Equity in Health and Health Care Reforms

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In planning healthcare reforms increasing attention has been focused on the issue of equity. Inequities in the provision of healthcare exist even in relatively egalitarian societies. Poverty is still one of the major contributors to ill health and there are many powerful influences in society that continue to thwart the goal of a maximally equitable system for the provision of healthcare. The principles of equity in a healthcare system have been well articulated in recent years. It is incumbent on healthcare professionals who understand the issues to join the efforts towards a more humane and equitable healthcare system in their societies.

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In our 1989 conference here in Stockholm I participated in a panel on priorities in medical care in which Daniel Callahan and I clashed on the issues of rationing and priority setting (1). I objected vigorously to his now famous age-based criteria (2).

What has happened in this field over the past decade? Have we advanced or have we regressed?

By simply comparing the programs of the two meetings, it is clear that the subject of rationing and equity has grown significantly so that it now occupies fully one-third of the entire program. This expansion is perhaps reminiscent of the seemingly endless pressures for growth in healthcare expenditure in our societies.

I believe that in our discussions, and surely in our summing up of the issues, we should preserve our sense of proportion. All of today's presentations are from countries representing only a relatively small percentage of the world's population; essentially only the relatively wealthy societies. According to the World Bank figures (3), the world's 1990 annual health expenditure was 1700 billion dollars or 8% of the world's product. High-income countries spent 90% of this amount, with the United States alone consuming 41% of the global total. At that time the average annual expenditure in the high-income countries was $1500 per person. The developing countries spent about 10% of the world's total, 4% of their gross national product for an annual average of $41/person, 1/30 of the amount spent by the rich countries.

Thus when we address issues of equity and ethics let us not forget that we are talking mostly about *intranational* inequities, which in the poorest of the rich countries do not approach the magnitude of the catastrophic differences between the developed and the developing world. These gaps are so great and so seemingly unbridgeable that we generally avoid the topic. But the point should be made, if only at least to pay lip service to our consciences.

The past decade has seen the virtual collapse of the Soviet-style socialist economies with serious disruption of their albeit poor, but superficially relatively egalitarian, health services. In another part of the globe, South Africa is undergoing a major crisis in its healthcare system, seeking to bring the healthcare services to the long-neglected black majority to some kind of minimal level without totally destroying the outstanding academic and scientific infrastructure which for generations served a largely white elite.

The World Bank, long regarded by many as a bastion of incorrigible conservatism, lacking adequate social consciousness, broke precedent by devoting its entire 1993 World Development Report (3) to health. It went on record stating loudly and clearly that spending on health represented an investment. Indeed the impressive 300+ page report was entitled, as might be expected from a bank document, 'Investing in Health'. As Dr Taipale (4) warned us, this approach has inherent dangers.

This decade has been marked by an almost incessant struggle by different Western societies to cope with what seems to be an inexorable rise in healthcare needs, demands, desires and costs, almost invariably outstripping the available resources, or at least those made available, to

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meet those needs and demands. The coping methods used vary from country to country, as does the degree of success; often, countries try out the failed methods of their neighbors. Clearly, the solution is still a Utopian dream.

One of the most important achievements of the decade in my view is the serious attempt to devise more rational ways of decision-making. Many of the initial attempts are ultimately abandoned, and may, in retrospect, seem pathetically simplistic. But concepts such as rationing, efficiency, cost-benefit analysis, priority setting, QUALYS, DALYS, and evidence-based medicine have become an integral part of the daily vocabulary of almost everyone involved in healthcare. Serious attempts at rational priority setting have occurred in a number of countries. Laudable steps have also been taken to arrive not merely at medically and economically sound bases for healthcare planning and reform, but also at systems of healthcare that meet a civilized society's concept of equity and fairness.

Rationing and priority setting were not discussed very much when I was a medical student in the early 1950s, for a variety of reasons. One of the reasons was that when you do not have any really effective treatments from which to choose, there is little need to focus on how to distribute them.

Yet, in reality, rationing has been with us almost from time immemorial. When a primary care physician spends only ten minutes with a patient, he is in essence rationing his time. When almost any hospital physician in training goes home leaving behind a lot of unfinished work from which patients might benefit, she is rationing her time. When a nurse hastily dispenses a pill without listening and reacting to the patient's emotional needs, she is rationing her services. The professional economists and health planners traditionally have not found this kind of rationing very interesting. It is to some extent similar to the difference in prestige between the small claims court and the Supreme Court. When you begin to deal with hundreds of millions of dollars, the economists and healthcare planners are obviously attracted.

How one rations, or more euphemistically, how one sets priorities, is of course the crucial question.

Decisions concerning rationing made on an ad hoc basis by the physician at the bedside are obviously far from ideal. Another undesirable approach, but used very widely even if not articulated as such, is what Dr Gerald Grumet (5) called, 'Healthcare rationing by inconvenience'. By putting administrative barriers in the way of healthcare services, one can definitely reduce costs. Last year at a conference on rationing Dr David Eddy (6) described the system in the UK as 'arbitrary, inconsistent, unsuccessful and harmful' and the leaders at the conference sent a letter to the Secretary of State for Health pointing out that 'smart' rationing is definitely preferable to 'dumb' rationing.

In the past decade we have witnessed significant progress. Now, even the United States and the traditionally reactionary American Medical Association have finally acknowledged, at least in word (7), if not in deed, that healthcare should be recognized as a human right in a wealthy and civilized country, and that equity in the distribution of healthcare is an important value. Unfortunately, a coalition of special interest groups in the United States successfully blocked the enactment of programs that implement that right.

In examining the overall picture there are several points that I would like to highlight.

First, I want to re-emphasize the 'Inverse Care Law' (8), to which Professor Whitehead has already made several references in her paper (9). This law, which is probably as powerful as some of nature's laws of thermodynamics, was described by Dr Julian Tudor-Hart. Tudor-Hart is an anachronism, a Marxist true believer, in the best idealistic sense of the term; a family physician who has devoted his professional life to caring for underprivileged and impoverished Welsh miners. He stated that even in societies that are allegedly egalitarian, the best healthcare is generally given to those individuals who need it least, and the worst to those who need it most. Enormous gaps remain between 'the haves' and the 'have nots' even in relatively egalitarian societies. While the existence of these gaps is an almost inevitable consequence of the human condition, awareness of this 'law' and conscious efforts to redress these unfair situations can help to narrow them. We have an ethical and societal obligation continually to strive to close the gaps, and certainly at least to prevent them from widening.

The second point I would like to re-emphasize is even more obvious. Probably the major contributory factor to ill health, even if we define illness in a purely biomedical sense, is poverty.

This is neither the time nor the place to examine the pathophysiology of this relationship, but it is universal in all societies in which it has been examined. (The papers of Whitehead (9), Taipale (4) and Rosen (10) reinforce this connection). The morbidity and mortality in the poor sectors of towns and countries is much greater than that among the well-to-do. Of course poor health, in turn, is a major contributing factor to poverty, and the poor sick are often trapped into a vicious reciprocal cycle. The consequences of this relationship are most relevant to health policy issues. The poor have much less free money to spend on healthcare after the non-optional expenses for food, housing, clothing and education have been taken care of. Therefore co-payments of most kinds, which might seem trivial to most people, are often seen as real barriers between the poor and the healthcare they need. Furthermore, the institution of even quite progressive health insurance payments, in and of itself, still does not fully redress the disadvantaged populations. These points must be hammered home to every individual involved in health-

care at any level and in any role. Unfortunately, many policy-makers unwittingly, or more likely deliberately, do not give adequate weight to compensating for the health burdens of poverty.

Thirdly, the potential benefits of competition and market forces as ways to increase efficiency are usually greatly exaggerated, as Professor Ham (unpublished study) has indicated. More often than not competition is likely to enrich particular interest groups and contributes less than might be expected to lowering the overall costs of healthcare.

I am old enough to remember the 1960s, when many experts told us that one of the reasons for the high cost of American healthcare was the shortage of physicians. All that was needed was to produce more doctors, who would then compete with one another, and the cost of healthcare would plummet. These ideas sound almost incredibly naive today, but this concept was promulgated and widely accepted as public policy. Medical schools were subsidized to increase their student body, and of course the results are well known. I still remember so well reading what was for me an eye-opening article by that remarkable and prolific nonagenerian Eli Ginzberg whose response characterized the then popular economic view as 'nonsense'. He testified before Congress and told them, if you turn out more physicians they will order more tests, write more prescriptions, carry out more procedures and run up more bills, which will raise, and not lower, healthcare expenditure. Of course he was right, because the healthcare system is not one where the required conditions for equilibrium by normal market forces prevail.

Much is spoken about the efficiency of the private sector as opposed to government bureaucracy, but in the United States the highest percentage of the total health budget goes on administrative costs, where profits and administrative costs skim about 25% off the top. Just ask any American physician today about the myriad of insurance companies, their bureaucracies and their efficiency.

Dan Wikler, the former president of the International Association for Bioethics, delivered a talk at the 1993 meeting entitled 'Privatization and Human Rights in Health Care—Notes from the American Experience'. He described the impact of relatively untrammeled market forces in rather dramatic terms. 'Skim and dump' was one of the picturesque terms he used to describe the policies of many profit-making, and even so-called non-profit-making, institutions who have to compete for economic survival. He described a closed meeting of hospital administrators who considered a variety of tactics in order to discourage the poor from using their institutions' emergency facilities. He also described the initial diagnostic procedure in American emergency rooms as a 'wallet biopsy'. Obviously, America is at one end of the spectrum with respect to minimal regulation of profit-making and competition. Clearly, too, there are certainly specific carefully regulated areas in which competition and market forces can indeed have a positive impact. But if equity is to be given serious consideration, one must be ever alert to avoid the potentially pernicious effects of unregulated competition on fair distribution of healthcare.

There is an unfortunate 'unholy trinity' coalition in many countries between the healthy, the wealthy and the finance ministers whose efforts to push payments from government to the private sector work largely against equity in healthcare.

A remarkably positive phenomenon of the past decade has been the increasing tendency of healthcare planners contemplating some kind of reform actively to obtain an ethics consultation in order to help them create a program which will meet not only economic and health criteria, but also ethical ones. These consultations have been conducted by a number of Western countries and by the State of Oregon in its famous plan.

Recently, there even appeared a remarkable book *Benchmarks of Fairness for Health Care Reforms* (11) written by a philosopher, an economist and a sociologist. Although the book was written with the specific intent of comparing the various health plan proposals that came before the Congress of the United States, the concepts are universally applicable to other countries as well.

President Clinton, with the naive enthusiasm with which he began his first term in office, appointed a Task Force on National Health Reform to which was attached an advisory ethics working group. They proposed 14 ethical principles on which they felt the reform plan should be based. In their description of these principles (12) Brock & Daniels, two prominent philosopher-ethicists, pointed out that these principles and values had not been pulled out of thin air, nor were they matched to a specific plan for healthcare reform. They stated that these principles 'are deeply anchored in the moral traditions we share as a nation, reflecting our long-standing commitment to equality, justice, liberty, and community'

The 14 principles they enumerated are:

1. *Fundamental importance*—Healthcare is of fundamental moral importance because it protects the opportunities open to us to pursue goals in life, reduces our pain and suffering, prevents premature loss of life and gives us the information we need to plan our lives. Interestingly, President Clinton, in presenting his plan to Congress, omitted this principle, as well as several others of importance.
2. *Universal access*—Every one must have access to healthcare services without financial or other barriers. This point, of course, represents a revolution in American thinking.

   Even in countries that have reasonable national programs, there are often attempts by treasury officials to erode this principle by excessive out-of-pocket

payments. Aliens and foreign workers are also often excluded from this universality.

3. *Comprehensive benefits*—The healthcare system should meet the full range of healthcare needs. Ideally, the program should cover primary, preventive, chronic and long-term care, as well as acute care, home care, hospital care and treatment for mental as well as physical illness. Obviously, no country can provide every single possible service, but if limitations must be introduced they should be confined to the least important benefits relative to their costs. Professor Gunning-Schepers (13) offers some suggestions on how to make these decisions.
4. *Equal benefits*—Healthcare services should reflect only differences in healthcare needs and not other individual or group differences. The drafters were emphatically opposed to a two-tier system of healthcare, and clearly indicated that, whereas in other realms of societal endeavor two tiers of services might be acceptable, they felt that health was too important to human function to permit two levels of services.
5. *Fair burdens*—The costs and burdens of meeting healthcare needs should be spread across the entire community with payments scaled according to ability to pay, by a progressive tax.
6. *Generational solidarity*—The system should respond to needs at each stage of life with sharing of benefits and burdens fairly across generations.
7. *Wise Allocation*—Society must balance wisely what it spends on health against other priorities such as education, housing, defense, and so on. It will therefore have to set limits for what percentage or amount to devote to healthcare, as well as make prudent allocation of resources within the healthcare budget itself. Unfortunately, in too many countries the military expenditures often greatly exceed those on health.
8. *Effective treatment*—Since money will always be limited, it is not only a medical responsibility but also an ethical one to spend only on services whose effectiveness has been proven, (evidence-based medicine) and definitely to avoid spending money on ineffective or doubtful services, whether they be diagnostic or therapeutic. This clause also mandates spending on research, particularly outcomes research.
9. *Quality care*—This clause mandates creation of systems of quality assurance in all aspects of the system.
10. *Efficient management*—The system should be simply organized, easy for patients or professionals to use and should minimize administrative costs. For a country like the United States that spends such an enormous percentage of its healthcare funds on administration, this recommendation is of paramount ethical consideration.
11. *Individual choice*—In the true spirit of American individualism, the authors propose that the healthcare system should permit maximum freedom of choice among providers, healthcare plans and treatments. Other Western countries have traditionally placed less emphasis on such freedom of choice, and this choice is now being actively restricted more and more by managed care plans in the United States, precipitating considerable displeasure among patients, as well as among physicians.
12. *Personal responsibility*—The healthcare system should help the citizens take responsibility for protecting and promoting their own health and that of their families. These steps should include provision for education, counseling and treatment in order to encourage healthy behavior patterns.
13. *Professional integrity*—The system must respect the clinical judgement of health professionals and protect the professional–patient relationship, while ensuring that the professionals fulfill their community responsibilities.
14. *Fair procedures*—To protect these principles and values, fair and open democratic procedures should exist for making decisions and for resolving disputes.

Obviously these 14 principles are Utopian to no small degree, almost like the WHO definition of health or of human rights. One value can often be in conflict with others, and clearly the fulfillment of the entire menu might break the bank. But they provide a kind of vision for goals toward which to strive; without a vision we are doomed to retrogression.

When President Clinton presented his plan to Congress he listed only six principles (security, savings, simplicity, responsibility, choice, quality).

Perhaps he thought 14 ethical principles were too many for Congress to handle. And of course we all know that even these six did not make it. The British Secretary of State for Health has defined seven principles for the National Health Service (fairness, efficiency, effectiveness, responsiveness, integration, accountability).

The Swedish government, in its practicality and great wisdom, simplified the list to three principles:

- *Human dignity*—which means that we treat all humans equally.
- *Solidarity*—which means that we have to pay particular attention to the needs of the weak and vulnerable.
- *Efficiency*—which means that in the absence of other overriding considerations we should spend our money in ways that give us the greatest return for the money.

Interestingly, the Israeli National Health Insurance legislation also describes three principles

- Justice
- Mutual assistance
- Equality

which are, in essence, very similar to the Swedish list.

Of course these principles are relatively easy to define and it is easy to pay them lip service only, but putting them into practice in the field is much more difficult. Nevertheless, these principles must be our lodestar when we evaluate the effects of each proposed change or reform, if we are to preserve our ethical equipoise in the face of the enormous economic pressures and those of special interest groups.

The role of those within the healthcare system, whether as physicians or economists, was defined eloquently by Professor Whitehead (9). Unfortunately, the medical profession has all too often been on the wrong side of this struggle.

While it is clear that access to healthcare services cannot eliminate the large inequalities in mortality, morbidity and other healthcare outcomes, we have a major role as advocates for those who are relatively powerless, for the poor, the aged, the disabled. We who are aware of the health burdens that these unfortunate individuals bear, in addition to the suffering caused by poverty and social deprivation, must represent them in public forums, in the media and in government circles. These unfortunate individuals are engaged in a battle for their lives against the 'unholy trinity' of the healthy, the wealthy and the finance ministry.

We in the field of healthcare must be part of a coalition to work towards a better, a more humane and a more equitable healthcare system.

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