

MEDICAL HUMANITIES REPORT

10th
Anniversary
Year
1987-88

MEDICAL HUMANITIES REPORT

MICHIGAN STATE UNIVERSITY

SPRING 1988

Just Health Care Financing: The Canadian Model

For roughly the past ten years national health insurance has been thought to be a dead policy option in the United States on the grounds that it would be too expensive. It would mean adding the costs of insurance for 35 million currently uninsured Americans, conservatively estimated at \$50-70 billion per year, which would mean an increase of 1% to 1.3% in the fraction of GNP devoted to health care.

Canada is a nation that is very similar to ours in terms of social values, economic institutions, and political traditions. But Canadians provide publicly financed universal health care, seem to enjoy the same high quality health care as we have in America, and that care is distributed both more equitably and more cost effectively. How are the Canadians able to accomplish this? And why are we failing to achieve these same objectives?

Canadian health economist, Robert Evans, has argued that universal coverage is a necessary condition for government achieving effective health care cost control(1). By way of contrast, when there are multiple funding sources, as in the U.S. system, there are always opportunities for health providers to do more in order to earn more. This is not just inefficient. It is unjust. The rhetoric for this decade has been that cost containment can be achieved most efficiently through competition among multiple providers and financiers of health care services. But the reality has been the diversion of resources into expensive marketing campaigns by competing hospitals and HMOs. **If justice requires that there be some proportionality between health needs and access to health care services, then a fragmented, competitive system for financing and delivering health care falls far short of being just.**

In 1960 both Canada and the United States were spending about .15% of their GNP on financial administrative costs for their health care systems. By 1985 the Canadian figure had declined to .12% while the comparable American figure had risen to .65%. What that means is that we are spending six times as much as the Canadians for administering the financing of our health care system, which represented about \$22 billion in 1985(2). It is very difficult to justify that kind of expenditure from the perspective of social utility. It is even more difficult to justify it from the perspective of justice since, in effect, **the poor and the uninsured are paying taxes to finance a system aimed at denying them the health care they need.**

When we consider that there are hundreds of health insurance companies in the United States and hundreds of HMOs, each with their own unique set of covered and excluded health services, plus fifty different state Medicaid programs, plus all the rules and regulations associated with Medicare and DRGs, plus 10-20 million people each year whose insurance status changes due to employment changes, death, divorce, marriage, Medicaid eligibility conditions, and so on, it is understandable that an army of bureaucrats would have to be employed to police the system. What is not so readily understandable is the rational warrant for remaining committed to a system such as this. Dickman and others(3) have correctly observed that "no interested party--not organized medicine, providers, the government, or consumer groups---sought the system of health care we now have."

Somewhere in our national conscience is the idea that we are committed to a single standard of care for all in our society. Certainly that moral commitment was a major

part of the rationale for the Medicare and Medicaid programs. Even though we have fallen short of that ideal in the past, our increasingly fragmented system for financing health care seems to be driving us still further away.

Unlike the British system, Canadian health care is not socialized medicine(4). Health care professionals are not employed by the state, nor is their hospital system owned by the state. All Canadian citizens are entitled to similar access to health care, regardless of ability to pay. Employed Canadians have an insurance premium payed on their behalf by their employers. The 30% of the population who are over the age of 65, or unemployed, receive premium-free health care. Each province has its own health plan, though the differences are slight. The federal government contributes about half the costs of these plans, the remainder being the responsibility of the provincial governments. There are virtually no costs to patients at point of service, which means patients are not put in the position of having to make rationing decisions for themselves on the basis of their ability to pay. These decisions, of course, are a common feature of health financing in America, which rapidly erodes the ideal of a single standard of care for all.

For all practical purposes the standard of care available to all Canadian citizens is one with which middle class Americans are familiar. How then can the Canadians avoid the problem of escalating health costs? The key seems to be the monopsony power that the Canadian people have granted to their government in bargaining with health care providers. That power is what maintains in practice the moral judgment of Canadians that all citizens should have roughly equal access to the health care they need. More specifically, the Canadian government controls very carefully the dissemination of expensive high-technology medical services. Individual hospitals are not free to just add expensive services in the hopes of gaining a competitive advantage over neighboring institutions, and the government negotiates binding physician fee schedules. Physicians are not allowed to bill patients extra for charges not covered by the province. Finally, hospital budgets are negotiated with the provincial governments. That is, each hospital is expected to live within a global budget, which means administrators and the medical staff will have to negotiate internally trade-offs that are necessary to stay within budget.

A major advantage of such global budgets is that gaming opportunities of the sort that push up costs are minimized. In America under Medicare DRGs all sorts of financial advantages can be gained by manipulating diagnostic categories, disaggregating bundles of services, shifting the provision of services to out-patient settings outside DRG boundaries and so on. None of these sorts of gaming opportunities are available to Canadian hospitals. Likewise, DRGs reinforce the acute care, high-tech approach to treating the medical problems of the elderly, when their fundamental medical needs are chronic and require more in the way of high-touch rather than high-tech care. The economic incentives in the Canadian system support that kind of more appropriate care for the elderly by discouraging inappropriate and expensive high-tech care.

Since it is one system that pays for the care of all patients, there are no opportunities for discriminating against patients with less ability to pay for the care that they need. In this respect clinical decisions are divorced from direct economic considerations. Still, the fact is that in matters of hospital care there are global budgets, which means that rationing decisions do need to be made. I am not aware of any research on precisely how these decisions are made. It seems that certain "professional understandings" emerge regarding appropriate and inappropriate care under specific circumstances, as opposed to explicit administrative rules that would govern such decisions. In other words, rationing goals are achieved in a way that is essentially invisible. There may be professional oversight, but the public seems to be excluded from participating in the making of these rationing decisions. I have argued elsewhere that invisible rationing challenges our basic intuitions of justice(5).

Evans concedes that no very careful evaluation has been done of the Canadian system for financing health care prospectively. Everyone recognizes that the incentives in such a system are for undertreatment. But if undertreatment means that expensive, marginally beneficial care is foregone, and if those marginal benefits are denied virtually across the board so that there is no identifiable group of patients who are arbitrarily discriminated against, then there would be no injustice. Of course, we have no right to assume that this is what happens in fact, which is why

there is need for careful empirical research. In conclusion, there is much to recommend the Canadian system of financing health care from a moral point of view. It certainly seems to have substantial advantages over our own system. If there is any strong negative point that needs to be made, it is that the Canadians have failed to initiate any sort of broad public conversation regarding the painful rationing choices that will have to be made in the future. But in that respect they are no worse than we in America. And they have some breathing room since they have been more successful in containing escalating health care costs thus far. Leonard M. Fleck

References

- (1) Robert G. Evans, "Finding the Levers, Finding the Courage: Lessons from Cost Containment in North America," Journal of Health Politics, Policy, and Law, 11 (1986), 585-615., at 597.
- (2) Robert G. Evans, Strained Mercy: The Economics of Canadian Health Care (Toronto: Butterworths, 1984).
- (3) Robert Dickman, Amasa Ford, and others, "An End to Patchwork Reform of Health Care," The New England Journal of Medicine, 317 (Oct. 22, 1987), 1086-89.
- (4) John K. Iglehart, "Canada's Health Care System," Parts I, II, III, The New England Journal of Medicine, 315 (July 17, Sept. 18, Dec. 18, 1986), 202-08, 778-84, 1623-28.
- (5) Leonard M. Fleck, "DRGs: Justice and the Invisible Rationing of Health Care Resources," The Journal of Medicine and Philosophy, 12 (May, 1987), 165-96.

Case Study: Obstetrics, AIDS and Ethics

Ms. R., a 21 year-old unmarried black woman, had an unplanned pregnancy diagnosed when she sought Emergency Room treatment for abdominal pain approximately one month after conception. A short time later she was notified by the County Health Department that she was a contact of an HIV positive individual; she did not know the identity of this person. In her fifth month of pregnancy she developed Pneumocystis pneumonia and later a Cryptococcal meningitis. Treatment required extensive hospitalization and administration of medications with unknown consequences to her unborn child. The uncertainty of treatment as well as the high likelihood of transmission of the HIV virus to her baby were discussed with Ms. R. by the residents and attending physicians on numerous occasions. Throughout the preg-

nancy she reaffirmed that she wanted everything possible done for herself and the baby. Throughout the hospitalization, caregivers were concerned about potential risks to their own health.

Discussion

Dr. William Weil, MSU Professor of Pediatrics and Human Development:

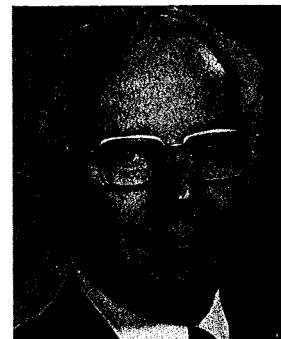
For a thousand deliveries in a hospital this size, the incidence of HIV seropositivity is probably one in a thousand, based on a cord blood study they did at Harvard. If you're worried about needle stick transmission in a hospital that does 4000 deliveries a year, one case will occur every 2500 years. That sort of puts things in perspective, but that's only needle stick transmission.

In the delivery room there are other kinds of contamination. There is a lot of blood around and you could get blood onto your mucous membranes or onto an open lesion on your hands if you were ungloved. If you figure that for one out of fifty patients delivered you might be contaminated by blood, and that the transmission rate by these routes is 10% (which is pretty high), then there would be a case transmitted at least once every 125 years.

Dr. A, Attending Physician: You are probably correct with one qualification. This center is being used as a referral facility for anyone with known seropositivity or in the major risk groups for AIDS. So we probably end up having a little bit higher potential for positive patients than one would encounter in general care centers.

Dr. B, Resident Physician: I think the thing that worries us most is that we really don't know the infectivity of this virus. We know there are people who are repeatedly exposed to HIV positive sexual partners who never become seropositive themselves. There are also people who test positive and show no signs of disease.

Dr. Weil: So...make an assumption. Make the virus as infectious as you want. We know that it is much less infectious than Hepatitis B and yet, even in the days before the ability to immunize people against Hepatitis B, we didn't have the same level of anxiety that we have about AIDS and it was a much, much greater risk to physicians. I think the reason we have so much trouble with AIDS, although it is presumably a fatal



William Weil

disease, is the fact that it is associated with homosexuality and drug abuse. If it was a disease which was randomly distributed in the population and had nothing to do with sexual preference or moral behavior, I don't think we would have the same problems.

Dr. C, Resident Physician: I think for me the issue is how lethal the disease is. I know hepatitis **can** be lethal, but AIDS is **absolutely** lethal and it's that absoluteness that makes it so scary. Yesterday for the first time I filled out an incident report and drew HIV titers on a patient without even asking, because she was an IV drug abuser.

Dr. Weil: What justification did you have for drawing blood without asking her?

Dr. C: I guess I really didn't have any justification. I was protecting **myself**. I want to know if I've exposed myself.

Dr. Weil: But you realize if she tests negative, you've learned nothing. She can be positive six weeks from now. **Then** will you track her down and draw another blood test without her permission?

I think as health professionals we should have the data well at hand. If we're part of the problem by virtue of our own ignorance, rather than part of the solution, then we have not fulfilled our role as a health profession. I've looked at the data and I think that this kind of behavior is craziness. If I worried to that degree, I couldn't get into my car and drive to work because the **chance of my being killed in my car is almost a thousand times greater than getting AIDS**. The fact is, we are in a risk-taking world. Every time we drive, cross the street, or get in an airplane, we take risks.

The AMA, among others, has written about the possibility of saying "I don't want to take care of a patient with AIDS." I think their position is based on the concept of professionalism or what we call a fiduciary relationship with people. That's a relationship built on trust. In other words, patients trust you and you trust them. Now it may be that I can't provide the professional service because I don't have the particular skill that's required (like surgery when you're not a surgeon.) But if they come to me for a thing I **can** do, I have absolutely no right whatsoever to say "No, I won't take care of you because you're black, or old, or smell bad, or have AIDS."

Medicine has faced this problem before. Hundreds of years ago we had the bubonic plague which was 90% fatal and much faster. It was thought to be immoral for physicians

to run away from plague patients. Interestingly, that has been the one ethical or professional principle that the AMA has had on the books and reinforced periodically from 1850 on. It's interesting that there's been consistency in this belief that the physician has a professional obligation to those that he or she is capable of providing care to. It may be that we have given up the concept that medicine is a profession, and this is important, because it will determine how the public, ultimately sees us.

Dr. A: Something that comes up on a regular basis is the question of whether we should routinely test patients in the delivery room where there is a lot of blood and body fluid. Is it appropriate to test, not with the idea of denying care but with the idea that this information might change a procedure in such a way that reduces risk?

Dr. Weil: You can't be sure for everybody. That was the whole point of the CDC Universal Precautions. It says "Treat Everybody!!" If you're really in that situation, treat everybody as though he or she were serologically positive.

Dr. A: But that is extremely costly and might not always be technically possible.

Dr. Weil: The counter argument is that we are talking about people's personal liberties. **This is a country founded on the concept of individual liberty, not coercive care. We should not infringe on those rights if we have an alternative, and we do have an alternative. It may be costly.** But also consider that if you single out a particular group, you might drive that group away. Many of your very high risk pregnancies are in women who are IV drug abusers, who might seek delivery elsewhere, under less optimal conditions because they don't want such testing done. So what you end up doing is subjecting those babies to a higher risk in order to protect your personnel. I would personally prefer to take precautions with everyone, rather than violate people's rights to privacy.

Dr. D, Staff Physician: I just want to say that I really share the concerns that these young physicians have. I think they are in a distinctly different position than most of the people you talk about when you refer to the ethical guidelines set by the AMA. People in other specialties refuse to take care of these patients all the time, for one reason or another. Probably most people around here in private obstetrical practice would too, if they knew someone was

HIV positive. These young people are the last stop. Society does not have another place for these patients to receive care if no one else will. Maybe your statistics say that it's only one person in every 125 years that can be expected to get AIDS, but they don't want to be that **one person tomorrow**. I couldn't agree with them more.

Dr. Weil: I agree with your sentiments, but I think there are better ways of handling this problem than to run all over and trample people's rights. I think we can do all the things they want without ripping people apart morally. I don't think that a bunch of physicians behaving immorally justifies **our** treating patients immorally. I can't use that kind of logic.

Dr. B: A hundred years ago we had this problem with tuberculosis and people were quarantined until they could figure out how it was passed and how to treat it. Now, here it is, the 1980s and we're faced with this issue of people's rights. What about **my** rights as an individual to protect myself? What about the rights of society in general? It seems as though the rights of an entire society should be more important collectively than the rights of any one single person!

Dr. Weil: That's where the argument breaks down, because **no one has yet shown that abrogating the rights of the individual will do any good for the society, given the current knowledge we have about AIDS**. People are making a lot of suggestions about how to handle this crisis. What we need to do when we consider these proposals is to ask ourselves "Will it change the epidemic? Will it change your chances of getting AIDS?" The answers are, by and large, "No!" If, on the other hand, the only effective alternatives **do** require the violation of someone's rights...well, then maybe you have a good argument.

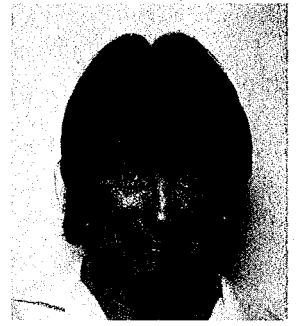
Deborah Mulrooney

Australian Nurse/Attorney Visits MHP

Margaret Wallace, RN, B.Soc.Sc., LLB, from Canberra College of Advanced Education in Canberra, Australia will be visiting MSU's MHP through the end of summer term. Professor Wallace comes to MSU as the result of a fortuitous meeting with MHP adjunct faculty member Dr. Bill Weil, at an international conference on medical ethics in Sydney during 1986. Both Professor Wallace and Dr. Weil were presenting papers to the Society of Law and Medicine on the ethics of discontinuing medical treatment of neonates, and through Dr. Weil, Professor Wallace

learned of MSU's Medical Humanities Program.

Professor Wallace received her nursing degree from St. Vincent's in Sydney, Australia, a social science degree from Auckland and Waikato Universities in New Zealand, and a law degree with honors from Auckland University.



Margaret Wallace

She has practiced geriatric, medical ICU, ophthalmologic and orthopedic nursing and served as a hospital nursing administrator. Professor Wallace is on leave from her duties as lecturer in law at Canberra College of Advanced Education in conjunction with Australian National University. Ms. Wallace is also a barrister of the High Court of Australia in New South Wales and the Australian Capital Territory and has served as a tutor in law at Macquaria University in Sydney.

While in residence at MSU, Ms. Wallace will be focusing her investigations on issues concerning institutional ethics committees, particularly hospitals. Her particular interest is in the role of attorneys in the functioning of ethics committees. She has been working with local physicians, philosophers, nurses and others to identify their ongoing concerns with how federal regulations affect patient care decisions. Professor Wallace has also been invited to participate in some area hospital ethics committee meetings and case consultations while she is here.

As a result of her experience at MSU, and a subsequent three month stay in England for similar investigations, Professor Wallace will return to Canberra College where she will resume her teaching duties to medical, law and nursing students. She also plans to use her experience, expertise and ideas to develop a concept of institutional ethics committees and how they might optimally function in the Australian systems. This work, one of the very first in Australia, will serve as the focal point of her doctoral thesis in law, Ms. Wallace said. The decisions and recommendations of institutional ethics committees are relatively new concepts in the U.S. but much more so in Australia, noted Ms. Wallace. She said she is working with an eye to future legal reform, and development of new law in Australia concerning how the courts ought to view these IEC decisions. Ms. Wallace stated she hoped that the legislature will

recognize the need for individual judgments in most medical-ethical cases, and write the federal regulations such that the focus is on the ethics committee **process** rather than **product**. Professor Wallace also participated in the first annual meeting of the recently formed Medical Ethics Resource Network of Michigan (MERN), and commented that she felt the idea of a statewide network of this sort was "tremendously interesting....an excellent idea."

Paul J. Reitemeier

1st MERN Meeting a Success



James Tubbs (L), Mercy College and Tom Schindler, Mercy Health Care Corporation.

The first annual meeting of the new Medical Ethics Resource Network (MERN) of Michigan was held April 29-30 at Madonna College in Livonia, Michigan. MERN organizers reported the meeting was "very productive...a high level of discussion of problems faced by institutional ethics committees."

At the wrap-up session on Saturday afternoon MERN Council member Eugene Grochowski, MD, Kalamazoo, argued for a closer look at group processing in committees: how it's done, and how it can be improved. Dr. Grochowski emphasized that IECs must avoid a "sham" structure of only appearing to be multi-disciplinary, but actually dominated by one or two individuals. David Thomasma, PhD from Chicago, IL, focused on three chief functions of IECs. The main function is that of educating the hospital staff; of actually building a moral community where personal conscience and values are able to be freely expressed, and moral disagreement is to be expected. A second function of the IEC is to conduct only retrospective reviews of cases. Finally, the IEC is to participate in the policy making on all issues concerning ethi-

cal issues in the hospital. Dr. Thomasma said that each hospital must collect its own local data to determine where the problems are; not every hospital faces the same set of ethical problems.

Len Fleck, one of MERN's early organizers and a presenter at the MERN meeting, said he felt the meeting was useful to many of those who attended, and he noted several exchanges of very practical suggestions among different IEC members present at the meeting. Of particular interest to many were presentations by Allen Verhey, PhD, Eugene Grochowski, MD, Howard Brody, MD, PhD, the IEC training module on hospital policies concerning AIDS patients, and the MERN computer bulletin board.

One of the highest ratings on the meeting evaluation surveys went to the Madonna College Staff and food service. Howard Brody, MERN Council President said he was very pleased with this year's success and looked forward to a larger meeting next year.

Paul J. Reitemeier

MHP & MERN Announce Computer Bulletin Board

The Medical Humanities Program at Michigan State University and the Medical Ethics Resource Network of Michigan (MERN) have installed an electronic bulletin board on the IBM 3090 mainframe computer at MSU.

Currently, the Bulletin Board offers two options for users. A "News and Notes" section contains information of interest to persons concerned with medical ethics: summaries of recent journal articles, books, and court cases; calls for papers; announcements of upcoming meetings; or any other worthwhile news item which a user would like to share. The other section, "Discussion Forum", presents cases, drafts of hospital policies, short commentaries, and the like to which other users can respond, creating an extended community of informed persons with whom ideas can be tested and refined. The Bulletin Board and IBM also support file uploading and downloading, and electronic mail among members. A user's manual explains all the bulletin board functions.

Anyone in the U.S. with a computer and a modem can gain access to the MSU IBM and the Bulletin board through commercial networks like Telenet, Autonet, or Tynmet, once a member ID and password have been assigned. Memberships are \$50/year, and include a subscription to the MERN newsletter Ethics Information. A limited number of 90-day trial memberships are available for free, except for any commercial network charges made

against the MSU account.

To apply for full or trial membership, contact James Tarrant, MERN, 1305 Abbott Rd., E. Lansing, MI 48823 (517-337-1615). For more information about the features of the bulletin board, contact Tom Tomlinson, Associate Professor, Medical Humanities Program, C-201 E. Fee, MSU, E. Lansing, MI 48824 (517-355-7550). **Tom Tomlinson**

MHP & CON Host Conference

On May 13, the Medical Humanities Program and the College of Nursing's Division of Lifelong Education presented a conference on **International Perspectives on Ethical Issues in Health Care** at the MSU Kellogg Center.

The objective of the conference was to explore how differing cultural values, religious and political traditions, and resource limitations affect the ethics of medical treatment decisions, in particular with regard to seriously ill newborns. Each speaker drew from personal experience with such decisions in a variety of cultures and political systems. William Weil, MD, from MSU's Department of Pediatrics and Human Development, spoke from his experience as Chairman of the American Academy of Pediatrics' Committee on Bioethics to review the ethics and politics of recent "Baby Doe" cases and policies in the United States. Margaret Quain Wallace, SRN, LLB, a nurse-attorney visiting the Medical Humanities Program from Canberra College, Australia, described the social, legal and political climate affecting these decisions in that country. Japanese approaches to treatment decisions for newborns were analyzed by Donna Scheideberg, RN, CNM, a PhD candidate in the Department of Family and Child Ecology with experience as a nurse-midwife in Okinawa. Barbara T. Sparks, RN, MSN, who recently returned from a year's experience in Zimbabwe, spoke on some traditional African perspectives and the current political and economic conditions, and their impact on decision-making. She maintains an OB/GYN nursing practice, and is Assistant Professor in the College of Osteopathic Medicine.

Conference speakers, in their presentations as well as in a panel discussion of several cases, addressed a number of questions. How do different cultures respond to uncertainty of outcome? Are infants treated in the hope of a good outcome, or not treated in the fear that the outcome will be

bad? How do different cultural and religious traditions determine the achievement of "personhood"? Is this moral status acquired before, at, or after birth? Do different cultures take different attitudes toward physical or mental handicaps? How do these influence decisions when there is the likelihood that the child will survive with a handicap? What are the differences in the doctor-patient relationship, and how do these affect the involvement of parents in medical treatment decisions?

The conference also served to celebrate the 10th anniversary of the Medical Humanities Program. Featured luncheon speaker was Andrew Hunt, MD, founding Coordinator of the Program. Dr. Hunt reviewed the history of the Program in the larger context of the development of scholarly interest in medical ethics both in the U.S. and abroad.

Tom Tomlinson

The Winter 1987 Medical Humanities Report contained a call for recipes for a beginner's cookbook, compiled specifically "for the purposes of teaching medical ethics by using literary examples." While the initial response rate was somewhat disappointing, the recipes submitted appear well-chosen and undoubtedly very effective. Our thanks to those who took the time to share their pedagogic imaginations. The call for recipes remains open.

"The Heart Asks Pleasure First" by Emily Dickinson. (poem: truth-telling)

"Mercy" by Richard Selzer. (short story: active/passive euthanasia distinction)

Above Submitted by Howard Brody, MD, PhD

Antigone by Sophocles. (play: patients' needs vs. secular law)

"Kinder Totenlieder" (Songs on the Death of Children) by Gustav Mahler.

Henry VIII by William Shakespeare. (play: stillbirth and death of newborns)

Oedipus Rex by Sophocles. (play: adoption and identity dysphoria)

Macbeth by William Shakespeare. (Act IV, Scene III) (play: bereavement)

The Unbearable Lightness of Being by Milar Kundera. (book/film: empathy)

Above submitted by Jack M. Stack, MD, Alma, Michigan

"Silent Snow, Secret Snow" by Conrad Hiken. (short story/film: autism)

"The Yellow Wallpaper" by Charlotte Perkins Gilman. (short story: schizophrenia)

"The Hunger Artist" by Franz Kafka. (short story: anorexia)

"The Death of Ivan Illych" by Anton Chekov. (short story: cancer)

Snows of Kilimanjaro by Ernest Hemmingway.
 (book/film: gangrene)
Tell Me a Riddle by Tillie Olsen.
 (book/film: aging and death)
Dad by William Wharton. (book: aging and
 senility)
 Above submitted by Suzanne B. Kaplan
 Literature Professor, Schoolcraft College

Send all submissions to MHR Editor,
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