varying its coverage and standards from state to state. The idea of what is “medically necessary” is one that has neither been explored in theory nor used in practice. Whatever the full range of reasons for this omission, one reason is surely the conceptual difficulty of specifying a basic standard of care.

Why has the idea of a basic package or a minimal level of care been so hard to clarify and use? Perhaps many began with the assumption that such a standard could be developed on purely medical grounds by determining a common level of medical need for all people on scientifically specifiable grounds and working outward from there. It has proven impossible, however, to use “medical need” as a single meaningful criterion for a basic health care package. Instead, that package must be grounded in an array of ingredients—medical, ethical, social, and political. More importantly, there must be a political dimension to the idea of a basic package or at least some role for the public to express its own values about what it believes is a minimally adequate level of care. It is also necessary to have some idea of the proper ends and goals of medicine, as well as the scope of “health” care, otherwise there is no clear way to determine what people desire in the name of health is what they actually need. Should medicine provide all the health care that people want or request, or should medicine have its own independ-

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1. Anita F. Sarro, *Determining Medical Necessity Within Medicaid: A Proposal for Statutory Reform*, 63 NEB. L. REV. 835, 842-43 (1984).

ent standards regarding what are appropriate treatment and symptoms? No clear answer has ever been given to this question.

The concept of "need" is itself enormously variable and culture-driven. Inevitably, definitions and interpretations of "need" will be a function of available technologies and cultural visions of health care. It is something that will also be determined by the way people understand the world, the extent of their available resources, and their understanding of science in relation to their needs. The very idea of a "basic package" is full of puzzles and problems.

One might well ask why Americans have had so much trouble with this issue while Europeans have not. The reason may be that the European health care systems, all of which provide universal health care in one form or another, began shortly after World War II in a time of relative poverty.<sup>2</sup> At that time, excessively high expectations about the range of health care benefits and the full impact of technological advances had not been felt. European countries began, therefore, with low expectations and relatively ineffective medicine. Their notion of "minimally adequate" placed a great deal of emphasis on primary care, public health measures, and disease prevention. By contrast, Americans have started their search for a decent minimum and basic package from a higher level, based on greater affluence, well-developed high technology medicine, and greater public expectations of medical benefit. The American health care system has developed into a strange private market and public entitlement system over the years. This system has become more expensive, more profitable to those who take part in it, and more ambitious in its visions and demands. Initially, almost any level of health care was acceptable to Europeans, whereas, for Americans, practically everything that can be mentioned is not quite adequate. Europeans started with relatively low expectations and have been able to build up gradually to higher expectations. The problem here is just the opposite: The United States has to find a way to bring down the high expectations to a more reasonable level. Also, in Europe, most of the allocation and rationing decisions are made in private by politicians and experts working together without a great deal of public participation. This makes life much simpler for everybody; surprisingly, the public in those countries does not complain very much about the matter. Over the years, the medical and political authorities in those countries have been willing to tolerate limited technology, the wait required for some forms of health care, and the idea that one cannot

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2. See generally RUDOLF KLEIN, *THE POLITICS OF THE NATIONAL HEALTH SERVICE* (1983) (tracing the transformation and development of state provided medical care in Europe).

expect perfection of a universal health care system. That has been a helpful psychological base, but one that does not exist in this country.

As one looks more closely at the efforts to define a basic package, it is helpful to examine some models and approaches that have not worked. One simple, common approach is to specify a list of services that ought to be available under any form of universal health care. For example, the bipartisan 1990 Congressional Pepper Commission stated that a basic package should include "[h]ospital care, surgical and other inpatient physicians' services, physician office visits, diagnostic tests, . . . limited mental health services[,] . . . [and] [p]reventive services . . ."<sup>3</sup> The only qualification for those services was limited mental health; other services were not limited. The problem with specifying no limits in this type of service-oriented approach is that it creates a blank check. If hospital care is included as one of the services, then almost everything occurring in hospitals—including repeated, expensive organ transplants for the same patient—would have to be covered. It is an inherently open-ended standard.

In formulating a system to hold down health care costs, it is attractive yet problematic to start with human health needs. The flexibility embodied in the concept of needs, as demonstrated by the cultural and psychological variations in response to it and the impact technology has on its definition, means that needs can neither be used in isolation nor dispensed with entirely. People want to avoid illness and hold off death, and such basic needs animate the entire enterprise of medicine.

Still another approach is to look at medical benefits and seek to develop a basic package out of known efficacious treatments. David Hadorn of the Rand Institute asserts that a basic package should provide treatments proven significantly effective after evaluation by technology assessment.<sup>4</sup> He argues that the best way to define need is by the availability of medical treatment to maintain health standards. As such, he would not include as any need any medical condition for which a treatment does not exist, such as an inoperable brain tumor. By limiting the basic health care package to the availability of effective treatment, he deals with one aspect of the problem, namely giving people what will actually benefit them. At the same time, this approach seems terribly narrow because there are some medical needs which cannot be met currently but could possibly be met under a future system if money was allocated for research on such needs. However, that would expand the scope of the basic package and increase its costs.

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3. PEPPER COMM'N, U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION 61 (1990).

4. David C. Hadorn, *Defining Basic Health Benefits Using Clinical Guidelines* (Apr. 24, 1991) (unpublished paper on file with author).

Moreover, Mr. Hadorn assumes that we have both effective technology assessment, which we really do not presently have, and the ability to pay for whatever proves to be technologically efficacious. The latter assumption may be referred to as the "affordability fallacy," whereby it does not necessarily follow that just because something works it is therefore affordable. Although there is considerable waste and unnecessary costs in the present system, we cannot afford unlimited expenditures on health care, no matter how useful or cost-effective.

A final approach, advanced by David Eddy,<sup>5</sup> determines what the average person would want with respect to medical care and uses that as a standard for determining what is "essential" care. The problem with this approach is that "essential" is defined independently of resources. It is possible that what the average person would want might turn out to be unaffordable. It is also possible that the average person does not want the appropriate treatment. A program of this kind would require some educational component, making certain that people had reasonable desires and taking into account the fact that some desires might still be unreasonable. These considerations would be factored into the "majority choice by average [p]atients."<sup>6</sup>

Any discussion of the future of the American health care system will have to consider public opinion, which influences the legislative possibilities. The American public is highly confused, divided, and ambivalent about the future of the American health care system. On the one hand, public opinion surveys indicate that most Americans are reasonably satisfied with their own health care, although highly critical of the American health care system in general.<sup>7</sup> Recently, more people have become anxious about the future of their own health care and are particularly concerned about the possibility of losing health care if they change or lose their job. In response to calls for national health insurance, the public is enormously ambivalent. There is a great interest in national health insurance and a general acceptance of the idea. However, when it is projected that the costs might be high, that there might be limitations on the choice of a physician, or that some services might require a delay before becoming available, then the interest declines considerably. While there is a willingness to see government play a stronger role in controlling the costs of drugs, physicians' and other health care workers' fees, and hospital costs, there is also a great suspicion of government in managing the overall health care system. Legislators claim they lack public

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5. See David M. Eddy, *What Care is "Essential?" What Services Are "Basic?"*, 265 JAMA 782 (1991).

6. *Id.* at 788.

7. Cindy Jajich-Toth & Burns W. Roper, *Americans' Views on Health Care: A Study in Contradictions*, 9 HEALTH AFF. 149, 149 (1990).

support on this issue because, first, the public is not willing to pay more money for a better or more just health care system and, second, the public is not certain that its money would be well or efficiently spent.

The decisive factor will be whether the American public will accept a plan which calls for higher taxes and additional spending on health care services. Because this is unlikely, a more appropriate health care system would be one which moves away from the enormous fragmentation of the present system and toward greater unity and centralization. Presently, the American system is marked by an unstable relationship between private and federal programs, on the one hand, and an ideological mixture of programs based on market theories of competition and the need for government to provide a safety net in the face of that competition, on the other. It is an uncoordinated, unfair, and needlessly fragmented system.

The following model sketches an ideal approach implementing a basic package of health care benefits. An analysis of this model will determine whether it is conceivable in this country.

The first step in this model approach requires a broad-ranging national discussion of the relationship between health care and other societal needs, as compared to other systems which mandate that health care compete directly with other resources. In the case of the British National Health Service, many citizens complain that less than six percent of their gross national product (GNP) is devoted to health care.<sup>8</sup> Initially, that system was designed to make certain that health care did not have a special, privileged position and that such expenditures would compete directly with allotments for housing, transportation, defense, and the like.<sup>9</sup> A system of this kind is necessary in this country. Health has had an unduly privileged situation in the United States and health care expenditures have rapidly out-distanced all other social expenditures. Twice as much of the American GNP is spent on health care as compared to education. No one, however, has tried to analyze whether the present expenditures are appropriately balanced.

In determining the relative priorities between health and other needs, a basic consideration of the goals of medicine and the relationship between health and human happiness is required. Should Americans have a broader or more limited notion of health? In other words, should health be narrowly restricted to physical conditions, or should it represent general well-being, including mental health issues that might otherwise be considered nonmedical?

Ideally, health should be compared with other societal goods in the com-

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8. KLEIN, *supra* note 2, at 165.

9. *Id.* at 37.

petition for resources. Therefore, the design of a health care system must reflect the particular values and culture of the society in which the system is developed. Some background assumptions on health must be made considering its relation to other goods and in comparison with the allocation of resources within the health care system. First, a health care system must be culturally relative. It must reflect the values of the people who will pay for the system and make use of it, despite the attractiveness of other national systems. To the extent possible, the American system must reflect the American culture. Second, the system must be resource relative. It is possible to design a health care system that would not be based on available resources, but it would be foolish to do so. Finally, a system must be sensitive to variations of individual needs. Difficulties arise because resource allocation, for the most part, is based on general societal needs and it is not possible to tailor national policies to an enormous range of individual variations. Nonetheless, a health care system that is not sensitive to those individual variations would neither meet political acceptance nor be likely to pass ethical muster.

Furthermore, it might someday be necessary to set an age limit on health care for the elderly. The American health care system, among others, will be unable to afford much longer the costly combination of an expanding population of the aged and increasing expenses associated with life-extending technological treatments.<sup>10</sup> That point has not yet been reached, however, and the United States can still afford expensive, individualized treatment that is indifferent to age.

In creating a basic package of health care, it is important to recognize two very different rationales. One rationale is based on an individual's medical needs and her overall welfare. This rationale questions what is the necessary minimum of health care for individuals. Accordingly, a health care system should express human solidarity in the face of the individual burdens which we all share, including pain, illness, and mortality. Using the individual and his need as a point of departure would be compatible with the values of his culture, thereby recognizing the phenomena of an individual's pain and suffering.

The other rationale might be termed a public health rationale. A society needs healthy citizens so that its institutions function well. For instance, the American public education system, founded in the middle of the nineteenth century, was developed out of a recognition that the economic and social well-being of the country depended upon an educated population; it was not

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10. DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* 215 (1987).

designed to help children flourish individually. The goal was in the interest of the common good rather than the particular good of the individual being educated. Similarly, a society may ask what level of health care is necessary for its institutions to function well. In so doing, society may develop a plan that raises the general level of health based on economic, educational, and familial considerations.

This latter rationale is compatible with the history of most European health care systems. The majority of these health insurance systems are based on a perspective of the common good rather than individual rights. This public welfare model is present in American police and fire departments. For instance, each citizen receives a basic level of police and fire protection; there is no particular provision for variation based on individual needs. If a man in a wheel chair lives in a wooden house, he does not receive any better service from the fire department than his able-bodied neighbor who lives in a stone house. The same fire department serves people equally, and if additional protection is desired because of special problems, it must be purchased by the individual. The same is true of police protection. People accept this model because it is egalitarian, making sure that there is a minimal level of protection for all, even though it is not specifically tailored for individuals. A health care system should operate in the same way; placing emphasis on good public health services and good primary and emergency care. Beyond that, individuals would have to buy whatever additional care they needed to deal with their individual variations.

Attractive as that public health or public welfare model is, it is not sufficient for health care. A middle ground between an individual-centered and a public-centered standard for providing health care must be found. On the one hand, a purely individualistic model of health care is not feasible in the face of unlimited medical possibilities. There is no end to the various ways of meeting individual needs, which continually fluctuate as a result of changes in cultural values and developments in medical technology. On the other hand, using a purely societal standard is too utilitarian for the welfare of society and too insensitive to individuals. A plausible way must be found to bring individual needs into a basic package, while maintaining a strong emphasis on public requirements for good health.

The middle ground approach proposed by this author must begin with a set of *prima facie* priorities, namely an individualistic, nontechnological standard—the necessity of caring for individuals. Caring does not simply represent medical needs; it focuses on the emotional and social needs of the ill. Since medicine is a finite science and cures will eventually be ineffective, each person will, at some point, need caring. Therefore, the health care sys-

tem's first premise should be that no one be abandoned, particularly those whom medicine cannot cure.

The highest priority should be that of care, displacing our present priorities in which cure is given the place of pride. The second priority should be those measures that promote public health: immunization, screening, health promotion, and disease prevention. The third priority should be primary and emergency care. The experience of other countries demonstrates that a high ratio of primary care physicians to specialist physicians is an effective way of maintaining the public health. This ratio is also sensitive to individual medical needs because everyone will need primary or emergency care at some time during their lives. Not only does that kind of care save lives, but it also provides the necessary basis for diagnosing the patient and prescribing treatment. Additionally, people are reassured that there will always be someone to assist them with their medical problems. The fourth priority should be advanced technological medicine, including elaborate forms of surgery, chemotherapy, and the like. The fifth and final health priority should be highly advanced technology, particularly organ transplantation and kidney dialysis. Advanced technological medicine and highly advanced technology are last on this list because both are expensive and provide more benefit to the individual than to society as a whole. Although they contribute to public health, they are not the main ingredients in maintaining the high level of public health. Nonetheless, they do not have the same effect as primary and emergency care. Placing caring first, by moving on to those things designed to help the greatest number of people and by giving the last priority to advanced forms of technological medicine, will achieve a good balance between the individual and society.

At the same time, it is necessary to address other priorities in this basic package, namely the competition for funds. It is reasonable to give priority to the young over the old, the poor over the rich (particularly in government programs), family members over single people, and, barring exceptions, life-saving care over other forms of health care. It is also perfectly legitimate to use cost/benefit calculations and other economic tools. However, they should be a tool, not the dominant factor nor the kind of technical device used solely to make a decision.

In reforming its Medicaid program, the State of Oregon used the model approach, although not giving the suggested high priority to caring. Oregon created its own system of setting priorities. The number of items to be covered on the list of priorities will depend on the amount of money the legislature appropriates. The final list of priorities supported by the budget

constitutes the basic package.<sup>11</sup> Although Oregon did not establish a minimum package for all, it assumed that by providing a good proportion of its priority list to its Medicaid recipients, it would serve the same function. What Oregon recognized, however, was that making decisions about both priorities and the balance between the public and private good must be done through the political process. People will disagree profoundly about how priorities should be set and what kinds of health care have relative importance. Hence, only by submitting technical considerations and moral evaluations to a decent political process will everyone get a chance to see their values reflected in a basic health care package.

In the end, the amount a society spends on health care should be a political decision. It should cover enough people but not harm other societal sectors. The political process should recognize that all who are affected should have a role in the process. It should utilize good technical data, compare different needs and demands, and provide a period of public education prior to or during the political process.

In sketching the ingredients for creating a basic package, fundamental questions should not be neglected: How should individuals think about their own health care needs? What should society do to meet those needs? From an individual standpoint, what is appropriate for each person's health care? If politics represent the demands of citizens, what ought a citizen want and desire as a person? What should people be encouraged to think about in their own lives? Without offering a full answer, some general points should be made. First, individuals need to think about the role of health in their own lives. In other words, what kind of priorities should it embody? For instance, hypochondriacs give health too much importance, while others are much too careless and indifferent about their health. A good balance is needed, and it is the duty of the individual to determine the appropriate balance. Furthermore, individuals should think about the role of health in society in general. How much emphasis should be placed on health in comparison with other needs? Even if health is a necessity for the pursuit of other goods, does that mean it always supersedes other goods? While health is a means of achieving human good, it is rarely an end in itself. Society needs only as much good health as will insure its civic functioning; it does not require perfect health.

There are three different moral demands or claims being made for health care. There can be a claim upon the individual, *i.e.*, the duty of the individual to take care of herself. There can be a claim upon one's family to provide

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11. Charles J. Dougherty, *Setting Health Care Priorities: Oregon's Next Steps*, HASTINGS CENTER REP., May-June 1991, at 1, 1-16.

that person with health care. Lastly, there can be a claim upon society for that which neither the individual nor his family can provide. One fundamental problem in devising a decent health care policy is in deciding how to balance these different claims. Put another way, to what extent is the individual required to provide for her own health care? To what extent can the individual require that his family help with such health care? In what ways and to what extent can the individual make a claim upon society to provide assistance? How should responsibilities be allocated among individuals, family members, and citizens?

It is reasonable to believe that, as a primary obligation, the individual ought to take care of his own health, both for the individual's sake and to spare others from unnecessary burdens. Each person should not knowingly engage in unhealthy types of behavior, even those that do not seem to affect anyone else. In the American health care system, it is practically impossible to meet a health care need without affecting others directly or indirectly.

What claim can be made upon the family? Families ought to provide love and emotional support during one's illness; they should also be prepared to provide some financial support if that is necessary and possible. The family is next in line to do for the individual what he cannot do alone. However, that claim upon family members is not without limits. It is improper for a person to ask others to jeopardize their own health and welfare on her behalf. Although it is difficult to draw a line between charity and duty, it must be recognized that such a line should exist.

Finally, with respect to the claim upon society, it must be asked what is reasonable. What can be asked of fellow citizens during one's illness or disability? Society ought to help people function as citizens, relieve their most egregious suffering, and grant reasonable access to health care facilities which are generally accessible to all other citizens. To make an unlimited claim upon society for health care, however, is unreasonable. No one has the right to jeopardize the health of others in pursuit of her own needs. No one can ask for or expect immortality. No one can place his health needs above other important societal needs.

There is, and will remain, a basic tension between individual aspirations for improved health and the reality that humans are finite beings. Scientific progress guarantees that medicine will continue to do more, thus stimulating individuals to want more for themselves than earlier generations might have contemplated. Presently, medical progress has gone beyond the minimal level of general health care needed for a good society. One can live a reasonably long life and make a considerable contribution as a citizen. However, a life span beyond the present average life expectancy of seventy-five will not

necessarily create a good society. If most people live into old age—though not into a very ancient old age—they will have lived long enough to guarantee themselves active and adequate participation in the common life. This is only to say that society does not need unlimited medical progress to have adequately decent common health.

Ultimately, the most fundamental question in designing a health care system is to ask about the relationship between health and happiness. What is that relationship? At one extreme, if someone is in terribly poor health, it is likely that he cannot have any happiness at all. Yet, at the other extreme, people can be sick, disabled, chronically ill, or otherwise suffering to some extent and still have a reasonably decent and happy life. Thus, the relationship between health and happiness is not a fixed one. It is a function of values, different ways of looking at life, and the possibilities medicine offers. Nonetheless, to debate about designing a health care package or determining the place of health in our society, Americans must constantly consider the question about the relationship between health and human happiness.