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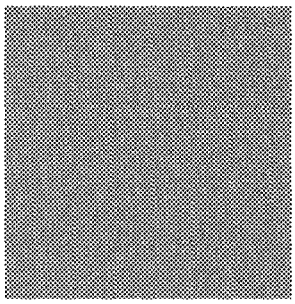

Communitarian Illusions: Or why the Dutch Proposal for Setting Priorities in Health Care must Fail

Theo van Willigenburg
Center for Bioethics and Health Care, Faculty of Theology, Utrecht, The Netherlands

Abstract

This article accounts for the failure of the Dutch Government Committee on Choices in Health Care to develop useful criteria of necessary care by which to set health care priorities and ration resources. The Government Committee has been inspired by philosophers who think that allocation problems cannot be solved without placing broad moral questions about the good life, and about the place of health and illness in our lives on the public agenda. The fruitless attempts of the Committee to formulate an effective notion of essential care, based upon a community-oriented perspective of health, shows why the communitarian approach is bound to fail. Questions about essential health care cannot be answered on a macro-level. The only way to get some reasonable control over day-to-day health care allocation decisions in hospitals and institutions is by trying to understand the history, laws, habits and contingencies of what is going on between doctors and patients. Such an understanding can be gained by developing a relational and biographical view on the doctor-patient relationship.

The amount that could be spent on health care is, in theory, unlimited. We all, as mortal beings, tend to put the highest value on good health and a long life. It is true that many of the public recognise some of the problems of health care cost, but at the same time they want more rather than less medical care and are apt to demand the best available technology. Public expectations continue to grow, while expensive medical technology rapidly proliferates.

In the Netherlands, since the beginning of the 1980s, the government has tried to moderate expenditure on health care by means of various cost-containment programmes. Notable among these is a budget-system where hospitals receive a lump sum, every year, based on payment forecasts, and limited by macro-budgetary constraints. This system has proved to be successful in tempering the annual increase in health care costs, but at the same time it has led to an enormous growth of waiting lists, with lengthy waiting times for many forms of health care. For example, currently the waiting time for a bed in a home for mentally handicapped persons may be up to 8 years, and many people die on waiting lists before life-saving therapy can be made available. The threat of underservice and erosion of quality is everywhere.

At the end of the 1980s it was increasingly recognised that implicit rationing through limiting the resources available to hospitals and institutes is not enough. Planned resource allocation requires the courage to set priorities. In the Netherlands a basic insurance programme is being introduced which will cover a large part of normal health care, so the resource allocation issue has hardened to the question: which services should be included in the basic package and

Theo van Willengenburg, Center for Bioethics and Health Care, Faculty of Theology, Heidelberglaar 2, 3584 CS Utrecht, The Netherlands.

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which should not? What kind of services should be supplied to everyone, and which should be positioned at the bottom of the priority list?

Criteria are necessary to set priorities, and should provide good reasons in support of any distinctions made between services. Such distinctions are of greatest importance to explain the difference between services which are recommended as part of the basic package, and those which are not. The Dutch Government Committee on Choices in Health Care has tried to develop criteria for setting priorities, in particular by formulating a notion of *necessary health care*. In contrast to the Oregon Experiment this notion is not derived from a survey of the preferences of the population, but is based on one particular perspective on health and the purpose of health care. The Government Committee has proposed a 'community-oriented perspective' from which health is seen as the possibility for every member of society to function normally and, thus, to participate as much as possible in the community.

In this article I present a brief exploration of this community-oriented approach, and investigate the validity of the notion of necessary (or essential) care.

Necessary Health Care

According to the community-oriented approach, care is necessary 'when it enables an individual to share, maintain and if possible to improve his/her life together with other members of the community'.[1] But the central question is 'which care is necessary to sustain community involvement?'

The Government Committee feels that the most necessary facilities are those which guarantee 'normal functioning' or which simply protect a person's existence as a member of the community (see ten Have's paper, this issue). More interesting, however, than the question of which services should be included is the question which services are to be excluded from the basic package because they are 'not necessary enough'? The effectiveness of the community-oriented criterion of necessity depends on its power to exclude. The Government Committee mention *in vitro* fertilisation (IVF) as an example of non-essential care, because undesired childlessness in the Netherlands 'poses no danger to the community, and it can not be said that childlessness interferes with normal functioning in our society'.[2] But this is a curious argument. First, it may be said of many diseases that they are 'no danger to the community'. According to such a definition only the fight against very serious, infectious diseases might be categorised as necessary. Second, it seems to state *in general* that childlessness does not interfere with normal functioning in society. For some childless couples the impossibility of having children is an unbearable load in their life which seriously hinders their normal social functioning. Does the Dutch Government Committee really think that it is possible to determine *on a macro-level* which diseases or needs interfere with normal functioning? Is it possible to determine on a macro-level whether, for instance, a motion sickness, a skin disease or a certain allergy threatens a person's normal functioning? It is hard to see how such issues can be determined without taking into account the unique situation of the individual patient. For some patients psoriasis may be a blockade to any participation in social life. Others may have learned to live with their disease. The idea of 'normal functioning', therefore, hardly seems effective as a method to determine what is essential care.

Moreover, even if it can be argued that a particular class of handicaps or diseases interferes with normal functioning it is not at all clear that it can be determined, in general, which particular health care provisions are then necessary. For instance, if we agree that a mental handicap interferes with normal functioning in society, is it possible to determine in general what kind of care for the mentally handicapped is necessary in order to enable an individual to share his life with others? What care is more necessary: 24 hours institutional care or part-time care, day time activities or home care?

Callahan's Trap

Why has the Dutch Government Committee chosen a community-oriented approach which offers such powerless criteria for setting priorities? It appears that the Committee has walked into a trap which philosophers like Daniel Callahan have been setting during recent years. The

Choices in Health Care Committee rejects the approach which connects health to personal autonomy. It also rejects the 'medical professional' approach since this offers a limited definition of health in biological terms while neglecting psychosocial functioning. According to the Committee, on these theories man is perceived too much as an individual organism and not enough as a member of the social community which determines what is 'good' functioning. Leaving 'individualistic atomism' behind, the Committee embraces a more communitarian approach inspired by Callahan's ideas.[4] According to Callahan, the great problems in health care, especially the problem of the allocation of scarce resources, will remain unmanageable if society does not try to find specific answers to broad normative questions like: 'What makes a good and fulfilled life?', 'What is the place of illness and old age in our life?' and 'How may health care contribute to the good life?' Callahan is critical of the strictly liberal approach which assumes that each individual should determine what the good life is. It is essential, according to Callahan, that a community perspective on 'the good life' is developed which transcends the individual perspective. Without this no good reasons can be produced for setting priorities in health care.

Now, it may be essential, at least in Callahan's opinion, to attempt to develop a normative vision on a macro-level, but is it really possible? The Committee's proposal is a good example of what happens if one tries. In order to develop a criterion of essential care which transcends individual preferences but which may still be acceptable to different individuals, the Committee gives a very broad and vague definition of health in terms of 'normal functioning', which is hardly effective as a starting point if decisions are to be prioritised. In order to make a communitarian approach practicable the meaning of 'community', 'participation in community' and 'normal functioning' must be clearly and substantially defined.

Even a minimal consensus seems hardly attainable in our pluralistic, diverse and atomistic society. That is not to say that a communitarian approach is impossible, only that our modern societies are not—in any sense—the communities of which the communitarian philosophy speaks. If this hypothetical community is postulated then either one will preach substantial normative visions which are not acceptable to many people, or one will end up with a 'community-oriented' approach which is too vague to have the necessary steering power to exclude unnecessary health care.

Back to the Primary Process

What basis do we have, then, on which to develop criteria for setting priorities in allocating health care resources? On the macro-level there is hardly such a basis, and this means that we need to return to the level where the actual choices in health care are being made: the primary process. On the 'shop-floor' in hospitals and institutions each day thousands of allocation decisions are made. Decisions which cost a lot of money and which have a direct psychological and sociological impact. The only way to develop enough steering power to get reasonable control over these processes of day-to-day health care allocation is to try to understand the history, laws, habits and contingencies of these processes. In trying to understand what is going on between doctors and patients it is, however, of little help to describe the reality of the decision-making process at the micro-level in terms of an 'individual' or 'medical professional' approach, as the Dutch Government Committee does. The Committee sketches the individual approach as being identical to 'the customer is always right', and it pictures the medical professional approach as 'the clinician is always right'. This has little sense. It is a pity that the Committee did not try to transcend the simple consumerist and 'medico-biological' picture, while also eschewing an appeal to the impotent communitarian approach. This would have been possible by stressing the quality of the doctor–patient relationship. Not an individual and professional approach next to each other, but a relational approach which does not focus on the individual demand or the objective medical supply, but which stresses the importance of the biography of the patient and the way in which health care may contribute to this biography. A relational approach would also notice the biographical involvement of the health care provider who has to translate the want of the patient in a particular form of care. According to a relational

approach, health care, should be provided on the basis of a mutual determination through dialogue of what care is necessary. Not necessary from an 'individual consumer' or 'medico-biological' perspective, but a necessity determined by critical doctors and well-informed patients. A broad discussion in society about the limits of necessary care may, of course, provide for a loose framework within which particular decisions are to be taken. But this does not mean that cost-containment can reasonably be reached by setting priorities on a macro-level. For, on a macro-level no powerful criteria for prioritising are available, except side-criteria like effectiveness and efficiency. Real prioritising can only be reached by again trying to get a grip on what is really going on in the primary process.

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