Commentary

Ethics And Priority Setting In Oregon
by Daniel Calkthan

The past few years have been remarkable for the array of proposals advanced to address the American health care crisis. Their very quantity and diversity, however, suggest the intimidating range of the issues before us. We have difficulty agreeing on the nature of the problem; determining how to interpret the history and values that lie behind our affluent and advanced, yet inefficient and inequitable, health care system; and deciding how to devise a political strategy that can bring needed reform.

The great attraction of the Oregon initiative to prioritize state health spending is that it proposes a bold and integrated way of dealing with these daunting problems. It challenges the widespread belief that health care can and should be an unlimited benefit. It rejects the common presumption that no rational way can be found to distinguish and set priorities among the bewildering array of individual health needs and claims. It embraces an open, democratic process to make painful policy choices. It questions the pervasive view that any plan that denies to the poor care available to the rich is of necessity unjust and unacceptable.

These premises are unsettling. They go against the grain of a number of values and practices that have marked the American health care system. For years, Americans have held fast to the belief that if we are just smart enough, and tough enough, and optimistic enough, we can give everyone the advantage of unlimited medical progress at a reasonable price. Unfortunately, reality has continually intruded into that optimism, in a variety of forms: the high cost of continuing medical progress; the social and technical difficulties of (and resistance to) technology assessment; unreasonable public and professional expectations for improved health care; growing resistance to higher taxes to pay for better health care, combined with a deep distrust of government as the vehicle for a more effective and equitable system; and, as a powerful historical legacy, a health care “system” that is not a system at all, at least if that term

Daniel Callahan, a bioethicist, is director of the Hastings Center in Briardiff Manor, New York. An earlier version of these remarks was presented at the 1990 Cleveland Conference on Bioethics.
implies a coherent, organized set of institutions, practices, and values.

The Oregon initiative is an attempt to cope with these realities and other problems, by targeting the state Medicaid program. To meet the problem of access to health care, the plan provides coverage for all persons under 100 percent of the federal poverty level. To meet the problem of budget constraints within the context of that universal coverage, a priority system has been established. The priority system, based on the analysis of a special commission, ranks the medical treatments that could be covered by the program; additional cost figures will be developed to show the financial impact of covering the ranked treatments. The legislature then will establish an overall budget figure, and these dollar amounts will determine how far down the priority list of specific treatments the program will be able to cover.

The results of the entire process will be highly visible, and the accountability clear. Public unwillingness to pay higher taxes for better coverage, and legislative unwillingness to vote higher budgets, will be reflected directly in the level of coverage made available. Additional features of the program will provide incentives for effective and appropriate care, avoidance of incentives for overtreatment, a plan for improved employer health care insurance, and a method of funding designed to create an economically affordable system. The long-term goal is a system of universal health care for the state.

The ethical problems potentially raised by the Oregon plan fall into four categories that require scrutiny: (1) its moral context and political setting (including its ideological meaning); (2) its formal and explicit goals; (3) its means of achieving those goals, that is, its process of priority setting, public participation, and public accountability; and (4) its practical implementation, including possible unintended consequences.

**The Moral And Political Context**

The context of the proposed Oregon plan is that of a present Medicaid budget that, in responding to a shortage of funds, has set its cutoff point for coverage at 58 percent of the federal poverty line; those covered by Medicaid, however, receive a full range of services. To date, the state has responded to its money shortage by manipulating eligibility standards rather than coverage of services. This is a common tactic among states faced with this situation. Under the new plan, by contrast, coverage will extend to everyone below the poverty line, but the range of services provided will be limited.

**The existence of rationing.** This history makes several salient moral points. First, for those poor people whose income placed them above the
old 58 percent Medicaid eligibility level, health care rationing was already a reality. The legislature had set the eligibility level by establishing a priority system based on income. It is thus hard to conclude that the new plan represents a radical departure from the old in its background assumptions: that not everyone can get all that they might need or want, and that some system of priorities must be set. The Oregon plan remains a system of setting limits, only now in a different way. The question to be asked is whether it is a more rational, equitable way.

The main criticism of the new plan is that the heaviest burden will fall upon mothers and children in the Aid to Families with Dependent Children (AFDC) program, the least powerful and most needy group. Other needy groups (the blind, the disabled, and the elderly) will be exempt from the priority system. The result will be to remove a significant number of mothers and children from their present privileged place in the Medicaid program and force them to compete with everyone else. This is a serious and telling deficit. But it is offset, in part, by the inclusion of additional previously excluded mothers and children who will now be covered because of a federally mandated extension of the coverage up to 100 percent of the federal poverty line. It is not clear whether the overall benefit to mothers and children under the new plan will add up to a better balance of health care for this group as a whole, but if the balance can be determined with any clarity, it would be a relevant consideration in any final moral judgment about the Oregon plan. It is also possible, of course, that the Oregon plan could be amended to return AFDC mothers and children to a special place in the system.

Comparing care of the poor to care of the affluent. Second, it is obvious that the Oregon plan, as a Medicaid program, is designed for the poor, not those middle-class, affluent people covered more generously by employer health plans. It could thus be said, in the harshest construal of its meaning, that the Oregon plan is a targeted rationing program for the poor that sets limits for their care in a way that will not be borne by their more affluent fellow citizens. The Oregon plan’s context is a two-tiered economic society, now matched by a two-tiered health care system.

The logic of this line of potential criticism is obvious. Unless Medicaid recipients are provided a level of health care equal to that of the more affluent, it can be seen as unjust and discriminatory. At least, this view will prevail if it is assumed that the poor have a basic right to equal access to the level of care that the affluent can buy or have provided them by private employer insurance plans. The obvious question is whether, in fact, our society has accepted as normative a right to equal access for all persons. The answer would seem to be no, at least in practice, even if public opinion polls find rhetorical support for the idea.
The most serious issue for debate is whether, by changing the Medicaid program, the actual result is to reinforce an unfair system, one that should not exist in the first place. Does the Oregon initiative wrongly legitimate the absence of a universal health care system in the United States? Does it also wrongly legitimate the idea of systematically (through the priority system) depriving the poor of some forms of health care they could have if they were more affluent? How these questions are answered will depend in part on two considerations. Is it wrong in all cases to use less-than-perfect programs to improve health care for the poor, and is working within the boundaries of public support a wrongful compromise for legislators?

What seems clear in response to these questions is that the Oregon legislators have little room to maneuver. The gap between aspirations for a one-tiered, ideal program and the political realities can be seen by the Oregon public’s unwillingness to pay higher taxes to support a more generous Medicaid program. Thus it is the voters, not the legislature, who must bear the blame for the legislature’s inability to provide support for Medicaid recipients equal to what the affluent can afford to buy (or get from their employers). A hard but obvious truth emerges: unjust or not, discriminatory or not, the legislature must work with the resources available to it. Its moral task, in that context, is to deploy resources in the fairest way possible. At the same time, we must not assume that because the affluent can obtain forms of health care not available to the poor under Medicaid, the poor have lost an intrinsic benefit. If the private sector has not learned how to set limits, must the public sector do likewise? That does not follow. In any case, the private sector is also working to set limits and priorities in its insurance and coverage practices. Increasingly, a restricted range of choices is being offered.

Are we to imagine that a government entitlement program could provide unlimited access to the highest-quality health care, regardless of cost? The possibilities for such care are infinite, and no other country—even those with universal health insurance plans—provides that level of care. The wealthy everywhere can buy better care than what is available to them under government programs, if only because of their ability to travel elsewhere to get what is denied them domestically.

What ultimately matters is not whether the new Oregon plan legitimates a two-tiered system—it surely does that, just as surely as does the present Oregon system, with its total exclusion of many thousands of poor people from the program—but whether the care provided under the new plan will be decent, humane, and reasonably adequate for most if not all legitimate medical needs of the poor. If that standard can be achieved (assuming we can define it with any precision), it could be judged reasonable and fair, even if the affluent do better.
The goal of the Oregon initiative is to provide a basic and adequate level of health care for all of the poor, but within the externally imposed constraints of a limited budget. These constraints in turn dictate that not all needed or desired care can be provided. There will be a ceiling on expenditures—a necessity in the case of a limited budget. The old ceiling was managed by limiting eligibility. The innovation in the new program is to manage the ceiling problem by making all of the poor eligible but then setting priorities to manage the available funds.

To the question of whether it is sensible and equitable to extend eligibility at the price of reducing coverage, no definitive answer can be given. It is a classic question of prudence, not fixed moral rules. The consequences of these two approaches can and should be evaluated: full eligibility and less coverage versus less eligibility and full coverage. To make this choice, various incommensurable goods will have to be compared, and no striking imbalances are likely to appear. Even if they do appear, none are likely to be so dramatic that they automatically condemn the plan cd which they are the outcome.

One possibility, however, could make a real difference. Should it turn out that the coverage provided under the new plan systematically and continually deprived recipients of some crucial benefit or benefits that would drastically affect their health and lives, we might then conclude that it was unfair. But that could only be concluded if two conditions were met: first, that the program was unnecessarily deprived of funds by a stingy public; and second, that a reasonable effort was not made to balance the available resources to minimize that kind of outcome. Unhappily, of course, it could well be that even an otherwise rational priority-setting process might exclude some forms of care that are of intrinsic value and necessity to some individuals. Life-saving but expensive organ transplants might be an obvious example. If they end up as a low-priority item, they are not likely to make the budgetary cutoff point. Yet to limit coverage of such procedures for the sake of other important health care benefits would not necessarily be unfair. The right to a decent minimum level of health care need not entail coverage of each and every form of medical technology, no matter how expensive and how limited the number of beneficiaries. It is hard to see how any society could make that kind of promise for long without doing damage to other health and social needs.

Yet we are left with a terrible problem once we recognize that kind of limitation. Might it be said that a process that resulted in denial of certain forms of care would be a prima facie unjust process—because the right to
those forms of care is so basic to human welfare that any system that jeopardizes them must be condemned? The way in which the denial of what Albert Jonsen has called “rescue technologies” (those necessary to save a patient’s life) almost always results in acute public and professional discomfort illustrates both the moral and political issue here. The denial of some forms of care will be seen as both morally wrong and politically unacceptable. But, if that is so, that leaves us with a genuine dilemma. In addition to a fair political process, will we also need some independent moral criteria by which to judge the outcome of the process? But, if so, will that not undermine the credibility of the process—making it subject, so to speak, to a moral veto if the results are unacceptable?

I see no way out of this dilemma other than to define a basic package of health care benefits available to all regardless of ability to pay. If the Oregon plan could be amended to guarantee such a package prior to the setting of priorities for additional care, the dilemma could be avoided. As matters now stand, it looks as if the priority system might deny some forms of care that seem imperative, and as if the price of avoiding such an outcome would be an arbitrary setting aside of the priorities. Some forms of care might be required to be available to all regardless of the priority they might receive if they had to compete with other forms in the political process; that is, they would be allowed to trump the priority-setting process. Of course, too much trumping would threaten the credibility of the process. Some therapies would be declared winners before the struggle over priorities even began. A basic health care package not subject to priority setting seems a preferable alternative, but it could of necessity exclude some important but expensive forms of acute care as the price of making that package financially tolerable.

The Process Of The Oregon Initiative

How might such a set of problems be decided? Ineluctably, considera-
tion of the goals of the Oregon initiative must include consideration of the means to achieve them. Must the process of priority setting assume that a well-designed procedure will itself be tantamount to a just pro-
cedure, that is, that any outcome that results from a conscientious, scrupu-
ulous adherence to the procedure will be declared just, as if that is what “just” means? To come to grips with this question, two problems must be confronted. The first has been alluded to above: whether there are some health needs so preeminent that they must trump their way to the top of any priority list, or so important that their omission from any health care package based on the priority-setting process would tend to discredit the process altogether. Both possibilities could suggest a compromise of the
integrity of the priority-setting procedure. Yet there may be no choice but to accept the need for such compromise.

The second problem is whether the design of the plan to set priorities is reasonable, organized to produce the fairest possible outcome. This is hard to say in the absence of any experience with such a procedure. The lack of any clear community historical tradition or present consensus on the setting of priorities, and the lack of any established method of determining the comparative importance to individual welfare of different procedures, make it problematic to evaluate the plan’s design. A safe assumption is that there would be strong community support for the high priority of life-saving treatment, and a lower priority for treatments that affect the quality and comfort of a life. But it is less clear what the community, and the commission, will think of life-saving treatments that help a few people at a very high cost per person, or of a quality-enhancing treatment that can help many at a lower per capita cost.

A priority-setting process that neatly and deductively builds upon available ethical principles and community sentiment, and extracts from them a theoretically elegant and obviously acceptable set of priorities, is not wholly feasible. Instead, a more likely model is one that constructs a fresh way of looking at health care, one that will need to invent its own methods and set of standards. It will require a unique blend of principled equity, supportable preferences, and community sentiment. Only over a period of time, after the priorities have been put into practice, can this new approach pass the test of ethics. The final test can only be that of experience. The process must be found satisfactory in practice. It would, then, make most sense to look upon the process as a social experiment, the invention of a policy out of the less than whole cloth of existing preferences and values. Its tests will be its public acceptability and, independent of the process, whether the outcome is fair. Since there are no commonly accepted norms available to provide a wholly independent standard, there must be continuing public discussion and debate about the balance between good process and good outcomes. That is hard work, but a necessary part of life in a free society that strives for procedural justice and yet also recognizes that moral claims may on occasion transcend what can be achieved by procedural means alone.

One of the purposes of the Oregon process seems to be to serve as a goad to the public. If the public is told that the money they are willing to pay in taxes will determine how deep the coverage of individuals will be, that is, how far down the priority list the funds will allow the state to go, the public will ultimately be accountable for the welfare of Medicaid patients. No longer can the consequences of limited funds be hidden or obscured by administrative obfuscation. The winners and losers will be
known. The citizens of Oregon are being asked to accept a priority-setting system as well as to accept the pressure it will (and should) put on them to be more generous in what they provide as taxpayers. It remains to be seen whether both the public and the legislators will be able to stand this bright, cold light of accountability.

**Problems Of Implementation**

Problems inevitably will abound when the Oregon plan is actually put into practice. One is the likelihood that powerful interest groups will feel aggrieved that the illness or condition for which they speak is not covered by the Medicaid coverage priority list. They will then mount a campaign to make an exception to the list, or, if that is unsuccessful, to claim that the method of setting priorities must, of necessity, be wrong or unfair because it ranked their condition too low. The attachments of riders to legislation, the meeting of “special” needs, and the specifying of exceptions to ordinary policy are staples of the American political process, however distasteful they may be. But too great a capitulation to such forces will sink the plan, the very essence of which is to cut through competing claims in the name of a reasonable ranking of priorities. (One reason, I am told, for initial resistance to a waiver for the Oregon Medicaid plan was that it would wipe out mandated coverage for many conditions, thus undoing the work of earlier reformers.)

A closely related possibility might also be not to deny the need for priorities but to say that severe cases of conditions otherwise ranked low would not be unreasonable exceptions, not in themselves subverting the idea of priorities. Again, some flexibility might be possible here, but not much without risking the plan as a whole. Indeed, a chief difficulty with a set of priorities for various illnesses and conditions is that it will not be responsive to individual patient variation. A severe case of a low-ranked illness might be as potent in its effect on an individual as a mild case of a more highly ranked condition. It is difficult, however, to justify exceptions of any magnitude, or the making of (otherwise valid) distinctions.

The greatest source of anguish in the implementation of the plan will come in learning how to live with, and to rationalize, its failure to cover some people whose condition will pull at our sympathies. This anguish will be all the greater when the victims are visible and when the accountability for their condition can not be evaded. This is the greatest logical and emotional problem created by any set of priorities that set limits. We will, for one thing, always wonder if we are doing the right thing. We will always wonder, for another, if it might be possible to relieve the pain by some stratagem we have not yet devised.
The likely price, however, of letting that pain triumph over our reasonable efforts to be fair will be to move the injustice elsewhere, to stint on the need for education, or roads, or housing–where issues less momentous than life and health seem at stake. For just that reason, a resoluteness will be necessary to make the priority-setting plan work. There will always be what I have come to think of as a “ragged edge,” a line that separates what we can in fact do from what we might in theory do. An ability to tolerate and accept that ragged edge is imperative to making the Oregon plan work.

Some Final Thoughts

I have raised here what seem to me the most important moral problems in judging the Oregon initiative. The most obvious general problem is where to start. Ideally, we should have a universal health care system in the United States, complete with mandated federal and national standards. The present system is both unfair and administratively chaotic and expensive. Most of the maneuvering over the Oregon initiative should be seen as a response to those national shortcomings, yet both the old program and the proposed new ones partake of those shortcomings.

Should we then reject the Oregon plan as just one more patchwork effort to redeem and legitimate an inherently defective system? I confess to deep ambivalence here. There are yet no signs of a universal health care system in the immediate offing in the United States, even if pressures are growing in that direction. Does it hurt the cause of universal health insurance to tolerate interim, less-than-perfect solutions?

On the one hand, it might make it harder, not easier, to gain a decent universal system if we continue to find ways to slightly improve the present fragmented system. The 1965 Medicare and Medicaid programs were meant to be the incrementalist precursors of a universal health insurance program for the United States. This did not happen, and, in fact, that approach may have backfired. The unexpected high costs of those programs dampened enthusiasm for a more comprehensive program. There is, then, reason to be wary of piecemeal approaches. On the other hand, at some point we must take better account of the present realities, not forever holding out for ideal solutions that may never appear. We will not in the near future find a way to assess all, or even most, of our technologies, introduce dramatic cost-saving efficiencies into the system, or persuade the public to radically increase their tax burden.

The popular idea that we should never put in place any rationing or priority scheme until all waste and inefficiency have been wrung from the system has two major flaws. One of them is that serious cost containment
and waste reduction would themselves have to make use of many of the same techniques used in rationing and priority setting: tough discipline, guidelines and protocols for treatment, denial of some forms of care believed efficacious by many practitioners, and so on. The other flaw is that it amounts to little more than a subtle way of maintaining the status quo, particularly since we know that the historical record over twenty years shows an almost unbroken record of failure to significantly reduce health care costs. Given that record, why should we believe that it can or will work in any substantial fashion in the near future? To cling to such a hope in the face of that history guarantees continued paralysis.

If we can accept the idea, then, that there is a kind of folly in waiting until everything is ready for some ideal system before taking some reform steps now, then the Oregon initiative promises a helpful step forward. Its goal is to introduce immediate reforms into a bad system. If, as its proponents hope, those reforms have an effect on all forms of health care in the state, private as well as public, they will have put in place some important ingredients of an eventually decent system.

At the heart of the Oregon effort is a simple perception. If a Medicaid or any other health care budget must be limited, then it makes sense to set priorities as a way of most effectively using the available funds. It is hard to fault the theory of this approach. Indeed, the chaotic nature of the present system, with its erratic coverage and mixture of mandated and optional coverage, shows what happens when there is no priority system. I happen to believe, moreover, that we will never have universal health insurance until Congress is persuaded that there can be a way of controlling the costs of such a plan and a way of specifying some boundaries to what it will cover. Congress will have to start with the premise that it cannot provide coverage for all the health care that will be desired, or perhaps even needed. It will then have to know how to say “no” —effectively, rationally, and humanely. A priority method, based on some combination of technology assessment and public preferences and values, is one of the only conceivable ways of bringing that about.

On balance, my own inclination is to support the Oregon initiative. A number of practical problems are associated with it, and the potential harm it might do to women and children is a serious (but probably correctable) flaw. Assuming a genuine effort to make corrections and adjustments, we have few more promising routes open to us in this country. Universal health insurance is an important and imperative national need. Its absence is a national scandal, and it can not come soon enough. In the meantime, however, we must work within the available limits of resources and public unwillingness to pay higher taxes. It is not enough, but it is the best we have. It deserves a chance.