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Health Care and Distributive Justice

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ABSTRACT

HEALTH CARE and DISTRIBUTIVE JUSTICE

Commander Evelyn R. Shaia

Health care has reached a level of crisis in the United States. Costs are skyrocketing while thirty-five million individuals are uninsured. Certain characteristics and economic aspects unique to American health care contributed to the overall problem. Efforts to gain control of the crisis will center around two main issues: access and cost containment. Ethical principles, particularly distributive justice, or the allocation of scarce resources, must be considered. Discussions of rationing occur with increasing frequency in political, social and professional circles. Ultimately, we must be prepared to address whether or not we can increase health care access and control cost without implementing some form of rationing.

DISCLAIMER

This research report represents the views of the author and does not necessarily reflect the official opinion of the Industrial College of the Armed Forces, the National Defense University, or the Department of Defense.

We are kidding each other, we are all just sitting here making this up if we think that we can fiddle around with the entitlements and all this other stuff and get control of this budget if you don't do something on health care. It is a joke; it's going to bankrupt the country.

Bill Clinton

December 16, 1992

During the last decade health care cost has continued to spiral upward and out of control. Numerous aspects of the American health care industry contribute to the crisis. An example is the unique way Americans perceive health care and their right to it. Also, the medical insurance industry itself has a major role in cost and a direct impact on the provision of care and how individuals utilize health benefits.

This paper will address factors that play a role in the astronomical cost of health care today. The United States, among the richest countries on earth, does not provide access to health care for thirty-five million uninsured individuals. It is both access, and escalating cost, which together provide the impetus behind the effort to solve the health care problem.

Causes are easily identifiable. The tougher issue is what to do about it, specifically, how to distribute health care in a just way. We may find ourselves, for example, unable to provide increased access without concurrent restrictions on the amount or type of care

provided. The ethical dilemma presented by any restriction on care while redirecting efforts to distribute resources fairly is significant, and perhaps even divisive.

Characteristics of American Health Care

Each nation's approach to health care is formed by the priorities and values of its citizens. Three unique aspects of U.S. health care are: an emphasis on cure of disease instead of prevention, physician specialization and overall expectations of health care.

Cure vs Prevention

Medical care in the U.S. places an emphasis on the cure of acute, episodic health problems. Far less emphasis and funding is geared toward prevention. Americans tend to be an overweight, sedentary society with generally poor health habits and lifestyle. In turn this leads to chronic health problems that are more difficult and costly to cure than they would be to prevent.

Specialization vs General Practice

The physician-patient relationship has become less personal over the years. The traditional "family doctor" concept was gradually replaced by costly specialization and fragmented impersonal care. Family Practice, as a physician specialty, has increased over the last decade. Family Practice physicians are comparable to the "family doctor" of days-

gone-by, caring for an entire family, from adult to infant. This generalist, while popular with patients, is less popular and less lucrative from the physician's perspective.

Expectations

As technology has advanced and improved there have been subtle changes in the way medical care is perceived with a subsequent rise in overall expectations. America is not a fatalist society. In medicine, we assume that an illness can be cured. Americans have come to expect, and often demand, that "everything be done" to preserve and prolong life. Pain, illness and disease have become a challenge to overcome. The medical profession is a major contributor to the level of predetermined patient expectation. American physicians feel compelled to "do something" and practice an aggressive, comprehensive and costly form of medicine.

Each of these factors alone can significantly increase overall cost; combined the effect is greater and increasingly complex to sort out and control.

Health Care Economics

Three major factors contribute to the escalating health care crisis: the aging society, rising medical costs, and high technology medicine.

Aging Society

In 1900, the life expectancy in the United States was 47 years. The latest statistic (1990) shows an increase to 75.2.[1] People are living longer, in part due to advances in medical practice. The average number of physician visits increases directly with age, and the rate of increase accelerates as one gets older. Not surprisingly. the cost of health care for the elderly can be enormously expensive. Almost 30 percent of Medicare outlays for hospital care occur within the last year of a patient's life.[2]

Rising Costs

The fragmented system of health care financing in the United States is complex, cumbersome and expensive. Our third party payment policy, through mostly private insurance companies, has insulated society from the staggering cost of hospitalization and health care in general. Vast insurance pools that pay the bills encourage both the provider and consumer to utilize health benefits without regard to cost. Medicine is a lucrative, big business. The temptation to inflate charges, generate fake bills and refer care to self-owned labs and clinics by the provider attracts greedy schemers.

The way medicine is viewed and practiced, in general, has impacted overall cost. Physician specialization has driven down the number of general practitioners. Patients are forced into higher-priced care by specialists when the skills of a general practitioner may be sufficient.

The practice of medicine has become increasingly defensive. In response to outrageously expensive litigation and settlements, malpractice insurance rates have been forced up and physicians have resorted to ordering numerous tests as protection against negligence charges.

Technology

Most assessments of increasing health care costs find the advancement of medical technology as the major factor. A succinct description of "high tech" medicine might be this one:

> *apparatus and procedures based on modern sciences, as opposed to simpler healing arts; new, as opposed to long accepted methods; scientifically complex, as distinct from common-sense approaches, costly, rather than inexpensive treatments; and limited, rather than widespread, expertise in using a particular technique."*[3]

"High tech" encompasses more than mere machines. It includes drugs, medical and surgical procedures and the organizational and support systems required to deliver

advanced technology. Some examples of high tech, high cost items are neonatal intensive care units dedicated to saving premature infants, organ transplants, magnetic resonance imaging (MRI) and AZT, a drug that can delay the onset of AIDS in patients who test positive for HIV.

Dramatic advances in technology have proven their effectiveness in medical care but in turn have driven costs up astronomically. The use of technology, like other health spending, faces little market discipline offering minimal assurance that cost will be justified by use.

One additional side effect of advanced technology is the ability to sustain life beyond the previous capabilities of medicine. Technology is often used in treating chronic conditions, thus transforming a once fatal illness into a costly prolongation of life.

The Health Insurance Industry

The private health insurance market and the rise of third party payment has had a profound impact on the bureaucratic layering of the health care system. Americans have come to view health care as a limitless commodity they are entitled to under their insurance coverage packages, often provided either as part of a work-related benefit plan, or paid for directly by individual subscription. There are few incentives built into the system for either the consumer or the provider to encourage medical services cost control.

Massive, expensive and seemingly unwieldy, the health insurance industry over the last twenty years has been intensely scrutinized and criticized, with little improvement or reform. Health insurance was designed to provide security, but instead, individuals are discovering that they do not have adequate coverage, are underinsured, can no longer afford their policy or may be at risk of health care bankruptcy.

The original philosophy behind health insurance was simple in concept; that is, it pooled group resources so that an individual would not be financially overwhelmed in time of need. Initially the insurance market provided coverage at a fixed rate to everyone regardless of risk or age. This is known as "community rating." Gradually, insurance companies turned their interest to groups that were considered low-risk. The number of young healthy workers was growing and insurance was offered as a fringe benefit of employment. Employers sought insurers who based premiums on their group of low-risk employees vice pooling them with higher risk, higher cost, individuals. This is known as "experience rating." The pursuit of lower premiums made it increasingly undesirable to insure the old and the sick.

As the cost of premiums rose to keep pace with rising health care expenses, larger companies turned to self-insured plans. The employers put money aside to pay for employee health care costs, often purchasing insurance themselves to cover against potential company losses. Companies made this move toward self insurance to hold down benefit

costs. More and more, the insurance business seeks "good risk" individuals and screens out, or refuses, high risk individuals.

Managed Care

The "managed care" concept has been embraced by insurers and employers as a mechanism of cost control. The basic philosophy is that the thirdparty payer does not just pay the bill; it plays a role in what bills to pay. Providers are encouraged to manage resources economically and patients are carefully screened prior to referral to costly specialists. Finance and medicine are intertwined, reversing previous disregard for the cost of care.

The common elements of managed care as developed by the Health Insurance Association of America are:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members
- Explicit standards for the selection of health care providers
- Formal programs for ongoing quality assurance and utilization review
- Significant financial incentives for members to use providers and procedures covered by the plan

Managed care plans are an alternative health care route that many see as a possible answer to the cost dilemma. The most popular managed care plans are the Health Maintenance Organizations (HMO). An HMO controls cost through the use of a limited network of health care providers. The physicians participating in an HMO assume the financial risk of care provided to HMO members. Services are prepaid for each enrollee before it is known what services will be needed.

There are numerous advantages for HMO participants. Usually there is no deductible paid. A small copayment fee is charged per visit, but normally, 100% of most procedures and tests, including hospitalization, is paid. HMOs emphasize the preventive aspect of health care, and cover routine annual physicals and prenatal care.[4] The disadvantage of an HMO is the restriction regarding which doctor to see. Participating employees usually must agree to see a physician from a list compiled by the HMO.

Constraint through restriction of participants is the philosophy behind HMOs. The individual's primary care provider controls and directs care through referral to a network of HMO specialists, labs and hospitals. Unless it is an emergency, a member's care will not be paid for if the care is received outside the HMO's network. Through this kind of controlled referral, HMOs have a 50% lower rate of hospital stays than the traditional fee-for-service plans.[5]

Traditional fee-for-service plans such as Blue Cross/Blue Shield pay the full benefit for care regardless of what the treatment is or where it is received. They pay for a general visit or a specialist visit. If you decide to see an orthopedist for a sprained ankle, the tab is covered. Since doctors and hospitals are reimbursed for any service, the longer the treatment or the hospital stay, the greater the reimbursement. This blank check type of insurance, and the free spending philosophy it follows, does little to encourage restraint.

Skyrocketing health care costs have placed an enormous burden on insurance companies. Many of these insurers will go to great lengths to avoid, rather than manage, high risk individuals. This pressure has led to unorthodox and unethical behavior on the part of numerous insurers. When individuals or groups make expensive claims, there is little hesitation in raising premiums to unaffordable levels or to terminate coverage altogether.[6]

Government Subsidies

For clarification, the two largest government subsidies need to be mentioned: Medicaid and Medicare.

Medicaid

State operated, but jointly financed by national and state governments, Medicaid is an assistance program for a select low income population. Although Medicaid is supposed to be the poor patient's health insurance plan, it serves only a minority of the poor. Federal

and state rules determine eligibility levels. The national government's share of Medicaid funding averages about 57 percent.[7] Even with a proportionately larger federal contribution, states are only partially compensated for the difficulties they face when trying to meet the needs of Medicaid recipients. To receive federal funds, a state must provide a minimum health package to its eligible clients.

Welfare income eligibility is the usual guideline for determining Medicaid benefits. The individual states establish that level of eligibility. The less a state can afford to contribute, the lower it sets the income cut-off level for Medicaid. As an example, in 1987, an Alabama family of four was ineligible for Medicaid if its income was over $1,860 per year![8] As a result of such severe restrictions on eligibility, only 37 percent of the poor are covered by Medicaid.[9]

Medicaid's complexity and extreme unevenness in application is due, in part, to a variation in range of services covered, eligibility stipulations, and a lack of physicians accepting Medicaid combined with other detailed issues.

Medicare

The largest of the government's health care programs, Medicare helps defray medical care costs for those age 65 and older or for specific disabilities. With age being its primary eligibility criterion, it is simple to qualify for Medicare.

Despite Medicare's hefty price tag of $118 billion in 1991, it is a successful program. Major gaps in the program's coverage are long-term care, nursing homes, prescription drugs and hearing aids. These gaps are vital health requirements of the elderly. Additional needs, such as glasses, dental care and podiatry are also not covered by Medicare. Even with Medicare, the elderly are paying almost 20 percent of their incomes for medical expenses.[10] Medicare and Medicaid are the fastest-growing p i of the federal budget. Spending on these two entitlement programs has grown from about one percent of GDP in 1970 to three percent in 1991.[11]

Ethical Considerations in Health Care

Bioethical questions will prevail during any discussion of how to resolve America's health care crisis. The expansion of technology has brought the possibility of medical intervention to all stages of life: procreation, birth, and death. The resulting philosophical and ethical discussions cut to the core of our social values and institutions. Decisions on various issues such as termination of life, organ procurement and transplantation and withdrawing or withholding treatment present conflicts for all involved. Increasingly, hospital ethics committees are established and called upon to resolve dilemmas arising from conflicting and competing interests as well as concerns among hospital staff, patients and families.

Most situations of an ethical nature have no clear-cut answer to the problem. Often, there are numerous options to choose from in seeking an acceptable solution. Issues range from individual to institutional to community concerns. Individual issues may deal with conditions under which a life may be terminated or how to balance survival and quality of life. Institutions may address who should be admitted and who should not, given limited resources and when ability to pay may influence decisions. Communities must balance demand and need for all residents.

Such is the nature of many issues, problems, and questions facing any effort to reform the U.S. health care industry. While many of the industry's problems are addressed in terms of economics, it is the ethical or moral aspect of health care that clouds the decision making process. This creates difficult and painful choices. The purpose of ethics in health care decision-making is not to create new moral principles for society. Rather, medical ethics prepares the foundation for the application of general principles of ethics.

There are fundamental ethical principles relative to the process of formulating opinions and outcomes. Four principles that apply to medicine are:

- Autonomy - an individual's personal liberty, independence, self-reliance, and self-contained ability to decide.[12] In medicine for example, autonomy deals with informed consent, an individual's competence to make a decision and the right to refuse treatment.

- **Justice - "fairness" as related to society and the demands placed on individuals. To be fair and equal each person should receive his dues, burdens and benefits of society.[13] Justice is a broad term but basically encompasses the idea that individuals must be treated impartially and fairly, not in an arbitrary manner.**

- **Distributive Justice - applies to distribution under conditions of scarcity, e.g. where there is competition for benefits.[14] An example is the competition for health care dollars and other resources.**

- **Utility - generally means producing the greatest good for the greatest number. The utility of an action may be determined by the extent to which it produces the most desired outcome. Good and bad effects of a decision must be weighed against overall outcome.**

It is necessary to have a general understanding of these basic ethical principles in order to appreciate the impact they have on decisions in health care and the need for reform. While all of the principles can be linked to health care, the concept of distributive justice requires further exploration.

Distributive Justice and Health Care

When attempting to formulate health care policy changes, availability, or access, is the greatest concern. There are thirty-five million Americans without insurance who are unable to obtain basic health services while at the other extreme, some receive extraordinary care with little regard to cost. This disparity presents a problem concerning the distribution of health resources. Some suggest need be a deciding factor. Need is a difficult concept to define in a way that would satisfy everyone. Need as a health care determinant would surely exceed the limits of current resources.

Merit is another term often mentioned in determining distributive justice. Who should have the opportunity for health care? Who really deserves it? Merit-oriented proponents of distributive justice believe individuals are responsible for their behavior and therefore responsible for their relatively good or ill health. Further, the gainfully employed earn their living honestly and "deserve" their health benefits. One "merits" things because of what one is or does, and how the individual or his or her actions benefits society.[15]

How then, would we allocate treatment to those who seem not to have merited it? Those, who through their own fault or not, seem to contribute very little to society. In this light, merit is not a humanistic way to allocate resources.

The more one grapples with the concept of distributive justice and its relationship to health care resources, the more gray the area becomes. As previously mentioned, there

are not clear cut answers that present themselves in a logical manner for selection and prioritization. There will be painfully difficult choices requiring sacrifice and the realization that true necessity may greatly differ from one's desires or wishes. Selecting choices will be painful, however, we are slowly realizing that we cannot afford everything we want.

The Oregon Plan

The state of Oregon recently attempted to find a way to address the difficult issues of rising health care costs and delivering health care to the uninsured. The Oregon Basic Health Services Program, or the Oregon Plan, proposes to ration health care, an approach which has created a storm of controversy.

The current health care crisis has developed slowly and insidiously over the years. The continued failure of the federal government to develop comprehensive health care policy reform led Oregon to seek a solution. The two basic, and seemingly irreconcilable issues which confront any reform attempt, access to care and cost control are at the root of the solution.

During the 1980's, Oregon faced the problem of declining funds for programs such as Medicaid, an increasing number of uninsured residents, and a slow economy.[12] For these reasons the Oregon legislature decided to stop Medicaid funding for soft tissue transplants

including bone marrow, pancreas, liver and heart (but not kidney or cornea).[13] This denial of Medicaid funding gained national attention six months later when two Oregon children were denied necessary transplants based on the legislature's decision.[14]

The public outcry that resulted from these two cases led to a phenomenon that is likely to follow any allocation of resources. The question of utility - the greatest and good for the greatest number- in terms of cost effectiveness, makes sense until human nature takes over. People react differently to a case when an individual is identified and emotions and empathy become a factor. We cannot afford a philosophy of "any care at any cost to everyone who wants it". Rationally, we understand that, but find it difficult to implement or reinforce when a name, a face and a plea is attached.

Attempting to better utilize Medicaid funds and expand the base of people covered, in 1989 Oregon's legislature adopted sweeping initiatives designed to significantly reduce the growing number of individuals who had no health care access. In order to expand coverage to individuals without health insurance, the tradeoff was a forthright decision not to cover some medical procedures. The Oregon Plan has three distinct parts intended to improve the state's health care delivery system. Briefly the plan would:

- **Expand Medicaid to cover all people with incomes less than the federal poverty level; $928 per month for a family of three in 1991. This coverage would apply regardless of age, family, employment or pregnancy status**

- **By 1995, have health care coverage for employees and dependents that is equal to, or greater than, the Medicaid group:**
  - **Establish an insurance pool for individuals who do not qualify for insurance based on pre-existing medical conditions.**

  - **Create a "liability shield" to protect providers against prosecution for failing to provide unfunded services or procedures.**

- **Public participation was solicited for definition of a basic health care package for Medicaid eligible residents.**

It is the third component of the plan, the attempt to identify a basic health care package for all Medicaid recipients, that has created the most controversy. The Governor of Oregon appointed a commission with instruction "to report...a list of health services ranked by priority from the most important to the least important, representing the

comparative benefits of each service to the entire population served."[15] The commission solicited public input throughout a tedious eighteen month process of prioritizing medical care to be funded. The final result was a list of 714 medical condition and treatment pairs assigned to various categories. These pairs were then ranked within each category according to their net benefit - that is, the degree to which a person's overall well being would improve by receiving the treatment paired with his or her specific medical condition. The commission further adjusted condition-treatment pairs up or down the list based on cost and public value.

Oregon's Ranking of Selected

Condition - Treatment Pairs

RANK	CATEGORY	CONDITION	TREATMENT
123	2	Low birthweight	Medical therapy
158	5	HIV disease	Medical therapy
311	5	End-stage renal disease	Renal Transplant
393	11	Osteoarthritis	Hip Replacement
499	11	Hernia without obstruction	Repair
600	15	Infertility	Medical treatment
701	15	Tubal dysfunction	In-VitroFertilization
713	17	Extremely low birthweight	Life Support

The lawmakers next step was to decide what was to be funded. A system of 17 categories was created to organize the items logically, placing the categories into priority order and then rank-ordering the items within each category. Three sets of categories were created: essential, very important, and valuable described as follows:

Categories:

1-9 Essential - funded within the basic plan

10-13 Very Important - funded to the greatest extent possible

14-17 Valuable - to certain individuals, but less important to society as a whole or of questionable benefit.

The lawmakers then "drew the line" for services to be funded; the top 587 items of the 714 item list. Effective treatment, diagnostic services and preventive and primary care are covered. Treatments found to be not as effective, or futile, were not to be funded.[16]

This summary of a long, painful process for the Oregon legislature and its citizens is a less than adequate explanation of the entire plan. This plan has not yet been put into action pending significant waivers of the current Medicare law. The plan will act as a demonstration project to study the positive and negative effects of restricting certain treatments.

Lessons of the Oregon Plan

Recently approved to take effect 1 January 1994, the Oregon Plan offers food for thought, discussion, debate, outrage, enthusiasm and a whole list of other adjectives and emotions. Oregon has made a real contribution to health care policy reform by defining basic services and qualifying and quantifying high and low-technology services. There is now some basis for discussion, some jumping-off point, some proponents and some opponents, and an opportunity to test the concept and effectiveness of rationing.

As previously mentioned, the aspect of the Oregon Plan that generates the greatest public outcry is the definition and prioritization of a basic health care package. The Oregon proposal offers the alternative of explicit choices based on systematic, rather than ad hoc methods. No matter how they word the terms or describe the process, what they are proposing is health care rationing.

> *"Rationing can be summarized as a system of deliberate choices about the sharing of health care resources among persons (ie, who gets what care, and in what order of priority) on grounds that go beyond an individual patient's clinically defined needs; the criteria specifically include both comparative medical need and social equity."*[17]

Health care and health policy in the U.S. are in the midst of a crisis of incredible magnitude. The scope, complexity and consequences of such a quagmire seem to have left the government overwhelmed and inert. The issue of reform generates much debate, but

results in little action. Discussions of rationing occur with increasing frequency in political, social and professional circles. The rising cost of health care, and a perception that cost containment measures are not working, have forced consideration of radically different alternatives.

In the U.S. people, not services are rationed. It is an implicit rationing, excluding the poor and other individuals without insurance. An inability to pay is a cruel form of rationing. This is not a government enforced policy, but rather, the end result of a weak health care system. To those with insurance, cost is not an issue for obtaining the best technology that modern medicine has to offer. For the poor, basic humane health care is a non-issue. The inability of vast numbers of Americans to even access the health care system has placed national health care near the top of the political priority list. Will the U.S. be able to direct health policy reform without turning to some form of explicit rationing? The issue of distributive justice in allocating finite resources of health care must sooner or later be addressed.

Rationing and cost containment are inextricably linked in the health care arena. It is unjust to perpetuate the practice of high cost, high tech, treatment that is of great benefit to some while numerous others lack even the most basic health services. As a society, we want to believe anyone needing a medical procedure gets it. This response reinforces cultural traditions of human rights, personal autonomy, and benign neglect on questions of resource allocation.[18] It is an impossibility for <u>any</u> system to provide everything to

everybody who wants it. No plan will be perfect and totally acceptable to everyone. There will be compromise, and the first step is to decide what we want for America in a health care policy.

Again, we return to the two central themes of health care: access and cost containment. Hemodialysis is a classic example of an incredible health care expense that the U.S. government funds, but is rationed elsewhere. In 1973 the United States Congress passed legislation granting Medicare funding to all patients with kidney failure who need hemodialysis or renal transplantation. Essentially, the government granted access to everyone without regard to cost under the End Stage Renal Disease Program. This does not occur in other countries. In the United Kingdom for example, more people are allowed to die of chronic renal failure than in any other comparable European country.[19] Prior to 1973 and government funding, dialysis was a scarce resource in the U.S.. Potential recipients were selected on the basis of economic, medical and psychosocial reasons. Fair? Probably not. On the other hand, is it fair to use government funds for a group of individuals with an end stage disease while millions of others cannot afford basic health care? Rationing scarce medical resources means someone gets hurt and someone gets left out, and that is painful. We don't like to think about it on a broad basis and we like to think about it even less when it is <u>our</u> loved one.

No final decisions have been made on any issue of the health care overhaul currently underway. Some anticipated changes include coverage for every U.S. resident that would follow individuals when they change jobs or move. Numerous health plans would offer consumers coverage for one annual fixed rate. The plans would be required to sell a standard package of benefits, defined by the government, to anyone who wants to buy one and ill people cannot be charged more. Still not defined are sources of coverage, financing or cost controls.[20]

It is unlikely that attempts to reform health care policy will turn to explicit rationing as a viable alternative. "The idea of explicit rationing is not only to set limits on total expenditures for care, but also to develop mechanisms to arrive at more rational decisions as to relative investments in different areas of care, varying types of facilities and manpower, new technological initiatives, and the establishment of certain minimal uniform standards."[21]

Is There An Answer?

Political bureaucracy, gridlock and special interests have joined forces in blocking effective action and decision-making. One writer contrasted the health care game to baseball identifying the playing field, the teams , their agendas, rules of the game, a chronicle of the games, innings to date and an assessment of the "American Health Care

League's" off-season issues. The "rules" of this spoof on the health care crisis highlight the political mind-set and denial of the reality of hard choices:

Rules of the Game

- Ensure that high quality health care is available to all individuals - even those who can't pay.
- Provide health care cost effectively.
- Allow a fair profit in exchange for the delivery of medical services.
- Offer competitive and attractive employee health care benefits to recruit and retain good employees
- Maintain a competitive position in the domestic and world economy
- Do not adversely impact the federal budget deficit
- Don't raise taxes.[22]

What is apparent is the theme of political gridlock; each team has its own agenda, and the individuals on the same team often pursue their own interests.[23]

America will need to come to grips with the possibility of rationing. Even if the country were willing to pay much more for the health care budget, there is a limit to the

portion of resources this area should consume. There are so many other areas in need of funding that we cannot allow health care costs to continue to spiral upward. Americans must change their basic outlook, their attitudes and the way they consume without regard of consequences to others or to the future.

The task of setting priorities and distributing limited resources is not easy or pleasant. We need to emphasize dignity, comfort and basic care for all. The voiceless among us, the ones who can't fight back and the have-nots are the ones who suffer the most. The "haves" of the world will likely create a two-tiered health care system and high tech, high cost treatment will still be available for those who have the choice to pay. That does not excuse us from an obligation to provide decent, adequate care to those that have no choice.

A new health care plan may well meet the initial goal of access for the millions who currently have none. As the millions access and tax the system however, we should be prepared to address the issue of rationing. The health care budget is a finite commodity while demand is infinite.

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