INTRODUCTION
The purpose of this essay is to look at health reform using a framework of values. Values are the elements or characteristics that we find desirable or good about a system; they are the ideals that we strive to make a reality. Values lie at the core of any system. Values shape the organization and financing of health services. As we work to reform our health care system, a fundamental question arises: Can our problems of cost, access, and quality be solved in our current system with its emphasis on individual values, or must we shift priorities to a community-oriented values system? Interestingly, this question is asked by both economists—notably Victor Fuchs(1) and Henry Aaron(2)—and by ethicists—Charles Dougherty(3), Daniel Callahan(4), Reinhard Priester(5), Bruce Jennings(6), and Ezekial Emanuel(7). This is the juncture where economics meets ethics, or more specifically, where resource allocation meets justice.

To outline the remainder of the article, first a set of health care values is defined. Then, the priorities of our current system are described and compared to a community-centered alternative. Next, individual-centered and community-centered systems are compared with respect to resource allocation, an issue with ethical and economic implications. Finally, the role of public discussions and public input in health policy and resource allocation decisions is explored.

A FRAMEWORK OF HEALTH CARE VALUES
The values framework presented here is based primarily on the work of Reinhard Priester(5), but it is also congruent with a framework presented by Charles Dougherty(3). The framework includes 11 health care values. Again, values are the elements that we desire in our health system. Although we desire all these elements, values may conflict with each other. Thus, while most of us may agree that a health care system should display or attain these 11 values, we may disagree over their relative priorities and which should be dominant. The values are:

**Fair Access.** Access refers to each person’s ability to receive essential, basic, or adequate health care services. Fairness means that similar persons are treated similarly, without regard to socioeconomic status. The value of fair access is based on the inherent dignity of each human being and on the moral dictate of helping those who are the least-well off.

**Quality of Care.** We want our medical procedures to be performed correctly, to be medically indicated, and to likely result in desirable outcomes. Quality can be viewed as the use of sophisticated technology and intensive services. Alternatively, quality can be seen as achieving the health status outcomes desired by patients.

**Efficiency.** In an efficient system, resources are used wisely, and they generate good value. Efficiency involves providing only necessary care as well as producing necessary services in the least costly manner. To “waste” limited resources in either fashion is economically and ethically undesirable.

**Patient Advocacy.** This is the obligation of providers to be advocates for their patients and to promote the best interests of each patient.

**Respect for Patients.** This value involves several aspects of the provider-patient relationship: the patient’s right and responsibility to make informed, voluntary decisions about their care (patient autonomy and informed consent); maintaining the confidentiality of information; treating patients with respect and dignity; and promoting caring relationships between providers and patients.

**Provider Autonomy.** This includes the clinical autonomy of practitioners and the regulatory autonomy of the professions. It allows practitioners the freedom to practice their profession as they see fit, the opportunity for just compensation, and the right to refuse patients. It also allows the profession to control its education and entry into the profession.

**Consumer Sovereignty.** This refers to the rights of consumers to select their health care providers.

**Personal Responsibility.** This involves several elements; specifically, assuming responsibility for one’s own health, being responsible for contributing to the common good, and assuming one’s fair share—based on ability to pay—of funding the health care system.

**Social Advocacy.** This is the obligation of providers to be advocates for the health care needs of society in general—

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1Presented by Dr. Larson at a Section of Social and Administrative Sciences session titled “Health Care Reform as a Social and Political Phenomenon” at the 95th AACP Annual Meeting, Albuquerque NM, July 17, 1994.
other words, to be advocates for the public’s health, in addition to being advocates for their individual patients.

Social Solidarity. This refers to promoting a sense of community and bridging the gaps between different segments of society.

Personal Security. This is the security that one’s health care needs will be met without financial impoverishment.

CURRENT SYSTEM (INDIVIDUAL-ENTERED)

What are the priorities among values in our current system? Priester’s analysis(5) indicates that four values are dominant (Table I). One is provider autonomy. Over the past century, the organization and financing of services in the U.S. have been greatly influenced by professional dominance(8). Providers—especially physicians—have been free to practice as they see fit, with little outside oversight and interference. In addition to this clinical independence of the individual practitioner, the health professions have been allowed to regulate themselves, setting entrance requirements and monitoring their members.

A second priority value in the current system is patient advocacy. Providers are expected to act in the best interests of their patients. However, often this has been interpreted as doing everything medically possible for their patients. This leads to a third priority of the current system: quality of care. For many, high quality is equated with aggressive, intensive interventions involving sophisticated technology. Thus, we have the “technologic imperative”; that is, the belief that good medicine is using every technology available. Only recently has patient outcomes—and patient preferences among outcomes—become a focus of quality assessment.

A fourth priority in the current system is consumer sovereignty. This is the right of patients to select their providers—either individual providers or insurance plan. To some extent, this can be viewed as a check on the system, in that patients can express their dissatisfaction by seeking another provider.

The value of fair access is of mixed importance in our current system. Insured persons have access to virtually any service. Social policies such as Medicare and Medicaid indicate a desire to guarantee access. Yet many people are without insurance coverage, and many more face social and transportation barriers to care. Access involves more than insurance coverage; universal access and universal coverage are not synonymous with each other.

Another value of mixed importance is respect for patients. Informed consent and confidentiality are emphasized, but lesser priority is given to patient autonomy (i.e., patient decision making) and empathic caring.

The remaining values are of low—very low—priority in the current system. One of these is efficiency. Economists have noted that health services are not produced in the least costly manner, and the distribution of resources across services is not optimal. In other words, the system is marked by technical inefficiency as well as allocative inefficiency. As another indication of our current inefficiency, some speculate that unnecessary procedures are so common that eliminating them would generate sufficient savings to pay for universal coverage(9).

Finally, our current system places low priority on the social values, such as being responsibility for one’s health and for providing service to the common good (personal responsibility), developing a sense of community (social solidarity), providers serving as advocates for the public’s health (social advocacy), and freedom from fear of the financial burden of health care expenses (personal security).

PRIESTER’S COMMUNITY-CENTERED SYSTEM

As mentioned at the beginning, the key question is: Can our problems of cost, access, and quality be solved in our current system with its emphasis on individual values? If not, what might a more community-centered alternative look like in terms of values and priorities? Here we again rely on Priester(5) and his formulation of priorities in a community-oriented system (Table II). Priester labels values either as essential or as instrumental. Essential values are fundamental to the health care system. They should be realized to the maximum extent possible, without interfering with other essential values. They take precedence over instrumental values. Instrumental values are generally desired as means to achieve the essential values.

In Priester’s community-oriented system, five values are designated essential. These are: fair access, quality, efficiency, respect for patients, and patient advocacy. Among these essential values, fair access is preeminent. In a conflict with any other essential value, fair access should be given priority. For Priester, fair access means that everyone can obtain a basic level of care. This is a minimum level of care which no one falls below. It does not imply universal access to all services—rather universal access to basic services. Further, Priester’s formulation of this value does not prohibit individuals from purchasing non-basic services with their own financial resources.

Quality of care is an essential value because desired outcomes are the primary reason that the health care system exists. However, in contrast to the technology-focused definition of quality in the current system, the community-oriented system focuses on quality as achieving patient-desired outcomes.

Efficiency is an essential value, because resources are
scarce and they have an opportunity cost. A dollar spent on a particular health service cannot be spent on other health service or non-health services. Thus, any unproductive use of resources or inefficiency is to be avoided, because such waste impedes the ability to accomplish other goals, including fair access.

The fourth essential value is patient advocacy. Providers should be advocates for their patients, acting in their patients’ best interests. In Priester’s formulation, the patient advocacy is done within previously established practice guidelines. Thus, in this system, the provider is not compelled to do everything that medical science has to offer, but rather everything that is approved for the patient’s condition. These practice guidelines would be established by experts and practitioners.

Respect for patients is the final essential value in the community-oriented system. As mentioned before, this includes respecting patient autonomy and treating patients with dignity. In essence, this value places the patient at the center of the health care system and makes the patient the key decision maker.

In this community-oriented system, provider autonomy and consumer sovereignty fall from their preeminence in the current system to being instrumental values. Provider autonomy is desired in that it can enhance quality and patient advocacy; it is not desired in and of itself. Similarly, consumer sovereignty is desired because it can enhance efficiency and quality. Other instrumental values include personal responsibility and service to the common good, social solidarity and sense of community, the social advocacy role of providers, and personal security. While not essential values, they are more relevant in a community-oriented system than in an individually-oriented one.

In sum, in a community-oriented system (compared to our current individual-oriented system), individual self-interests are tempered with the interests of the community, less emphasis is placed on provider autonomy and consumer sovereignty, and fair access becomes the dominant value.

RESOURCE ALLOCATION

We now focus on one issue and note the difference between a community-oriented and an individual-oriented values system. The issue is resource allocation. Allocation deals with such questions as the level of resources devoted to the health care system, the proliferation of new technologies, priorities among already available services, and who receives those services. Resource allocation is the core of economics; it is also intertwined with the ethics principle of justice.

Resource allocation is synonymous with ‘rationing’. Sometimes, the term rationing is applied to situations in which explicit decisions are made to limit care. However, according to the definition of Aaron and Schwartz, rationing occurs when “not all care expected to be beneficial is provided to all patients”(10). Using this definition, we are rationing now—based on ability to pay and social class—but the rationing is quiet. Rather than equate rationing with explicit allocation, the term is more appropriately used as a synonym for allocation—whether the allocation is explicit or implicit. In essence, the question is not whether we are going to ration, but how.

Five thought questions are useful in highlighting key aspects of the resource allocation issue. The first question is: What is the relative contribution of health care services in enhancing the quality of life in the community? This question differentiates health services and health status. In addition, it encompasses a comparison of health services to non-health services, as well as the relative contribution of health services to each other.

The case that our current health expenditures are a wise investment in human welfare is difficult to make. For instance, McGinnis and Foege(11) analyzed 1990 mortality data according to actual causes of death. Their estimates indicate that nearly half of all deaths were attributed to nine leading causes: tobacco (19 percent of deaths), diet/activity patterns (14 percent), alcohol (five percent), microbial agents (four percent), toxic agents (three percent), firearms (two percent), sexual behavior (one percent), motor vehicles (one percent), and illicit use of drugs (one percent). Many of these are related to behavioral or environmental factors factors that are outside the medical care system.

Similarly, a report recently published by the Robert Wood Johnson Foundation is titled, “Substance Abuse: The Nation’s Number One Health Problem”(12). Again, the current medical care system is not particularly effective in dealing with this problem. Finally, to highlight our emphasis on length of life rather than the quality of life, Callahan points out five chronic health problems that are virtually endemic among the elderly: dementia, urinary incontinence, hearing impairment, osteoporosis, and osteoarthritis(4). All adversely affect quality of life, yet only the first one receives attention as a health problem on the magnitude of ‘killers’ like heart disease and cancer. In sum, the contribution of our current level of health care expenditures—devoted largely to acute, life-saving services—to quality of life is debatable.

The second question is: What limits—if any—should be placed on the development and proliferation of technology in the medical care sector? Economists Henry Aaron(2) and Victor Fuchs(1) as well as ethicist Daniel Callahan (4), among others, argue persuasively that technology is the engine driving health care costs.

Currently, these decisions are made quietly, without public debate. For instance, no formal decisions are made as to the levels of spending for cardiac treatment versus prevention, for prenatal care versus neonatal intensive care units, or cancer treatment versus prevention. These decisions are made by individual organizations, professionals, and patients, within the incentives provided by insurance benefits. Providers—organizations and physicians—invest in and adopt new procedures and equipment; physicians perform them or prescribe their use; some patients demand to receive them. Often the decision makers are immune from the cost considerations of their decisions. Thus, the invisible hand of marketplace is not merely invisible—it is absent. As a result, governments and employers have found that health benefits or health entitlements are virtually ‘unbudgetable’. Resources seem to flow into the health sector—especially for personal health services—on their own accord.

The consensus is now quite widespread that health care expenditures must be contained and, further, that the proliferation and use of medical technologies must be better controlled. One approach is to enhance market forces—that is, instilling cost-conscientiousness in health care utilization decisions—coupled with the idea of developing practice guidelines to eliminate medically unnecessary procedures(9). This is the thrust of managed competition. Whether or not managed competition can effectively and efficiently employ technology is one of the key questions in health policy.
This approach is appealing. We all would like to hope that eliminating waste or unneeded services would be sufficient to solve our health care problems. This is a solution that harms no one. However, this may be wishful thinking. Callahan makes the argument that medical necessity is an elusive, ever-expanding concept that is ultimately ineffective as a basis for deciding what services should be made available(4). Furthermore, even medically necessary services may not be affordable. For example, society does not provide children with every educationally necessary or developmentally necessary service; so is society obliged to provide all medically necessary services?

The third question is: Does each individual have the right as a human being to receive medical services that will relieve pain and suffering and enable him/her to live a normal life-span? And as a corollary, do we—the fortunate ones—have an obligation to help pay for the services needed by those less fortunate? In Jennings’s formulation, this is the allocation of defining just access(6). Defining ‘basic’ or essential services is an exercise in allocation, in that persons needing a non-essential service may not receive it. Access and allocation are inexorably linked.

The fourth question is: Is it in the community’s best interests to have a medical care system—and a populace—whose motto is, “Never say die”? Or is it better to recognize and accept the human life-span as limited? Daniel Callahan(4) argues very persuasively that intensive, life-saving services should not be available to persons who have already lived an average life-span, which he puts at 75-80 years of age. Instead, he would put our emphasis on chronic care and palliative care, giving the elderly personal security and comfort, while accepting the reality of mortality and seeking to regain the meaning of growing old.

This ties into the fifth question—the question which ultimately separates the community-centered and individual-centered values systems: Should each individual have unlimited access to community resources through his/her use of medical care services—services which may have minimal impact on length or quality of life? With public programs like Medicare and Medicaid—and less directly through private, group insurance—health care services are paid through community resources. Currently, many of us have a blank check to draw upon society’s resources (or our fellow employee’s resources) to whatever extent we desire to satisfy our medical care wants.

In sum, allocation decisions in our current system are made quietly and informally as individual providers and patients make investment and treatment decisions. In many markets, society is best served with individual buyers and sellers pursuing their best own interests. However, medical services are not the same as other goods and services. They affect human potential; and they are produced and used in the absence of economic incentives. A community-oriented system would include explicit decisions as to limits, priorities, and basic services; in other words, a system with explicit allocation decisions—a system which formally considers the needs and the priorities of the community.

PUBLIC INPUT AND PARTICIPATORY DEMOCRACY

These are difficult and emotional issues. How can such decisions best be made? Theoretically, cost-effectiveness analyses can tell us how to best spend a limited sum of money; but practically speaking, these analyses cannot give us the answers. While cost-effectiveness analyses are certainly useful, they do not offer us a complete way out of our dilemma. Can these decisions be left to panels of experts? Expert opinion is an important input, but such panels may not be effective in making allocation decisions. While an oversimplification, many experts feel ill at ease to offer opinions outside their area of expertise, and in their field, every procedure, screening test, and scientific advance is regarded as very significant. Having a group of experts allocate resources for its own area of expertise is not necessarily in the community’s best interests.

An essential ingredient in making allocation decisions is public discussion and input. Not just opinion polls or comments to Federal Register musings, but discussion, deliberation, and debate—in other words, participatory democracy. Jennings describes the need for and the needs of public discourse in resource allocation decisions(6). He sees no single correct or best allocation pattern and suggests that allocation decisions best be made in accordance with ethical criteria discussed at public forums. Jennings suggests that public forums can fruitfully discuss the importance or significance of such ethical criteria as: the number of persons affected by a service, its effect on preventing disease, its effect on curing disease, its effect on prolonging life, its effect on enhancing quality of life, the worthiness of the typical patient receiving the service, and the social implications if the service becomes widely used. The results of these discussions could be considered in setting research priorities, setting priorities among existing services, and defining basic services (i.e., the services everyone is guaranteed, as part of fair access).

Community discussions help make allocation decisions legitimate. They enhance procedural justice—the justice or fairness of the decision making process. A legitimate decision is one that we respect and obey, even though we may disagree with it. With explicit allocation decisions, each individual will eventually encounter a situation in which some service—with some potential to benefit a loved one—is non-basic, and will not be covered by insurance. Such a circumstance is more likely to be accepted, if the individual believes the decision making process was fair and open.

Barber presents an excellent description of participatory democracy and the benefits that can be derived from an actively involved citizenry(13). He contrasts a participatory democracy with another model of government which he labels the client state. These two models differ along three dimensions: the role of the individual in governance, the form of communication, and the role of leaders.

The client state has consumers (or clients) of government services but no citizens, while the latter has actively involved citizens. The client state is marked by “Blameitis”—which marks the client state—is diminished. This is the condition where all policy problems are blamed on the leaders—and the leaders are looked to for solutions. In the participatory democracy, we take respon
sibility for our community’s problems and their solutions—in short, we govern ourselves. Participatory democracy and community discussions cause us to listen more carefully and to better understand the positions of those with whom we disagree. The discussions help us to find common ground—not just finding a compromise between competing interests—and to identify our shared interests. We develop a sense of community. The values of social solidarity, social advocacy, personal responsibility, and service to the common good are realized.

One attempt to bring the virtues of participatory democracy into reality in the health care system is the community health decisions movement(14,15). Essentially, this is an attempt to develop grassroots bioethics networks, whose purpose is to stimulate community discussion about values and ethical issues facing the health care system. The first community health decisions project originated in Oregon, where town meetings were held to discuss what the public viewed as important about health care services(16). The results were one of several inputs in setting the priorities of treatment-condition pairs in Oregon’s reformed Medicaid program.

American Health Decisions (AHD) is an umbrella organization of these local projects. The mission of AHD is to “use community education and discussion to promote and enhance understanding of ethical issues in health care, and direct involvement of citizens in personal, institutional and societal decisions about health care issues”(17). The Community Health Decisions projects oftentimes use town meetings as a forum for public discussion. The meetings have thought-provoking and discussion-stimulating exercises; they are not simply public hearings. The Community Health Decisions projects promote community discussions and participatory democracy in health policy.

Many are skeptical of public participation in allocation decisions. The public appears to want everything medical science can provide—for themselves and for others—without paying for it. They want high tech services even if they may not be cost-effective, and conversely, they may not place a high priority on very cost-effective preventive services. The concept of a statistical life is not widely understood. Given this state of affairs, Jennings(6) asks the key question: “Does health care allocation pose a dilemma that is irresolvable in a democratic society?” Rather than bemoan the current limits to public participation in allocation decisions, maybe the time has come to begin building the skills of the citizenry.

SUMMARY

We in the academy have an obligation to help our students be prepared to participate in public discussions of health policy and allocation issues—not only as advocates of pharmacy, but as well-informed citizens who are cognizant of their health care values and ethical criteria regarding resource allocation. Hopefully, this framework and discussion will be useful in this task. To ask the critical question a final time: Can our problems of cost, access, and quality be solved in a system emphasizing individual values, or must we shift priorities to a community-oriented values system?

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References