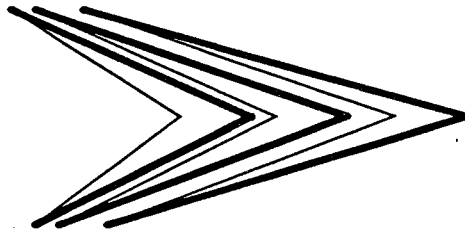


Medical Humanities Report



This Issue: Justice and
the Role of the
Government

Michigan State University

Winter 1990

Health Care For the Uninsured:

The Michigan Approach

By Leonard Fleck, Ph.D.

In July of 1987 Governor Blanchard ordered the creation of the Task Force on Access to Health Care. The primary purpose of the Task Force was to determine the nature and magnitude of the problem of those without health insurance in Michigan, and then to make recommendations for addressing that problem. There were forty individuals who were initially appointed to that task force. They were broadly representative of the relevant interest groups in the state. In addition, there was an Academic Consortium of about fifteen faculty members representing a number of Michigan universities from a broad range of disciplinary backgrounds who were responsible for doing the research required by the work of the task force. I became a member of the Academic Consortium only a year ago, at which time the Task Force itself asked that an ethicist be included.

The Task Force spent its first year getting a sense of the dimensions of the problem. There are just under one million people in Michigan without health insurance. It is a very heterogeneous group. While it includes a large number of people who fall below the poverty level (but are ineligible for Medicaid), almost 70% of the group are employed--mostly at low-paying jobs that carry no benefits. Also among the uninsured are large numbers of individuals who have been denied health insurance (or cannot afford private health insurance) because of pre-existing medical conditions. Over the past decade the problem of assuring access to adequate health care for the uninsured has grown significantly, primarily because the informal systems of charity care funded through cost-shifting mechanisms in the private sector have been severely constrained by cost containment pressures from both private and public purchasers of health services.

(Task Force continued on next page)

Medical Care in Scandinavia

By Peter Vinten-Johansen, Ph.D.

It is rare in 1990 to hear people in the United States voice public satisfaction with health care delivery and financing. Physicians, corporate executives, policy makers, and consumers usually agree that the status quo is unacceptable, even while they may differ markedly about what should replace it. The publication of *The Painful Prescription* in 1984 popularized the notion that the United States will eventually have to shift from current "invisible" rationing of hospital care to something akin to what Aaron and Schwartz argued happens in Britain under the National Health Service. While the British response to specifics in *The Painful Prescription* has been mixed, few commentators on either side of the Atlantic disagree with the general thesis in the book that "private" and "socialized" systems of health care in the

twenty-first century must borrow from each other's quivers. Thus, a major virtue of the 1980s was that the discussion of health care in the United States evolved a significant international dimension; however, that dimension was often narrowly focused on comparative hospital care in the United States and Great Britain. Recent assertions of national autonomy in Eastern and Central Europe have also brought renewed interest in the Scandinavian welfare states. That is, Scandinavia again is viewed by some as offering a "middle way" between capitalistic and socialistic systems. Actually, the Scandinavian countries constitute a spectrum rather than a single model, reflecting historical and cultural differences of long standing.

(Scandinavia continued on page 7)

Task Force (continued from previous page)

When I was asked to become a member of the Academic Consortium, the Consortium had just finished developing four different proposals for addressing the problem of the uninsured in Michigan. These proposals mirrored to some extent proposals that have been floating around at the national level recently. The least expensive of these proposals was referred to as the "categorical, voluntary" proposal because the state would provide incentives and subsidies to different categories of currently uninsured individuals who would then be given the option of buying into low-cost health insurance plans. Depending upon which categories of individuals were deemed worthy of subsidies, the initial annual cost of the plan to Michigan would be between \$125 and \$650 million. The second proposal mandated that health insurance be provided by all employers in the state, with the help of graduated state subsidies to small employers. There would also be public plans for the unemployed. This plan mirrors the plan Governor Dukakis has been pushing in Massachusetts. Its initial annual cost would be about \$650 million. The third proposal mandated universal coverage for everyone in the state through a variety of competing health plans, all of which would be funded through a state health care tax. This is essentially a version of the Enthoven-Kronick proposal described in The New England Journal of Medicine (Jan. 5 and 12, 1989). The initial net additional cost to the state for this plan would be about \$1.2 billion. Finally, there was the single-payor universal health plan, which essentially mirrors the Canadian system for financing health care. Instead of multiple plans competing for subscribers, as in the prior proposal, there would be a single comprehensive package of health services provided to all citizens of Michigan under age 65.

The Task Force operated with multiple criteria for assessing these proposals, but two preeminent criteria were fairness and efficiency, this latter concept including especially the capacity of a proposal to control escalating health costs in the future. I was asked to help the Task Force think more carefully about the concept of fairness and what the responsibilities of the state were to the uninsured. To that end I wrote a twenty-page paper "Health Care and the Uninsured: Choosing a Just Social Policy."

Very briefly, the argument in the first part of the paper presented a version of Daniels' argument (Just Health Care) that access to health care is intimately connected with fair equality of opportunity in our society--in much the same way that education is so

connected. In the second part of the paper I pointed out some of the more obvious injustices in our current health policies, trying as much as possible to stay away from controversial theories of justice. For example, I noted with Himmelstein and Woolhandler that the existence of absolute administrative waste in financing health care in America is not just inefficient, but it is unjust. Canada spends only 6% of its health dollars on pure administrative expenses while we spend 16% of our health dollars for that purpose. This is because Canada has a single mechanism for financing health care, as opposed to the 2,000 different health plans we have. Since we spent about \$610 billion on health care in 1989, that means that \$61 billion provided no health benefits to anyone in our society. This is not just a high price to pay for a pluralistic health financing system; this is an unjust price when 37 million Americans are without health insurance.

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I also pointed out that our current tax system provides a large subsidy to the middle class for health insurance, just about \$44 billion in tax revenues foregone by the federal government because middle class health benefit packages are exempt from federal and state taxes. There is a gross injustice here because the employed uninsured must then purchase health insurance with after-tax dollars and the sick uninsured must pay for health services with after-tax dollars. That means that those who

are less well off, both in terms of health and economics, subsidize those who are better off in both these respects.

The arguments of this paper, as well as papers from other members of the Academic Consortium, seem to have affected significantly the thinking of the Task Force in its subsequent deliberations. The key insight seems to have been that neither efficiency nor fairness would be well served by merely patchwork reforms of our current system for financing health care. In 1970 Canada and the United States spent roughly equal fractions of GNP on health care. It was at that time that Canada implemented its universal comprehensive health care plan. By 1989 a large gap had developed with Canada spending 8.7% of GNP on health care while the United States was at 11.5% of GNP. For the Task Force the lesson was clear: Michigan could not afford to do much at all by way of improving access to health care for the uninsured unless massive savings could be achieved in health care through very effective cost containment mechanisms. For the past fifteen years the prevailing wisdom among health policy analysts was that America could not afford universal health care. The lesson from Canada seems to be that we cannot afford anything less than that.

Task Force (continued)

At its meeting in September of 1989 the Task Force endorsed seven key propositions that will be the core of its recommendations to the Governor. The first "endorses the need for a universal health care plan which will assure access to essential quality health care for all Michigan residents, achieve required cost containment objectives, and be fiscally feasible." Michigan currently spends about \$13 billion on all health care. If we achieved the same 10% savings as Canada by having a single financing mechanism, that \$1.3 billion would easily pay for a very decent health package for all those currently uninsured in the state. The hope of the Task Force was that the federal government would implement such a universal plan. Failing that, Michigan could become a state in which such a demonstration project was undertaken. The details of what such a plan would look like and how we would effect a transition to it have been roughed out in a long, thoughtful paper by Professor Berki of the University of Michigan. I need to note that such a plan would be truly universal in that Michigan would ask for both Medicare and Medicaid waivers so that all our citizens would be covered by the same comprehensive health plan. That represents both generational and economic solidarity.

No one on the Task Force believed a proposal this sweeping could be implemented quickly. There was a long process of education that occurred within the Task Force itself. It will take a similar process of education for citizens of Michigan to understand and appreciate the moral and economic and political logic behind this recommendation. Hence, one of the last recommendations from the Task Force was that its own life be extended so that this educational task could be

undertaken. What I recommended to the Task Force in a second paper "Just Caring: An Experiment in Health Policy Formation" was a blueprint of an action plan for carrying out this educational task. Specifically, what I recommended was that there be twenty project sites around the state, that there be a core seminar group of about forty people at each site, that they be broadly representative of the community, and that they commit themselves to a two-year program of reading and discussion and planning. There would be fifteen to twenty seminars at each site, the first cluster of which would focus on a broad array of issues of justice and health policy, the second cluster of which would focus on assessing from moral and economic perspectives alternative approaches to universal health care. A statewide project like this, if well-designed, will draw the media attention to achieve educational objectives far beyond the local seminar groups.

No one should think that a Canadian style health insurance system will be a panacea for the many difficult moral and economic questions that must be faced regarding health care in America. Rationing access to health care is as much a reality in Canada as in the United States. Many difficult trade-offs will have to be considered. The virtue of the project I have proposed is that these trade-offs will be considered explicitly, publicly, so that whatever rationing decisions are made will be decisions we essentially impose on ourselves. In our society we have generally avoided such explicit public moral conversations, perhaps because we felt awkward about them, perhaps because we did not believe they could be productive. What this proposed project would demonstrate, however, is that such conversations are possible, indeed necessary, and they can be productive, as the work of the Task Force itself showed.

CASE STUDY: What To Do With a New Technology?

In 1972 the federal government enacted a bill which guaranteed any person suffering from kidney failure access to dialysis. The program is funded prospectively, that is each dialysis unit is guaranteed only a fixed amount of dollars per patient. The dialysis unit has to take care of their patients on that sum or cover the rest of the cost from some other source (i.e. their resources or the patient's). Within the past year an improved "high-flux" artificial kidney has been marketed which provides a substantially better quality of life for patients as well as a possible increase in life expectancy. The units cost two to three times more than the older models, but the initial hope was that an increase in efficiency would allow a better utilization of staff time. Unfortunately, this has not panned out. Should government payments for dialysis cover the increased cost of the units? If the government decides not to increase the funding, what is the obligation of the dialysis units who are faced with the choice between investing in the new units and finding some way to cover the additional cost, or not providing a decidedly superior technology?

First Commentary :
Tom Tomlinson, Ph.D.

In the absence of any specific data in the case study, let's assume that the new dialysis method provides a significant improvement in either survival or quality of life for dialysis patients. Moreover, let's assume that the new method indeed costs more, both in the aggregate and for each patient treated, and that the economies of scale which it first seemed to promise cannot in fact be achieved. Each of these assumptions is necessary for generating an ethical problem of justice or fairness about the use of the new dialysis technology. If further clinical research or creative clinic management prove either of them false,

(Tomlinson commentary cont. on page 4)

Tomlinson Commentary (continued)

the ethical problem disappears, and it becomes obvious either that we shouldn't pay for it, or we should. The resolution of the ethical problem that these routes offer is ever so much more satisfying and conclusive than moral analysis, that we should all hope that one or the other of them pays off.

In the meantime, however, what should we do? It's easy to argue against putting more money into treatment of kidney disease. It's the only disease whose treatment is already fully insured for all Americans, authorized by special act of Congress, and consuming several billions of dollars every year of Medicare money. If the objective of a just health care system is to provide equally for all of those persons in need of medical care, then special provisions for the care of persons with kidney disease seem patently unfair. Those with heart disease, or cancer, or AIDS, or a host of other serious illnesses are also in need of care, and because their need for care is as strong as the dialysis patient's, their rightful claim on health resources is equally strong as well. To invest even more money in new forms of kidney dialysis would only compound the injustice already being done.

But I think this argument is ethically superficial, and overlooks some special features of kidney disease. It's superficial because it focuses on medical treatment of disease as the resource to be fairly distributed by a just health care system, without reference to what it is about medical treatment that makes it desirable, a basic good to which all persons have an equal claim. A deeper analysis, made by Norman Daniels, argues that medical care is a basic good insofar as it enables us to pursue the normal range of opportunities of a normal life span. Justice in health care is not aimed at a fair or equal distribution of units of medical care, but at a fair distribution of life's opportunities through the provision of medical care.

Let's assume that Daniels is right (those interested should read his book, Just Health Care). If a just health care system aims at equality of opportunity, then judgments about the relative fairness of paying for treatment of one disease rather than another must look at more than the numbers of persons affected, or the relative impact in mortality and morbidity. It must also make comparisons of who is affected by the illnesses under scrutiny, and the relative degrees of opportunity those persons already enjoy. Two illnesses may have precisely the same impact in terms of mortality and morbidity, both with and without treatment; but if one group of patients already suffers from a diminished range of opportunities, fairness does not allow us to flip a coin to decide how health resources should be divided between them.

That is the sort of situation we face with kidney disease. Blacks get kidney disease at a rate almost four

times higher than whites (chiefly because of higher rates of hypertension and diabetes). Once on dialysis, they are less likely than their white counterparts to get off dialysis by means of kidney transplantation. The organ distribution system ranks potential recipients for donated organs by the degree of antigen matching. Since there are racial differences in antigen frequencies, and since whites donate the bulk of organs, white dialysis patients have a better chance than black patients of receiving a donor kidney. The result is that blacks are disproportionately represented among dialysis patients. In Michigan, 13% of the population is black, but 28% of dialysis patients are (these are very close to the national averages).

Thus, dollar-for-dollar, a decision not to fund improvements in dialysis treatment will disproportionately affect blacks, at least compared with decisions not to fund treatment for conditions which affect mainly whites, or which affect blacks and whites equally. But since blacks already suffer from diminished chances for a normal life's opportunities (shorter life expectancy, higher crime, more unemployment, etc.), fairness demands that we respond to those injustices by favoring those medical treatments that redress unfairly low opportunities. If, for example, the new dialysis technology makes it more possible for the patient to return to work (one of the markers for dialysis success), then perhaps it should be provided as a means for raising, rather than reducing, the relatively lower opportunities for employment faced by black persons. Remember, the aim of justice in health care is to distribute opportunities, not resources. If so, then judgments about fair allocation of health resources cannot be made with no regard for already existing social injustice.

I don't mean to suggest that the redressing of social injustice is the only factor to be considered in deciding whether fairness demands that we fund improvements in dialysis, rather than fund some other treatment or technology. But it must be one of them, if the coin of justice is opportunity.

Second Commentary : Jim Nelson, Ph.D.

This case presents two questions. The first is one of social policy: should prospective payments for dialysis be increased in the light of the extra benefits provided by the new technology? The second directly addresses the care providers: should the unit itself, in the absence of (prompt) government action, invest in the improved dialysis machines, and find "some way to cover" the extra costs?

Professor Tomlinson's remarks address the first of these questions in a way that makes dubious the common idea that our end-stage renal disease program is a paradigm of a bad response to the problem of allocating medical resources.

Nelson Commentary (continued)

The Tomlinson-Daniels analysis is clearly a valuable contribution to discussion. But consider the following "paradoxical" suggestion: suppose the government took seriously the idea that extra money ought to be allocated to the ESRD program for the improved technology, and estimated the cost of the shift. Someone might well then suggest that if our goal is to reduce mortality and morbidity from kidney disease, the extra money could be much better spent by education programs encouraging organ donation which especially target black audiences. As there seems a more effective use for the contemplated expenditure, it would be wasteful and hence unjustifiable to spend it on the new machines. But does the availability of a less-than-optimal improvement in the management of a disease obligate us to expend extra resources on a more nearly optimal response, if we weren't obligated to do so before that technology came on the scene?

Notwithstanding the important insight of the Tomlinson-Daniels view, it still seems questionable whether there is a moral obligation to increase spending on a program which is all ready especially favored, bearing in mind that blacks and other minority populations suffer differentially from other opportunity-limiting illnesses as well as kidney failure. For example, diabetes, which as Tomlinson notes is implicated in the greater reliance of blacks on dialysis, is an illness from which insulin-dependent blacks die at about double the rate of their white counterparts (and which may ultimately be cured by islet cell transplantation, another reason to push for greater organ donation awareness

among blacks, which, or course, we aren't going to do anyway.)

The second question-of reallocating resources, treatment at the facility level-is very difficult to advance, much less answer, without knowing the facility's options. If there's sufficient waste which can be cut to provide funds for the new machine, then, while ethical problems remain--perhaps those savings could be better used--the ethics governing the special relationship of the dialysis patients and their care providers could probably defend introducing the more expensive equipment into the unit. But that seems unlikely, and besides, the notion of waste in medicine is not theory-neutral. What sort of care will go by the boards if facility-level reallocation is introduced?

Another tact on this question concerns the permissibility of patient financing of the improved technology. Presuming that not everyone served by their facility could afford the extra cost, should the dialysis unit introduce a "two-tier" system into the clinic, erected on the basis of ability to pay? While the option of better dialysis care is almost certainly going to be available to those who can afford it, a particular facility ought to think twice about offering two modalities known to have distinctly different outcomes for the same disease and distributed on a financial basis. As Lester Thurow has pointed out, when it comes to health care, our capitalist values are in great tension with our egalitarian values, and while this is surely a tension with which we need to deal openly, flaunting it in a clinical setting doesn't seem the best way to go about it.

Literature in Review:

The Misfortune of Others by Thomas Halper

What Kind of Life by Daniel Callahan

The Misfortune of Others: End-Stage Renal Disease in the United Kingdom, Thomas Halper; Cambridge University Press, 1989.

Since the publication of Aaron and Schwartz' The Painful Prescription, the treatment of renal disease in the United Kingdom has become a paradigm for the hard choices faced when medical resources fall short of medical needs. Even though there was never any explicit NHS policy to ration kidney dialysis, Aaron and Schwartz argued that chronic underfunding of the NHS, and belt-tightening by the regional health authorities, had created a de facto policy to limit the use of dialysis, both on the basis of complicating factors such as heart disease, and on the basis of age.

The British medical establishment objected strongly to Aaron and Schwartz' claim. Although there were scat-

tered problems of scarcity, there was no NHS-wide pattern. Moreover, the comparison made between UK and US rates of dialysis begged the question of whether the British were underutilizing dialysis, or the Americans were overutilizing it. British physicians preferred the latter assumption.

Thomas Halper's book steps into the middle of this dispute to take a close and comprehensive look at the British treatment of kidney disease. Halper starts with an overview of patterns of treatment in the UK, comparing them with other European countries and the US. His conclusion is that the data show the UK lagging well behind not only the US, but many other European countries with nationalized health services (although there has been an upsurge in rates of treatment in the UK since 1987)

(Halper review continued on page 6)

Halper Review (continued)

He next makes a detailed tour of the administration of resources within the NHS, to explain how a pattern of underutilization could have arisen. He thinks that at least part of the responsibility rests with the medical establishment (both the specialist organizations and the British Medical Association), who until recently were reluctant to take a strong stand favoring increases in renal treatment. An interesting irony described by Halper is the positive role played by the Thatcher government in dramatically increasing rates of dialysis over the last 5 years. The government used the embarrassment of Britain's dialysis rate as part of its argument for setting performance targets for the health regions, thus restricting the power of the medical establishment to influence regional spending. The performance targets for dialysis were set to bring the UK more in line with its European neighbors.

The last third of the book examines how patients were selected for treatment. Here Halper is forced to rely on anecdotes, media reports, and sometimes anonymous admissions by general practitioners or consulting nephrologists that patients have been denied dialysis on the basis of age or other factors not plainly related to the potential for individual benefit. The book closes with a discussion of some of the ethical issues involved in any system of rationing.

What Kind of Life: The Limits of Medical Progress by Daniel Callahan. New York, Simon and Schuster, 1990, pp. 319.

It is widely known that the U.S. spends an immense share of its GNP on health care (now more than 11 percent, which compare to the 6.2 percent spent on education), that we have in addition, well over 30 million uninsured citizens, and that our overall national standard of health does not exceed Canada's or the U.K.'s, even though they spend much less of their social resources on health care than we do. Reports of high satisfaction with our massive health care system are conspicuous by their absence.

Despite this discontent, we are generally a healthy people--at least in the sense that pressing national problems (e.g., succeeding in world economic competition) are not due to ill health. The same cannot be said about the state of American education, or the infrastructure of our society. Daniel Callahan claims that our present health policy constitutes a severe and rapidly worsening distortion of what our social priorities ought to be.

He rejects the common hope that we can resolve the crisis technologically--with, for example, the development of cheaper therapies or the advent of new strategies for efficient delivery of medical service. Such ideas typically do no take full account of the deep

Although Halper writes clearly, much of the material becomes repetitive halfway through, as he reworks assertions already argued for in the first two chapters. The ethical analysis is standard stuff, almost perfunctory, and too scattered and unfocused to draw lessons from the history that Halper provides. (There is one glaring error, when he claims that Norman Daniels believes that all age-based rationing is inherently unjust.) Some readers may be annoyed by his penchant for over-heated metaphors, evidently intended to enliven otherwise dull descriptions of statistics and administrative hierarchies.

The strength of this book is its detailed look at the history of treatment for kidney disease, spotlighting a short period of NHS history, and providing substantial evidence supporting the Aaron and Schwartz conclusion that kidney disease was in fact undertreated in the UK for a considerable time. But its narrow scope is also a weakness. As Halper notes, there has recently been a dramatic increase in the use of dialysis, making the Aaron and Schwartz conclusion old news. Unless that narrow bit of history can be mined for guidance on facing the other scarcities that will repeatedly confront both the U.S. and Great Britain, Halper's conclusions about dialysis in Britain will quickly become irrelevant. Although Halper provides some important details, the bigger picture still needs to be painted.

Tom Tomlinson, Ph.D.

problems we face--an aging population, the number of un-and-underinsured, the AIDS epidemic, and so forth. But the chief problem is that there is no obvious limit to helping more and more people live longer and longer, pushing the "ragged edge" of medical knowledge and ability out further and further. To arrest what Callahan portrays as a cancerous growth, we need a substantial, not simply instrumental, conception of the place of health care among other priorities, and hence a substantial conception of relationship between human health, social flourishing, and individual happiness.

Broadly, Callahan's suggestion is that we distinguish between medical interventions directed at curing disease, and those directed at caring for the ill, and that our attempts to cure be limited in a roughly utilitarian fashion: we should take the perspective of society as a whole, as opposed to affected individuals, when determining what diseases to target. As most of our society's basic projects are attainable without further gains in our general health (as opposed to the health of certain groups in society), cure should take a back seat. What we do try to achieve along these lines should be guided by such concerns as enhancing the character of the whole of life, compressing the period of morbidity that plagues the latter parts of our lives, and forestalling premature death.

Callahan Review (continued)

But if as a society we cannot afford to seek to cure everyone, we must afford to care for everyone. Our energies should be directed "inward", toward better understanding how we can make of the life of the ill, the impaired and the dying a better thing. This part of Callahan's proposal takes the edge off the rather harsh, utilitarianism dictating limitations on cure, and has a self-limiting character which keeps it from warping our overall conception of what a good life in a good society ought to be.

Callahan grounds his proposal in a call for us to accept ourselves as mortal beings who acknowledge our limited power in the world, and who temper the significance of free choice and individualism to the good of the whole. Such overall conceptions of human nature have generally seemed unobtainable rationally, and totalitarian if imposed politically. But whatever their content, most such theories have identified happiness or human flourishing as the reward for a life spent in accord with their dictums. Callahan's image has some unusually strong backing, both because it is a fairly minimal picture of human nature, and because there is good evidence that we won't be flourishing much longer if things continue to go on as they have. But the very plausibility of Callahan's case forces one to ask why the issue can't be handled within prevailing liberal, "thin theory of the good" limits: if a policy is leading to disaster, that is a reason to change things round on any reasonable theory of what life should be like. And if it could actually be shown that intensifying our efforts to care for, rather than cure the ill is a cost-effective way of providing what may actually matter more to most of us in the long run, than that too seems a matter consistent with the procedures and values of a pluralist society.

In Setting Limits, Callahan made the bold claim that even if resources permitted continued efforts to cure disease and to extend our lives, it would not be good for us to do so. What Kind of Life stresses the economic repercussions of our current course more than did the earlier book, but at the same time, the rationale for a philosophical reconstruction of our conception of the place of health in the good life emerges more clearly. If it is not yet fully convincing, it certainly merits continued thought.

James L. Nelson, Ph.D.

Scandinavia (continued from page 1)

The medical care systems in Scandinavia have incorporated these variations and cannot be understood apart from them; the drawback of prior studies in English has been the isolation of Scandinavian medicine from the context necessary to understanding its development, as well as its strengths and weaknesses.

Until now, that is. A special issue of Scandinavian Studies provides a comparative and interdisciplinary framework for analyzing medical care systems in four Scandinavian countries--Denmark, Finland, Norway, and Sweden. While the articles are thematically wide-ranging, they are unified by the assumption "that medicine, as any other social institution, cannot be understood apart from the history and culture of each society, its economy and polity, and its approach to welfare in general" (126). Although the readership of the journal is international, the articles are written primarily for a North American audience. The table of contents below shows the range of topics and the explicit comparisons made with Canada and the United States. Copies of "Scandinavian Medical Care Systems" cost \$9.95; there is a 33% discount for bookstores and other bulk-orders (for example, for use in classes). Postage charges will be added to all orders. Please send purchase orders or requests only (no money!) to: *Interdisciplinary Programs in Health and Humanities (IPHH), Michigan State University, 328 Morrill Hall, East Lansing, MI 48824-1036*--or telephone (517)-353-9417. An invoice accompanying each shipment will indicate the total costs to be paid directly to Scandinavian Studies.

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SPRING/SUMMER 1989

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ANDREW TWADDLE, ISSUE EDITOR

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Published by:
Center for Ethics and Humanities
in the Life Sciences
C-201 East Fee Hall
Michigan State University
East Lansing, MI 48824-3316

Nonprofit Org.
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Intensive Summer Ethics Institute

The Center for Ethics and Humanities in the Life Sciences will be sponsoring an intensive summer institute in medical ethics, August 18-25, at Shanty Creek Resort (about 30 miles north of Traverse City near Lake Michigan). This Institute is designed to meet the educational needs of members of institutional ethics committees, faculty in colleges of medicine and nursing, and hospital administrators. Topics will include informed consent, treatment refusal, withdrawing life-sustaining treatment, confidentiality, ethical issues in neonatal care, reproductive rights issues (maternal-fetal conflicts), AIDS-related issues, "gatekeeper" issues and health policy. But the primary emphasis of this Institute will be skill-building, especially skills needed to engage in productive moral conversation. Hence, a substantial amount of time will be spent in small groups. The Institute will be staffed by nationally known faculty including Professor James Childress, Ph.D., of the University of Virginia and Professor William Winslade J.D., Ph.D., of the University of Texas Medical Center in Galveston as well as faculty from the Center. Program costs and a brochure will be available after March 26.

For further information call (517)-355-7550 or write to the Center.