MODULE 9

Public Health and Health System Reform: Access, Priority Setting, and Allocation of Resources

Michael Garland, D.Sc.Rel.
Department of Public Health and Preventive Medicine
Oregon Health & Science University

John Stull, MD, MPH
Department of Public Health and Preventive Medicine
Oregon Health & Science University

Humans live in a threatening world. Individually and collectively we respond to threats. We protect. We run. We fight. We repair. We build shields, weapons, and walls. Cultural, socio-political, and historical forces shape the social institutions that protect both individuals and groups from harms. The health system is an organized set of societal responses to the health problems that threaten human well being (Fields 1973).

The object of interest in public health is protection from threats to health. The ethics questions explore our relationships in community and our obligations within community. Which protections from what harms should we expect as members of a community? How seriously does solidarity oblige us? What does it oblige us to assure to one another? How do we distribute both the benefits and the burdens of having an effective system for protecting health? How do we exercise our community responsibility politically?

Individuals and communities as well as institutions and culture stand in dynamic relationship. Historical choices affecting these relationships are essential aspects of an adequate analysis of the ethics of access to health care and allocation of social resources for health (Walzer 1983, Starr 1982 and 1994). The concepts of social solidarity, wisdom, prudence, and fairness are central to our analysis. We note that access arguments tend to flow from assumptions about rights or common good or enlightened self-interest. Allocation arguments tend to rest on assumptions about societal wisdom and affordability of programs. We argue that questions about health systems lead to political process questions about democratic participation and representation (Garland 1994). Because of the complex and technical nature of health policy, a partnership between experts and the general public is a desirable strategy for reasonable public participation in this process (Garland 1999).

Protection against morbidity and mortality. The health system is a social mechanism devised to deal with morbidity and mortality as they affect the physiologic, psychological, institutional, and cultural domains of human activity (President's Commission). Those components of well being comprise society's notion of health and disease. All of these domains change over time under their own dynamics as well as under the influence of specific health related forces. Our central collective responses to morbidity and mortality have produced the social institutions of medicine and public health. In addition to these central activities, a host of community-based services and various forms of alternative and complementary medicine also serve important protective and rehabilitative functions. All of these

elements constitute the full health care system about which questions of the ethics of access and allocation arise. Throughout the essay we will us the expression “system of health protections” in an expansive sense to refer to all forms of societal response to morbidity and mortality in the community. We include in this meaning those responses that are simply compassionate without possibility of protection or cure (for example, providing palliative care to dying persons).

The medical literature gives ample documentation of the genetic and environmental factors that act at the physiological and psychological levels to produce disease. From the time of Rudolph Virchow in the 19th Century, social factors have been recognized as contributing to the occurrence of illness, disability, and other threats to well being. Epidemiologists increasingly explore the complex interplay between biomedical individualism and a profusion of social factors. Contemporary researchers are elaborating the theoretical underpinnings of the web of causation model and exploring the thesis that social conditions are fundamental causes of disease. In this view, social, economic, and political factors profoundly affect the distribution of health-related conditions and the genetic and environmental factors associated with them.

Key Questions to Identify Frame of Reference

We will highlight several key questions for exploring the ethics of access to health system benefits and the allocation of societal resources to maintain the system. We will introduce the questions in relation to specific aspects of the issues. The accompanying fact sheet for this module will gather all these questions in one place and connect them to the three cases for discussion. The first two key questions are useful for uncovering the general frame of reference that underlies thinking about problems in access to care and resource allocation.

1. *Which of the many threats to human health and well being deserve organized response from the health system?*
2. *Which social factors that threaten health (e.g., poverty, risky behaviors, environmental degradation) should be countered with social interventions to limit their impact?*

These same social, economic and political factors also affect the distribution of the organized responses to these health threats – both in terms of the distribution of goods and services and in terms of the ability of those in need to access those goods and services. Research into effective interventions to protect health and to counteract pathologic events points to the need to address both individual and social domains. In addition, the health services research literature documents the role of social and behavioral factors in determining the way individuals and groups seek and obtain health services. The challenges of social wisdom, prudence, and fairness require crafting health care access solutions in the context of social norms, structures, and practices (Garland 2001).

Dynamic relationships and historical choices. The links between medicine and public health have not been strong over the past century. The growth of science and technology and the related increase in the power of diagnosis and treatment partly explain this phenomenon. The medical profession has moved toward a narrower focus on the individual both in its practice and in the ethical implications that come to bear on practitioners. Despite this, the perspectives and practices of medicine and public health complement one another.

Medicine carries out its social function of protecting and improving health by focusing on providing care and services for individuals with health-related conditions. This tends to focus on the biologic and physiologic and on the psychological and behavioral domains, although medicine incorporates recognition of the importance of prevention and of social factors in both health and illness. Public

health carries out its social role by focusing on identifying and ameliorating environmental factors that prevent or allow disease and injury to affect the health of individuals and communities. It also focuses on the early identification of, and interventions for, health-related conditions at the community level. These complementarities and the origins of both medicine and public health in social practices make it imperative that they work together. It also makes health policy about access and allocation of resources more complex. It is hard to determine when one passes from health protection to economic policy or social policy.

Practitioners and researchers in public health and medicine have unique and critically important perspectives on the core functions of public health (assessment, assurance, and policy development). Each of these functions has its complement in the practice of clinical medicine. The unique social position of these professionals within the formal institutions of health care especially equip them to advocate for systemic change as a means of improving the health of the communities in which they live and serve. Social responsibility imposes a moral obligation on health professionals to be engaged in addressing issues such as access to care, the just allocation of health resources, reduction in poverty and the effects of poverty, and education of the public about health risks.

There is a tendency in American health policy discussions to reduce all of health policy to decisions about medical care. This recurrent conceptual problem leads to a distorted definition of the problems and an excessively narrow selection of policy alternatives. The discussion of "health insurance" is a vivid example of this conceptual problem. For the most part health insurance covers medical care for illness and injury. Debates focused on how to extend health insurance to all members of the American community hide an important fact. Access to insurance that pays for medical care is only part of the larger ethical problem of access to health protections. Similarly, questions about allocating resources for medical care are only part of the ethical problem of resource allocation in pursuit of the community's health.

During the 20th Century, most advanced industrial nations determined that all their citizens should have access to medical care. That expression of social solidarity is usually understood in terms of a guaranteed right to medical care possessed by every citizen. Some nations took the path of making medical care delivery a government function (for example, Great Britain or the Scandinavian countries). Others made health insurance the focus of government intervention (for example, Canada or Germany). The United States, however, determined that access to medical care would remain a private good for most citizens. The government assumes a collective responsibility for securing access for some citizens through programs such as Medicare, Medicaid, the Indian Health Service, the Veterans Administration System, the military, and prisons. For the rest of the citizenry, however, access to medical care (except for emergency care) is left to the market. People get medical care they can pay for and this payment is usually mediated by insurance plans or prepayment schemes.

Although tax deductions encourage Americans to purchase health insurance, buyers and sellers in the marketplace primarily determine how health insurance is distributed in America. (Note: We deliberately use the misleading expression "health insurance" because it is the common name for this product. It is important to remember that health insurance is mostly for medical care and hospital services. "Health care" is a much larger frame that includes social, economic, and legal domains that have significant impact on human health.) Historically, America adopted the social practice of distributing health insurance through employment status, so that employers (not the employees who become insured) are

often viewed as the purchasers of health insurance. American employers manage the purchase of health insurance for their employees through a system of benefits that accompany salaries. A result of this market-based approach is that some 15 % of the American population makes a decision not to buy health insurance. Most often they simply do not consider health insurance as an expenditure option because they lack the financial resources to afford it (Schroeder 2001).

Numerous public opinion polls taken during recent decades show that a solid majority of Americans want health care access to be universally guaranteed. This is evidence of the moral sentiment of the American citizenry regarding solidarity and health care as part of the security and welfare we expect as members of our society. Because America distributes health insurance mainly through employment, the extension of health insurance coverage functions as a surrogate for guaranteeing access. The majority of uninsured persons work in low-income jobs that do not include health insurance as part of the total compensation. These persons do not fit into the categories for which government sponsored coverage is available. Many states are experimenting with tax-supported subsidies to assist families with limited incomes to purchase private health insurance. Still, the United States has not yet produced a political solution that can accomplish universal coverage through employment driven health insurance or through the creation of new government programs.

Central ethical concepts. What concepts help analyze the ethics of access to health care? On what basis and by what methods should we allocate collective resources for health care? What can guide us in setting priorities among needs for health care resources? We propose that social solidarity, social wisdom, rights, societal obligation, fairness, and justice are the most important ethical concepts to apply to this area.

Solidarity. The first important concept for exploring the ethics of access to health care, social solidarity, comes from the meaning of membership in a community (Walzer 1983). Solidarity is both moral sentiment and norm. Solidarity arises from the sense of belonging. It expresses itself in loyalty and self sacrifice for those we acknowledge to be "one of us." Security and mutual welfare are primary benefits of membership in a community. We rely on one another for these essential goods of human thriving. We come to human awareness in community. First we know family and gradually the circle enlarges to bring us awareness of many others with whom we share our lives. In community we find shelter, nourishment, attention to suffering, values, and knowledge. In society we live, build, reproduce, suffer, and die. Shared life builds social solidarity among members of the same community. In relation to threats to health, organized health care is the societal response to suffering and death.

Key Questions About Social and Historical Context for Health Policy

1. *How can we keep in mind medical care, public health, and other social factors that influence health while pursuing questions of social obligation regarding health protections?*
2. *How can we keep ideas of social obligation relevant to historical and cultural patterns of response to health threats?*

How the response to suffering and death takes shape depends on social decisions made in government, in economic structures, in law, and in intimate familial choices. Over time a community's responses take institutional form. Some widely available protections and services come to be seen as basic needs that the community feels obliged to meet. Through various social processes, a community determines who are its members and whose needs it must meet. Society determines how strong its commitment will be (Walzer 1983). In contemporary parlance, society sets priorities to guide the use of its collective resources. The underlying justification for institutional policies derives from the shared health needs, common exposures to health risks, socially produced health benefits, and caring response to pathology. Health investment includes conducting research in an attempt to generate the information needed to demonstrate and improve the effectiveness of both preventive and treatment practices.

Key Questions About the Foundation of Health Security in Community Solidarity

1. *What obligations arise from social solidarity among members of a community who face common threats to health and well being?*
2. *Who counts as a member of the community with respect to health protections?*
3. *What information does a community need about its health to design an effective health protection system?*

Rights, Societal Obligation, and Self-Interest. Moral arguments about access to health care follow several pathways. Some invoke the concept of human rights. This argument asserts that basic human needs (such as food, shelter, education, justice) create an obligation on society to provide some level of common access to these fundamental goods. Access to these is a matter of right inherent in all human beings. Creating social mechanisms for the distribution of access to these goods (including health care) is a primary obligation of civil society (Mann 1999). Other approaches simply assert that the basic needs ground a generalized obligation on society to assure access to health care for all its members. This is an argument based on common good grounds. Access to health care is an element of the common good that improves the general well being of all members of society. It is a benefit of social life that ought to be pursued by society because it is achievable and possible. (President's Commission, Walzer 1983.) Another line of argument appeals to self interest of members of society. A significant stable level of access to medical care makes human existence more secure for each member of society. In this argument, the pursuit of individual well being is the ground for the obligation to take social action (Churchill 1994). All three of these lines of reasoning are too often narrowly focused on medical care rather than the full frame of health care.

Social Wisdom. Reflections on wisdom come after a prior societal determination to guarantee access for all to health care (whether as a matter of right, or common good, or individual self interest). Social wisdom directs us to shape our systems of health care so that we accomplish what we value. The scope of a mutual guarantee of health care has to be defined so we can commit sufficient collective resources to the system. For example, in the last twenty years, neonatologists have made remarkable strides in delivering effective care to endangered neonates. Yet during the same period, rates of prematurity and low birthweight have been rising. A narrow focus on medical care access and allocations prevents society from focusing on social and economic factors that lead to these birth conditions. As a matter of social wisdom, the public health frame will look for some way to reduce this increasing flow of patients to costly neonatal intensive care units (Lantos 2001).

A subset of wisdom is the challenge to our social prudence to build sustainable systems of protection and care. Prudence is the social virtue that looks ahead in time to determine what resources we need keep our system working. What portion of services available in the medical marketplace merit guaranteed access? What counts as the basic or adequate health care we want to guarantee? What is required to achieve our social goals and sustain them over time? For example, American health insurance plans have favored low deductibles and co-insurance arrangements, despite the fact that economic researchers have demonstrated that this approach fuels unnecessary use of health services and makes costs very difficult to control.

Fairness. Given a determination that all members of society should have guaranteed access to adequate health care (the solidarity, wisdom, and prudence questions), how should we distribute the benefits of these systems equitably and share equitably the burdens of financing our mutual protection and aid? The problem of equitably distributing both benefits and burdens arises from our reciprocal commitments to one another in community.

To resolve problems of fairness we always have to consider both the distribution of benefits and the distribution of burdens. For the distribution of health care benefits (guaranteed health care services) fairness calls for equitable access based on health care need. Equality among citizens follows on universal coverage. No citizen would be excluded (the solidarity question), although some needs (e.g., experimental treatments, cosmetic surgeries) might be excluded from the guarantee (the wisdom question). The benefit side of the fairness puzzle must look carefully at the content of the adequate care package. Does the benefit package favor certain health problems over others on some basis other than the core values of the community for health care? Historically, mental health has been less well served than physical health. This may represent a professional and social prejudice unfairly affecting persons with mental health problems. The critique from the perspective of fairness needs to look for this problem.

The fairness question also requires an examination of the delivery systems for health care. There may be geographic barriers experienced by some members of society. Examples might be rural health care where the need for transportation and relative thinness of health care resources can make care inaccessible for some members of society even though care is theoretically guaranteed. Unless carefully attended to, the delivery system might incidentally incorporate linguistic and other cultural barriers to adequate health care that will affect some but not all members of society.

The other side of the fairness question focuses on the distribution of burden. Here income and health status are essential elements of the analysis. Income level is highly relevant to the problem of fairly sharing the burden of financing access for all. Tax based systems can achieve more or less fairness. Progressive taxation schemes (higher tax rates for higher income households) seek to achieve equality through inequality. By setting unequal levels of monetary contribution, progressive schemes approach equality of burden. Higher levels of contribution will be less burdensome for wealthier households. A straight proportional contribution (imposing the same percentage rate on all income levels) seeks equality of burden by a different form of unequal contributions. Equal contribution (the same absolute dollar amount irrespective of income level) starts with the goal of equality of burden, but easily results in significant inequality of burden across income levels.

Government sponsored programs use tax based contribution schemes. For example, Medicare is federally financed through Social Security taxes and provides health insurance for the elderly, persons with disabilities, and persons with end-stage renal disease; Medicaid provides coverage for certain persons with low incomes and is financed by matching funds from various state and federal taxes and revenues. Fairness evaluations of tax based systems need to explore the degree of burden experienced across income levels (Reinhardt 1993). Most taxes that support health programs are progressive, although some regressive tax programs (e.g., tobacco taxes) are also in vogue. Insurance premiums use the equal contribution standard. Premiums often adjust for age, health status, gender, and geographic location. Recent legislation at federal and state levels has ruled out some of these ways of adjusting premiums as unfair. Deductible, co-insurance, and co-pay mechanisms redistribute contributions from premiums (all members of a specific group) or taxes (all taxpayers) to those who use the health care system. The more severe the need (acute or chronic) the heavier the redistribution burden these mechanisms produce. The social ethics evaluation of fairness needs to examine the effects of the initial distribution and redistribution methods built into various financing programs.

Key Questions for Analyzing Ethical Reasoning About Access and Allocation

1. *Which path of argument seems most persuasive in grounding the social obligation to provide for health protections (human rights, common good, enlightened self-interest)?*
2. *What does social wisdom indicate are the essential elements of an adequate health system?*
3. *What are the major indications of fairness in the distribution of the benefits of the system of health protections?*
4. *What are the major indications of fairness in the distribution of the burden of maintaining the system of protections?*

Democratic process in health policy: participation and representation. It is essential to recognize that ethical solutions about access and allocation have to be joined to political solutions. Without this pragmatic link, ethical analysis and argument will not drive institutional arrangements. They may help us think more clearly about a problem but they remain hypothetical. They will not affect the life of the community in a material way unless joined to political process (Starr 1994, Garland 2001).

The movement into political process makes the ethical question more complicated. The work of developing a balanced interpretation of ethical concepts becomes engaged with economic effects, social power, and political ideology. It is not merely a question of the more rational or more efficient path. In the political arena one has to search for the path that leads to an acceptable outcome, even when that outcome is not the preferred outcome from a philosophical point of view.

In the context of American democracy (as practiced in local and regional communities), representation of the public interest in shaping and implementing health protections becomes a critical matter. In representative democracy, the elected officials are expected to act on behalf of their constituents but also on behalf of the whole community. How they form their conscience leaves considerable room for interpretation and persuasion. In the matter of access and allocation, the benefits and burdens of coverage and cost control make for contentious discussions.

Advocates of public participation argue that the citizenry should take on the responsibility of defining and promoting the common good. But the citizens are caught in the same conflicting currents of benefits and burdens that affect elected representatives. Theoretically, open dialogue about matters of shared interest (such as the system of health protections) can lead to finding better political solutions. The principle benefits hoped for from broad public participation are clarification of key values and commitment to pursue the common good ahead of private good.

Key Questions About Politics and Community Responsibility

1. *What are the central political concerns that need to be incorporated into modification and maintenance of the system of health protections?*
2. *How should community responsibility figure into political processes regarding health protections?*

The Oregon Health Plan (see case study below) is an example of an organized approach to define adequate health care using public discourse to define core values. It has succeeded to some degree in moving toward a politically effective definition of adequate health care. Similarly, the unsuccessful Clinton health reform plan called for a high-level national committee process to define basic health care (*Health Security*, Starr, "Logic").

Experts and the general community. In 1983 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission) proposed an ethical framework for pursuing the definition of adequate health care. For the Commission, a proper definition would reflect the kinds of services generally covered in market-driven health insurance, the informed opinion of clinical experts about efficacy of various services and standards of practice, and the relative value of health care in relation to other social benefits that rely on collective resources. This approach uses the market to help identify society's values about health care. It calls on experts to evaluate efficacy of specific services and relative importance for health. In addition to the market information (average benefit levels), several forms of social discourse and input can help determine the underlying values that should set the standard for wise use of collective resources (Garland 1994). A related ethical question asks what is required to achieve our social goals and sustain them over time. Social prudence requires policy that acknowledges fiscal constraints and the importance of developing policies that can guide ongoing institutions.

Moving from the ethics of access to the ethics of allocation of resources calls for careful attention to the data on which policy makers rely. Allocation of resources in pursuit of access requires the ability to achieve valued outcomes in sustainable systems. The systems have to distribute benefits and burdens fairly. To do this, society must have a way to determine the relative value of specific interventions in medical care and health protection efforts. Society also must be able to assess the relative value of various health-related institutions in the light of their effect on the general health status of the community and their contribution to the compassionate response to disease, trauma, and care for chronically ill or dying persons. To manage health care systems in pursuit of solidarity, wisdom, and fairness, leaders need data from quantitative epidemiology (knowledge of the distribution of disease and identification of probable causes). Quantitative data is useful but not enough to guide ethical discourse at the policy level. Complementary qualitative data from the stories of individuals living out health care relationships with one another and among various social institutions help policy makers understand the human value dimension of health care organizations. The capacity to care simultaneously for individuals and the community drives the assessment of needs and services. Knowledge of the values of the

community related to health and illness should guide the social ethics of health care provision. Scientific knowledge and technical capacity determine how society can respond to health protection opportunities and threats.

Allocation decisions affect which kind of protections or responses to pathology will be present and distributed in the community. Organizational preferences, individual choice, and social interests are in constant tension in the pursuit of fair allocations for health care. Social institutions suited to identifying the health interests of various parties or constituencies involve democratic and political process as well as judicial resolution of controversial claims. Emerging forms of deliberative process can enrich the function of political process in the pursuit of fairness, wisdom, and sustainability of the health system (Fleck 2002, Goold, Biddle, and Danis 2000, Lenaghan 1999, Garland 1999).

Participatory or deliberative democracy is an exercise of social responsibility. Three major goals define this process: education of the public, transfer of information from the public to policy leaders, and enhancement of the sense of responsibility in the community. Each of these goals is variably present in public participation activities. Some emphasize the education of the public about significant issues (for example, the National Issues Forum). Other programs seek to develop input to policy makers on specific issues (for example, the Oregon Health Decisions program, or a public opinion survey concerning a specific issue). The Oregon program also sought to build a sense of community responsibility for the Oregon Health Plan.

Several problems accompany the practice of deliberative democracy and public participation in health policy (Daniels 1992). The content of policy problems in the health arena are always very complex. Many critics say that the public is too ill-informed to have reliable input. They feel that legislators or other policy leaders should seek input from experts. Being elected or appointed by elected officials is enough input from the public to satisfy the conditions of democracy. In addition, most health legislation and policy activities have opportunities for public hearings or statements from the public during their work process. Finally, the legislative process is well attended by lobbyists who represent both special interests and public interest groups. These people, it is felt, are more informed and focused in their input, and therefore, more useful than general public input.

Key Questions About Public Participation and Technical Expertise in Health Policy

1. *What benefits and risks are associated with public participation in the design of health policy?*
2. *What benefits and risks are associated with the design of health policy by technical experts?*

We advocate general public involvement in health policy, but hold that it is important to structure it carefully to fit the circumstances of the general public. Leaders should not seek from the general public answers to questions better asked of experts. They should structure the encounters (community meetings, focus groups, surveys) to identify values relevant to the issue at hand. All members of the general public are able to give meaningful answers to questions about what makes health care important to them. This input helps the leaders specify the value-goals they should pursue. This information can help shape the questions leaders should ask of relevant experts (Garland 1999). Involving the public is a form of exercising community responsibility for the common good. This approach creates a partnership between the public and technical experts. The community

meetings and telephone survey used in the prioritization process for the Oregon Health Plan are an example of the partnership approach.

Experts in economics, insurance, epidemiology, clinical care, and public health have specialized knowledge relevant to health policy design. Data and expert opinion from these sources are essential to rational policy choices. Providers of special expert information, however, do not constitute the appropriate source for the articulation of community values. As members of the community, these technical experts represent only a narrow segment of the population. They are not a representative group. They tend to define problems from their specialized field. This leads to putting the perspective of the special field ahead of the values of the community. Priority should be given to articulating the social goals valued by the community. With a clearer view of these values, the experts can help leaders find the most effective or efficient way to achieve society's goals. The distinction between means and ends is an important one to bear in mind throughout the policy development process.

Conclusion

The ethics of access to health care in a community and of the allocation decisions required to maintain the system of health protections lead to fundamental questions about the meaning of life in community. Health systems are a social response to common threats to individuals in the community. The degree of social commitment to defending against these threats becomes a matter of social and political choice. Who is included in the community, what threats merit social defenses, how fairness will guide both benefits and burdens, and how the necessary political dimension of health policies, form a multi-dimensional frame for this examination. We derived a checklist of twelve questions that can guide the evaluation of a specific proposal for health protections reform (for example, the Oregon Health Plan or the Clinton Health Proposal). The same questions can easily be reformulated to guide an assessment of the status quo.

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Fact Sheet: Access and Allocation

A. National Health Expenditures

America spends $4,637 per person on health -- more than any other nation. Still 41.2 million, or 14.6% of the U.S. population in 2001 had no third party coverage for personal health services (private insurance or coverage under a governmental program).
Source: U. S. Census bureau (http://www.census.gov/hhes/www/hlthin01.html)

Total expenditures for health exceed one trillion dollars. The following table shows some of the categories of health spending. Personal health services account for 87% of the total. By contrast, government public health programs account for only 3% of the total health care pie. The table below shows information about US spending for health in 2000.

National Health Expenditures (selected categories)	Dollars (in millions)	Percent of total (Items do not total 100%)
Total	$1299.5	100%
Hospital Care	412.1	32%
Physicians and Clinics	286.4	22%
Dental care	60.0	5%
Nursing Homes	92.2	7%
Home Health Care	32.4	2%
Prescription Drugs	121.8	9%
Government Public Health	44.2	3%

Source: Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp)

Selected Web sources of information on allocation and access:

Centers for Medicare and Medicaid Services – http://www.cms.hhs.gov/
Kaiser Family Foundation – http://www.kff.org/
Health Affairs – http://www.healthaffairs.org/

B. General Questions for Analyzing Access and Allocation Issues

The following questions provide a general strategy for focusing discussion about specific cases. Use them to see if the discussion touches on all the points you think are important when considering access and allocation. Modify the list to fit your approach to ethical decision-making. A checklist allows you to keep track of important matters that are easy to forget in the course of working on a complex issue.

Frame of reference questions

- Which physiologic or psychological threats to health and well being are at issue in this proposed change?

- On which social factors that affect health (e.g., poverty, risky behaviors, environmental degradation) does this proposal focus?

Questions about scope of concern and historical context

- How broadly does the problem case construe the social obligation to provide health protections (medical care, long term care, public health, social factors)? What part of the full range of health care does this case seek to change?

- How does this proposal fit into its own historical and cultural contexts? What historical antecedents bring this case to critical status?

Questions about how community solidarity functions in defining health policy issues

- How seriously does this proposal take the obligation of social solidarity among members of the community (human right or some lesser obligation)?

- Who counts as a member of the community this proposal seeks to protect (eligibility requirements)?

- What information or assumptions about the community's health is this proposal based on?

Questions about ethical concepts and argumentation

- What vision of an adequate system of health protections is at issue in this case? What view of social wisdom does the case problem assume? What kind of social obligation is at issue in this case (human rights, common good, enlightened self-interest)?

- How does this case deal with problems of fairness in the distribution of benefits and of burdens?

Questions about community responsibility, political ethics, and technical expertise

- What are the central political concerns involved this case (power issues, status issues)? Which stakeholders have power? Which ones don't?

- What role should public participation play in this case (surveys, hearings, forums)

- What role should technical experts play in this case?

C. Fact sheet for Case Study I—The Oregon Health Plan

1. Goals of Oregon Health Plan (first legislation 1989)

- Coverage for all Oregonians (17% of population uninsured in 1989)
- Control costs of Medicaid
- Establish priorities for health services (guarantee the most important services)
- Prefer managed care delivery systems and administrative streamlining
- Private insurance reforms
- Mandatory coverage for employed persons
- Employers contribute to premiums
- Guaranteed insurance for persons unable to get private health insurance because of pre-existing conditions (High Risk Pool)

2. Target population: about 350,000 uninsured persons

- Medicaid: anyone with income below the Federal Poverty Level
- One third of the uninsured to be helped by Medicaid
- Two thirds of the uninsured to be helped by private insurance reforms

3. Funding

- Medicaid uses state and federal funds (40% state and 60% federal)
- Employment-based insurance would require contributions by employer (at least 50% of premium for employee, nothing for dependents).

4. Responsibilities

- Health Services Commission: creates and maintains prioritized list of health services
- Legislature
  - Establishes Medicaid budget by "drawing a line" on the list
  - Needed to pass legislation to implement the mandatory insurance program*

* The mandatory insurance strategy was never implemented because of complex federal laws protecting employee benefits. This part of the strategy was eventually repealed and partially replaced with a program to offer subsidies for insurance premiums to low income families. Current reforms (2002) seek to expand that subsidy program and require further waivers from the federal government.

D. Fact Sheet for Case Study 2—Using Intravenous Immunoglobulin (IVIG)

1. Clinical Facts

- The FDA lists 6 approved ("label") indications for IVIG use for which reasonable supportive evidence exists.
- Different institutions vary considerably in how IVIG is used even for these labeled indications (e.g. some provide routine initial prophylaxis for bone marrow transplant recipients, others limit use to prophylaxis for certain high risk recipients or treatment of specific clinical indications.
- Anecdotal reports and small clinical studies have led to a profusion of "off-label" uses. There is little supportive evidence for most of these off-label uses, but for some there is good evidence of effectiveness (both published and by clinical experience)
- For most indications (label and off-label) no data exist to support any particular treatment regimen.
- Current rationing of product occurs implicitly by a first-come-first-serve basis coupled with the "squeaky wheel" phenomenon.

2. Administrative Facts

- Several clinical units are frequent users of IVIG for quite distinct clinical indications (bone marrow transplants, neuro-muscular disease, infectious diseases, hematologic diseases, and immunologic diseases).
- The pharmacy administration had exhausted all available resources for the supply of additional product.
- Attempts to address the demand problem through provider education and by asking for provider justification for each prescription had failed to change IVIG use patterns.
- Current policy is simply "first come, first served" until the supply of IVIG is exhausted.

E. Fact Sheet for Case Study 3—Cutting a State Health Department Budget

The state public health agency is required to show the public health service consequences of a 15% reduction in its budget. The agency delivers its public health services through five service centers. Here is a summary statement of the services selected to feel the effect of the reductions. Other activities of each of the centers would remain unaffected by the proposed reductions.

- Impact on Administration and Special Programs: reduce funding to county health departments to make flexible strategies for local priorities.
- Impact on Center for Child and Family Health: eliminate teen health advice line and 4 high school based teen clinics; reduce support for maternity and well child care for families with low incomes.
- Impact on Center for Disease Prevention and Epidemiology: stop paying for drugs used to treat Hepatitis A and TB; eliminate support to counties for STD, HIV and TB case management programs.
- Impact on Center for Environment and Health Systems: eliminate some staff consultants on environmental issues; eliminate staff and subsidies for Emergency Medical Systems program; introduce fees for monitoring of public drinking water systems.
- Impact on Public Health Laboratory: eliminate free tests for parasites, syphilis, flu and other respiratory viruses; cease participation in U.S. and WHO influenza surveillance program.

Case Study 1: The Oregon Health Plan

For this case discussion, we will focus on the question of rationing health care that played a central role in the health care reform carried out in Oregon during the 1990s.

In 1989 Oregon passed several pieces of legislation that formed the basis of the Oregon Health Plan (OHP). The program aimed at achieving access for all Oregonians to affordable medical care. At the time, it was estimated that 350,000 Oregonians (of a population of 1.2 million) lacked coverage. The vast majority of these persons had incomes below or near the Federal Poverty Line (FPL). Although the reform seeks primarily to expand access to health care, it achieved considerable notoriety as a program that "rations health care."

The Oregon legislature, led by Senate President John Kitzhaber, MD, crafted a two-part strategy to get to universal coverage. First, Oregon Medicaid was redesigned so that everyone below the Federal Poverty Line, for example, a family of three with an income of $14,628 (in 2001 dollars), would be eligible for coverage. Income only, with no additional categories would be the basis for eligibility. By contrast, traditional Medicaid is a program in which income plus some category, particularly families with dependent children, constitute eligibility. In 1989, eligibility for Oregon families had fallen to 58% of the FPL so that a family of three with an annual income above $ 8, 484 (in 2001 dollars) would not be poor enough to qualify for Medicaid.

Medicaid is a federal-state partnership program in which federal dollars match state dollars based on a federal formula that factors in the relative wealth of the state. In 1989 Oregon received $60 for every $40 it put into Medicaid. A major part of the politics of the Oregon reform focused on satisfying the concerns of the federal government to maintain the matching federal dollars. The use of categories is a central feature of the federal Medicaid rules.

The second strategy required all Oregon employers to participate in the purchase of health insurance for their workers. Initially the program would be voluntary, but if employers did not reach the target, the requirement would become a mandate. Employers who did not participate in the purchase of health insurance for their employees would pay a special tax that the state would use to purchase insurance for those left out.

Based on population demographics, the Medicaid reform was expected to bring coverage to one third of the uninsured and the employer-sponsored insurance would bring coverage to the remaining two thirds.

Three other goals of the OHP were definition of an adequate health care package, improved control of the Medicaid budget, and a fair distribution of the burden of paying for universal coverage. The adequate package goal was pursued through the formation of a prioritized list of health services. The use of the list to structure Medicaid required an agreement with federal Medicaid administrators to exempt Oregon from the usual Medicaid rules (called a "waiver"), since the federal rules considered some services mandatory and others optional. Oregon felt a prioritized list would better approximate an adequate health care package, since some optional items (like hospice care, organ transplants, and dental care) were more valuable than some mandatory services included in a general category of physician and hospital services. (Several states besides Oregon currently have waivers so they can test local experiments with their Medicaid programs.)

Improved control over Oregon's Medicaid expenditures was expected to result as the legislature used the list to determine Medicaid budget ("drawing a funding line on the list") and from administrative efficiencies carried out by the Medicaid Agency. In 1989 the legislators held high hopes for a cost control strategy of using managed care for Medicaid clients.

A special committee, the Health Services Commission, was established to create the prioritized list. The list's first use was to give the legislature a tool for budget allocations. The Commission's role is to identify the relative value of various health services. The legislature's role is to identify the relative value of health care among other uses of the state's resources (for example, education, transportation, economic development, environmental protection, and non-clinical public health services).
Its second use was to set a benchmark for those private insurance packages that would qualify as meeting the employer mandate requirement. The benchmark role was intended to prevent employers from fulfilling the letter of the mandate by selecting cheap plans that offered inadequate coverage (thus failing to meet the spirit of the law—health protections).

The law required the Health Services Commission to hold public hearings and community meetings to identify the values that should guide the prioritization process. Two civic organizations, Oregon Health Decisions and the Oregon Health Action Campaign partnered with the Commission to design, publicize, and report the results of the community meetings. The Commission also held public hearings and commissioned a random sample telephone survey to complement the community meetings. All of these public involvement modalities focused on community values rather than specific services. The public was asked, "What makes health care important to us?"

The Commission also recruited more than 50 teams of clinicians to provide input on the probability that specific treatments for specific conditions would achieve results matching the values of the community. Each item on the prioritized list consists of a diagnosis and treatment pair (or groups of such pairs). All services available in the medical marketplace were open to inclusion on the list. The Commission used the *International Classification of Diseases* and the *Current Procedural Technology* to establish the range of condition-treatment pairs. The task of clinical experts was to help identify what services were likely to pay-off in terms of the community's values for health care.

The Commission created its own methodology using mortality, morbidity, treatment effectiveness, and costs as primary points of reference. Values derived from the community meetings, survey, and hearings guided their interpretations. The list that finally received approval from the Federal government for a waiver from the usual Medicaid rules had the following logic. First, the lines would be ordered in terms of the probability of the treatment being life saving. Lines with higher probability of saving life come before those with lower probability. The Commission believed this ordering serves two values expressed by the public: life saving and effectiveness of treatments. Second, among those items with identical probability of saving life, the commission placed lower cost services ahead of higher cost services. This incorporates the community value of cost-effectiveness.

The third ordering principle required the Commission to intuitively place items that served important values identified by the community that were not covered by the first tow principles. These values included the following. "Compassion" led to placing hospice and other palliative services high on the list. "Prevention" and "Effect on the community" led to placing maternity care, and many screening and

early intervention services high on the list. "Maintaining function" led to placing many mental health services and substance abuse rehabilitation services in secure positions.

Post script: The Medicaid program began operation under federal waiver in February 1994. The list is revised every two years. The entire list currently consists of 743 lines and is funded through line 574 (about 80% of the list). The employer mandate strategy failed politically in 1996 and has been replaced with a small subsidy program to aid families with incomes above federal poverty to purchase health insurance. Additional support for universal coverage comes from a federally stimulated program in 1998 to secure health insurance for children.

Questions for discussion

- Critics have attacked the Oregon Health Plan for rationing health care "only to the poor." They assert that the good idea of extending health coverage to more poor persons was corrupted by reducing benefits only for the poor (current Medicaid clients) and using those savings to fund care for other poor persons (new Medicaid clients). Fairness, they argue, would require that all citizens submit to the rationing of health services in order to extend coverage to more of the poor. Supporters of the Oregon Plan have responded that all the poor are better off because the extended income range will provide continuous coverage for current clients when their income improves. They argue further that the more rational benefit package (based on the list) is a better one than the traditional Medicaid package. What are your thoughts about the dangers of rationing medical care only among Medicaid eligible persons? How would you argue in favor of rationing medical care?

- Critics have objected that the community meetings were not sufficiently representative of the people whose lives were affected by the Oregon Health Plan. They argue that meetings should have been exclusively for persons below the Federal Poverty Level. Instead, although the meetings did include people with incomes below the federal poverty level, most of the people at the meetings were from the middle class and therefore their values were not relevant guides for setting priorities. This, say the critics, makes the community values of little relevance to the Medicaid reform. Supporters have responded that values about access to health care are widely distributed so the values of the middle class participants are quite relevant to this issue. They also point out that the discussions did not ask people, "What services do you want?" Instead they asked "What makes health care important to us?" What do you think of this criticism and response? What do you think is an ideal solution to this question of representation in public participation efforts?

- Some critics opposed the Oregon Health Plan because it is incremental rather than radical. "Being successful with a plan like this," they argue, "only delays America achieving true universal coverage based on progressive financing through taxes. Efforts put into plans like Oregon's distract America from the search for real solutions to the central problem of health care." What is your position on whether incremental reform is a barrier to needed radical reform?

- For several decades, public opinion polls have shown that Americans believe in the ideal of universal access. In recent years, opinion also supports significant reform of the system. Still,

America continues to have almost 20% of its population uninsured for health care. How do you interpret this contradiction between public opinion and public action?

- Some people argue that getting universal coverage won't do much to help the health status of the population. Health is more seriously affected by social causes (obesity, poor nutrition, poverty, stressful lifestyles, violence) than by access to medical care. What are your thoughts on this critique?

Case Study 2: Multiple Claims and Commitments in a Health Care Institution

This case explores the organizational ethics of dealing with a scarce resource within the context of a single health care institution. Different clinical units had differing clinical reasons for using this scarce resource for their patients. How do you think about resolving conflicting moral claims?
Intravenous immunoglobulin (IVIG) is a pooled and concentrated blood product. A single unit of human immune globulin comes from 100,000-300,000 units of donated blood. The FDA has identified six approved or "labeled" medical conditions for which IVIG is licensed and for which there is general agreement among clinicians and variable amounts of supporting evidence. Intravenous immunoglobulin has also been used and recommended for a host of "off-label" (i.e. non-approved) indications, for only a few of which is there good supporting evidence. Clinicians are free to use an approved substance for "off-label" indications, although they incur greater risks of malpractice action in the event of bad outcomes.

A nation-wide shortage of IVIG developed in the mid-1990s resulting from problems with both supply and demand. Growing concern about the possible risks of transmitting Hepatitis C and human forms of spongiform encephalopathy (Creutzfield-Jacob Disease) by blood products was largely due to reports of either disease or positive tests for disease in individual donors whose donated blood was traced to pooled blood products. These reports were all the more compelling because they occurred in the wake of the HIV threat to blood products in the 1980s.

Concerns about the safety of the nation's blood supply led to a marked increase in regulatory activities by the FDA around IVIG and its production. Manufacturers were required to make major changes in production processes in order to correct deficiencies. This in turn required manufacturers to stop or slow production, which had a prolonged negative impact on the output of final product. Some manufacturers discontinued production altogether–and substantial amounts of product were either recalled or withheld because of relatively conservative criteria for defining and increased risk of transmission, adding to problems with supply. These events contributed to the current critical shortage as well as decreased the long-term potential for recovery of supply.

In addition to the constraints on supply, demand increased markedly in response to research studies and anecdotal reports of IVIG use that expanded the list of off-label indications for IVIG. These off-label uses are not only numerous but often involve high dosage regimens that consume large quantities of product. The shortage of IVIG became an issue at the Kos University Memorial Hospital (KUMH), a large academic health center, during the late 1990s when the pharmacy began to experience a marked increase in the cost of IVIG (from $15 to > $40-50 per gram) and then reached a point where minimal quantities could be obtained at any cost.

The usual sources of IVIG began to dry up, requiring considerable ingenuity to keep KUMH supplied with enough IVIG to meet its ongoing need. By January 1998 the shortage had reached critical levels and the pharmacy looked to the administration for a solution.

Questions for Discussion

- Suppose you were the responsible hospital administrator involved in this shortage problem. How would you organize your thinking about this dilemma? What are your ethical obligations and what process would you call on to serve those obligations?

- Now suppose you were a clinician-leader in one of the specialties that regularly uses IVIG. How would you organize your thinking about this dilemma? What are your ethical obligations and what process would you call on to serve those obligations?

- Who are all the stakeholders that need to be involved in dealing with this problem? How would you most effectively engage them? What rules of discourse do you think ought to guide the process of developing a new institutional policy about clinical uses of IVIG?

- What are the ethical constraints faced by each of these stakeholders and how do you think each defines the ethical issues she/he faces? What are the ethical stories or central ethical metaphors (for example, healer, administrator, patient advocate) that each stakeholder uses to define the ethical context within which she/he works in thinks about that work?

- What information do you need to factor into your solution?

- What are the wider ethical implications of this problem? How do you think those implications are likely to be framed at different levels of the health care system? Do you think the treating physician should be concerned with shortages for other physicians and patients in KUMH? Or other hospitals served by the same regional blood supply system? Or the national supply system? Or the international supply system?

- What strategies for discourse and decision should the administrative staff use in addressing this issue? What are the ethical implications of how one uses data at different levels of decision making?

- What is the ethical justification for your recommended strategy?

- What do you think is the nature of what one might call an "ethical perspective" on allocating scarce medical resources?

Case Study 3: Making Cuts in a Health Department Budget

Frame of reference

A public health agency budget is the locus of allocation decisions. Ethical reflection on allocation decisions enters reality by working out a practical resolution of conflict among public health values in the context of an agency's budget. On a regular basis, state public health agencies set budgets and must deal with fiscal constraints on what they can do. This case explores the ethics of identifying places in a hypothetical state budget where administrators propose cuts to services that can produce an overall reduction in expenditures of 15%. In the aftermath of September 11, 2001 and the subsequent recession, most states across the country faced severe shortfalls. The 15% budget reduction imagined here is not an unusual scenario.

The North Upland Public Health Budget

North Upland has a state population of 4 million. Immigration from other states and foreign countries exceeds emigration from North Upland to other states and countries. In terms of per capita income it falls into the middle tier of states. The state has a lower percentage of persons without health insurance than the national average. In the past few years it has moved from one of the lowest rates of unemployment in the nation to one of the highest.

The N.U. Health Department organizes its activities around five Centers: 1) Administration and Special Programs, 2) Child and Family Health, 3) Disease Prevention and Epidemiology, 4) Environment and Health Systems, and 5) the Public Health Laboratory.

The North Upland State Health Department has proposed a two-year budget of $49,139,000 for 2002-04. The total budget of the Health Department is composed of 62% state general funds ($30,447,000) and 38% federal funds ($18,661,000). Federal funds are tied to specific programs. The Governor of North Upland has asked all state agencies to construct a budget showing what they would cut if faced with a 15% reduction in state general funds. The list below shows more than $4.5 million in cuts proposed by the Health Department along with a narrative showing the anticipated consequences for the health of the population if these cuts are made.

Proposed budget cuts and their consequences

1. From the Office of the Administrator and Program Services
   ($1,000,000 cut from a budget of $6,667,000)

   - Reduce general purpose public health support payments to counties
     Savings: $1,000,000
     Impact: This will reduce funds counties use to make flexible adjustments to various public health activities based on local priorities.

2. From the Center for Child and Family Health
   ($1,692,000 cut from $11,280,000)

- Eliminate Teen Health Information Line
  Savings: $97,000
  Impact: Would cut in half the capacity of the major metropolitan county health department to answer calls from an estimated 4000 teens on a variety of health issues.

- Eliminate funding for 4 High School Based Clinics
  Savings: $415,000
  Impact: Would probably result in closure of these programs which will have to be fully funded by the School District which faces severe loss of revenue at this time.

- Reduce support for Perinatal Clinical Services and case management
  Savings: $870,000
  Impact: Reduce support for counties to provide maternity and well baby services and case management for clients with complicated cases. Involves and estimated 10,400 mothers and babies.

- Abolish state funding portion of the Child Health Program
  Savings: $310,000
  Impact: Reducing payments to counties for this service affects a variety of well-child programs provided free of charge through county clinics. Examples: SIDS prevention, nutrition services, injury prevention, dental health education, adolescent health promotion. Counties would have to come up with the funds or eliminate services.

3. From the Center for Disease Prevention and Epidemiology
   ($1,035,000 cut from a budget of $6,900,000)

   - Eliminate provision of specific medical supplies and services.
     Savings: $425,000
     Impact: The state would no longer provide immune globulin used to prevent the spread of hepatitis A or drugs used to treat persons with active or latent TB. The state currently provides free treatment for 1570 persons with active or latent TB and 2900 persons exposed to Hepatitis A. In the future, persons in need of these drugs will have to pay for them or receive them through some private charitable source.

   - Reduce special payments to Counties for HIV/TB/STD programs
     Savings: $610,000
     Impact: This will eliminate the HIV case management program for persons with HIV and TB. It will diminish the capacity to notify sexual partners of persons who have been diagnosed with a sexually transmitted disease.

4. From Environment and Health Systems
   ($495,000 cut from a budget of $3,300,000)

   - Eliminate staff in the Environmental Services and Consultation Office
     Savings: $165,000
     Impact: This will reduce the capacity of the office to enforce restaurant, pool, and

lodging standards throughout the state. It will also eliminate direct service for environmental health issues in twelve counties that now rely on the state office. This funding might be replaced by increasing licensing fees to restaurants, swimming pools and public lodging businesses.

- Eliminate staff and subsidies in Emergency Medical Systems program.
  Savings: $165,000
  Impact: This will affect the ability of the program to oversee training certification, professional standards, investigation of complaints, and statewide system development and coordination. Subsidies (reduced licensure fees) will no longer be provided to small, primarily volunteer, ambulance services in rural areas.

- Initiate fees for Public Drinking Water Systems
  Savings: $165,000
  Impact: Replaces state dollars with new fees on systems (requires new specific legislation). Federal matching dollars (1:1) will be lost if replacement money is not available. Reduces the ability of county water programs to monitor safe drinking water standards.

5. From the Public Health Laboratory
   ($ 344,000 cut from a budget of $2,300,000)

- Eliminate free parasite testing.
  Savings: $114,000
  Impact: The lab would no longer provide at state expense testing for parasites such as Giardia (900 cases reported in 1998), Cryptosporidium, and many others. This will require local health departments to pay for tests needed to detect and control community outbreaks or identify the source (e.g., food handlers, day care centers).

- Eliminate free syphilis testing.
  Savings: $115,000
  Impact: We will no longer provide screening and confirmatory tests for syphilis at state expense. Local health departments, charity clinics, family planning clinics, and correctional institutions will have to pay for tests needed to detect, monitor, and control syphilis. We anticipate an increase in the number of cases and severity of disease in those infected.

- Eliminate free Influenza cultures and other respiratory infectious agents
  Savings: $115,000
  Impact: We will no longer test at state expense for influenza and other respiratory viruses. We will no longer participate in the U.S. and WHO influenza surveillance program. We will rely on others to detect a change in the flu strain that might affect citizens in North Upland.

Case Study 3: Discussion

The ethical pattern involved in this case involves "least harm" decision-making, where harm is identified by loss of valued outcomes as a result of budget reductions. An agency typically projects its budget by assuming the continuation of the activities carried out with the resources of previous budget. The agency then makes the case for two potential steps. It may propose to discontinue or reduce a previous activity. It may propose to initiate some new activity. The situation we will consider raises questions involved in reducing and discontinuing activities.

The case discussion should look at both the content (the reasons that support the choice) and the process by which the identification of reductions takes place. The content aspect considers ethical categories such as common good, fairness, justice, and rights. The process aspect considers democratic values such as participation, voice, representation, and sacrifice.

Context

Although the case provides little information about context (social, economic, political, historical) for these decisions, your discussion should explore what context issues your believe are essential for analyzing the case from the perspective of ethics.

Are there population health factors (e.g., age, state wealth, endemic diseases, environmental threats, etc.) that would be important considerations in selecting which of the programs would be cut? (Remember, 85% of the budget is still funded.) Draw up a list of important population health factors you think must be considered in this decision.

From a population perspective, what values do you want to use to guide the selection of budget cuts? The North Upland Health Department states that its mission is: "To protect, preserve, and promote the health of all the people of the state; to prevent unnecessary death and disability, improve the health status of all N.U. inhabitants, and to reduce the per-capita cost of illness care for all North Uplanders." Does this capture all the values you want to bring to bear on allocation decision-making? Make a list of any values you don't want to be left out of the consideration.

Ethical content

- What are the principles you would use to guide choices and evaluate the results of these budget choices? Try to articulate the rules or "guidelines" you think ought to be used to see that budget reductions deal with the following ethical concerns.

- How should we make sure that the cuts are *fair* to all involved?
  (State the decision-rule you think should be followed to achieve a *fair* decision.)

- What can we do to make sure that the cuts meet the requirements of *justice*?
  (State the decision-rule you think should be followed to achieve a *just* decision.)

- How can we be assured that the cuts serve the *common good*?
  (State the decision-rule you think should be followed to achieve a decision that promotes or

protects the *common good*.)

- What other ethical norms do you believe are essential to making an ethical decision about reducing (or expanding) a public health budget?
  (State the decision-rule you think should be followed to achieve a decision that incorporates these other norms.)

Ethical Process

- This part of the discussion focuses on *how* the decision is made. Process ideas will focus on who should have a *voice* in the decision, how *representation* of stakeholders is achieved, what *rules of discourse* are followed, and how a *conclusion* is reached.

- Who do you think should be consulted about these cuts? How should they be notified?

- How should inputs be sought?

- How should the decision maker use the inputs?

- How should the input process (or debate) be brought to a conclusion so a decision can be made?