# Basic Benefits and Clinical Guidelines

David C. Hadorn

# Basic Benefits and Clinical Guidelines

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# Basic Benefits and Clinical Guidelines

EDITED BY

David C. Hadorn

WITH A FOREWORD BY

Richard D. Lamm

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 1992 by Westview Press

Published 2018 by Routledge
52 Vanderbilt Avenue, New York, NY 10017
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

*Routledge is an imprint of the Taylor & Francis Group, an informa business*



**A CIP catalog record for this book is available from the Library of Congress.**

ISBN 13: 978-0-367-00786-7 (hbk)

*To my parents,*
*Erwin and Jean Hadorn,*
*with love and gratitude*

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# Contents

# Foreword

One of the most important tasks of scholarship is to anticipate and bring wisdom to tomorrow's problems -- today. Scholars are part of our early warning system in society. They gauge the rise of problems and their solutions; they start working now on tomorrow's problems. This is an immensely important role.

Public policy is too often driven by those who look in rear-view mirrors. Barbara Tuchman has observed:

> Policy is formed by preconceptions and by long implanted biases. When information is relayed to policy makers, they respond in terms of what is already inside their head and consequently make policy less to fit the facts than to fit the baggage that has accumulated since childhood.

This is especially true in public policy. It is also particularly true about the question of bringing cost containment to health care. There is too little critical thought going into an area that is taking 14 cents out of every dollar we spend. But in *Basic Benefits and Clinical Guidelines*, we have an important exception. This book advances the debate on one of the most important issues facing contemporary America. It forces us to start thinking about issues that will soon confront us.

### Better Health Care Through Setting Priorities

To govern is to set priorities. I believe we inevitably must start to set priorities in health care. There is a positive case for setting priorities. I believe we can have better health through priorities. The United States now has the worst method of denying people health care -- denying people by leaving them out of the system. A society will not start to maximize its health care until it fully confronts the issues involved in this debate. This is why this is an important book.

It is said that a problem well defined is a problem half-solved. Increasingly, our society is recognizing that the genius of American

medicine has invented more health care than we can afford to deliver to everyone. An aging society that is the world's largest debtor nation and whose economic growth is only one-third of historic rates needs to honestly deal with these issues. A society that is as inventive and creative as ours, yet has reduced financial resources, kids itself when it avoids discussing setting priorities. This is a society which would *benefit* from an honest discussion of what should be covered under a basic benefit plan.

The spending patterns in health care are clearly unsustainable. No element of our budget can grow at two to two and a half times the rate of inflation. No trees grow to the sky. No modern society can afford to give all the health care to everyone that is potentially beneficial. Health care is thus a bottomless pit. There is no end to the things that a creative and inventive society can do to aging bodies. It is a fiscal black hole into which we can pour all our public and private resources.

There is a brighter side to the basic benefit health plan debate. It is like the debate over energy conservation where energy conservation initially meant colder houses and less driving. The end of the debate was not so grim; it produced better insulated houses and more efficient cars. The same counterintuitive result is possible when we learn to design fair and reasonable basic benefit plans.

This is a dialogue which is long overdue. We have institutionalized too much of our health care spending. We have to liberate our minds and ask what policies and strategies will buy the most health care for our society. The United States spends 50 percent more than our international competitors. Yet, we do not keep our people as healthy as they are in Japan, Canada, Europe, or Great Britain. Setting priorities in health care by defining basic benefit plans allows us to break out of our restricted mode of thinking and ask some hard questions. This book helps us conceptualize some of those questions.

*Richard D. Lamm*

# Preface

Most proposals for reforming the American health care system rely on the notion of a basic benefit plan. Under these proposals, "basic care" would be provided to all citizens; more-than-basic care would be available to those who want it and can afford to pay for it. But defining basic care in practice has proved extremely difficult. This is so in large part because broad categories of care (e.g., "physician services") are typically used to denominate coverage policies. As a result of this rather clumsy, broad-brush approach, most proposed "basic benefit plans" are either very generous, offering almost unlimited coverage for a wide range of services, or are so "bare-bones" in their coverage as to provide limited protection should major illness or injury strike.

This volume explores the idea that basic benefit plans might be defined more flexibly using clinical guidelines which depict when desires for care constitute legitimate health care needs. Basic benefit plans would provide coverage for all and only legitimate health care needs. "Needs," in turn, would be defined as services judged to have been *reasonably well demonstrated* to provide *significant* net health benefit to the patients who receive them. Costs of care would not be directly considered in making judgments of necessary care, but would be addressed indirectly by eliminating coverage for many services that cannot meet the standard of demonstrated benefit. By restricting coverage to this subset of currently provided services, basic benefit plans could realize substantial cost savings while preserving patients' access to truly needed, *basic* care.

Defining necessary services in this way will require the use of a special type of clinical guideline -- "necessary-care guidelines" -- to depict the specific clinical indications for which various services are to be deemed necessary, and therefore covered under basic-level plans. A complete set of necessary-care guidelines would then constitute a basic benefit plan.

The idea that necessary-care guidelines might be used to define basic benefit plans was the focus of a two-and-a-half day conference, "Designing a Fair and Reasonable Basic Benefit Plan Using Clinical Guidelines," sponsored by the California Public Employees' Retirement System in Sacramento, April 24-26, 1991. I had the pleasure of

moderating the conference's five sessions; the five other contributors to this volume were among the conference speakers. A summary of the proceedings of that conference is available from the Director, Office of Program Development, California Public Employees' Retirement System, 400 P St. Sacramento, CA 95814.

The present volume serves a different purpose, however. Rather than summarizing the words said at a particular conference, the essays contained herein explore the enduring themes underlying any quest to define health care needs or basic benefits. Many of these topics, including the role of service costs in defining necessary care, have been around for a long time and will be around for many years to come.

An understanding of these enduring themes -- like most philosophical constructs -- is facilitated through the use of example and illustration. For this reason, a Model Proposal is presented which serves as the focal point of discussion and criticism throughout this book. Part I lays out the Model Proposal, explaining how guidelines might be used to define health care needs and basic benefits.

Part II consists of four critiques of the Model Proposal. First, Daniel Callahan explores some of the ethical and philosophical issues posed by the proposed attempt to define health care needs. Next, Robert Kaplan discusses certain technical issues of the Model Proposal, including the importance of considering both health outcome evidence and patient and public preferences during the guideline development process. Henry Greely then discusses the principal legal and political ramifications of the proposed process, concluding that legislation would almost certainly be required for successful implementation of any proposal to define basic benefits using clinical guidelines. Clark Havighurst disagrees, arguing that the proposed process would best be implemented using private contract mechanisms. I respond to each of these critiques in turn.

In Part III, the Oregon Medicaid "rationing" experiment is described as a counterpoint to the process envisioned in the Model Proposal.

Readers can determine for themselves how well the proposed process for defining basic benefits survives these analyses. What is important, however, is not simply whether a particular proposal should be enacted, or how it might be revised -- although these are also important goals. The main point of this volume is to identify and to shed some light on the key issues involved in devising a fair resource allocation plan. If this goal is achieved, we will have moved closer to resolving one of the most intractable social problems in American history: our inability to provide adequate health care to all at an affordable price.

*David C. Hadorn*

# Acknowledgments

There are many individuals without whose assistance and guidance this book could never have been written. My thanks goes out to all of them. In particular, I wish to thank Forrest Adams, M.D., for his vision and dedication to the cause of basic care for all, and Robert Brook, M.D., Sc.D., whose quick mind and soft heart have been consistent sources of inspiration for me.

*D.C.H.*

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

PART ONE

# The Model Proposal: Designing Basic Benefit Plans Using Clinical Guidelines

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# 1

# Defining Our Terms

*David C. Hadorn and Robert H. Brook*

This book presents an attempt to advance the debate concerning the problems of how to distribute health care resources in a fair and efficient manner. The scope and significance of this debate has increased substantially of late because of ever-rising health care costs, increasing concerns about inequitable access to care, and mounting evidence that inappropriate and unnecessary care continues to be delivered to patients in significant quantities.

A solution to these problems would likely be facilitated if those engaged in the health care resource allocation debate were to adopt clear and consistent definitions for certain critical terms -- particularly *rationing*, *"health care needs,"* and *"basic benefit plans."* In this chapter we propose definitions for these key terms and explain how each concept relates to the idea of defining basic benefits using necessary-care guidelines.

Let's begin with the word "rationing."

## "Rationing"

According to the dictionary, "ration[ing] refers to equitable division of scarce items, often necessities, by a system that limits individual portions" (American Heritage Dictionary 1987). During World War II, for example, coupons good for a fixed amount (i.e., a ration) of meat and butter were distributed among citizens according to rules established by social planners.

Only two types of medical and surgical services are currently scarce relative to demand: organs for transplantation (Rapaport 1987, McDonald 1988) and, sometimes, beds in intensive care units (ICUs). Patients in

need of organ transplants must (at least in theory) "wait in line," regardless of their wealth or insurance status, to receive their ration of (usually) one organ. Thus, *an equitable plan exists to distribute a physically scarce resource among individuals identified to be in need.* This is rationing in the traditional, or classical, sense. In the case of ICU beds, physicians often ration care informally by modifying criteria for admission and discharge based on the number of available beds (Singer et al. 1983, Selker et al. 1987).

Use of the word "rationing" in the contemporary policy debate has clearly transcended this original meaning. Far from carrying connotations of fairness, for example, the "R-word" has now come to represent discrimination on the basis of socioeconomic status. Concerned about this transformation in usage, Michael Reagan (1988) has urged that

> we agree to use "price allocation" to describe the workings of the market system and reserve "rationing" for situations of deliberate sharing of a scarce commodity. . . . [T]o call what we are now doing rationing is to dignify what is really discrimination in access to health care services on the basis of income, and thereby to defuse criticism of this highly questionable practice.

Retaining the connotations of physical scarcity and fairness within the word "rationing" will be difficult, however, in view of the broader meanings now almost universally imputed to the word (Callahan 1988, Blank 1988). This broader usage generally follows Henry Aaron and William Schwartz' widely quoted definition (1984) to the effect that rationing occurs when "not all care expected to be beneficial is provided to all patients." For example, Arnold Relman (1990a) recently called rationing "the deliberate and systematic denial of certain types of services, *even when they are known to be beneficial,* because they are deemed to be too expensive" (emphasis supplied).

Other recent definitions of "rationing" move even farther from the word's original roots in scarcity and fairness. In an article entitled "Health care rationing through inconvenience," Gerald Grumet (1989) in effect equated "rationing" with "cost-containment"; indeed, the word "rationing" did not appear anywhere in the article except in the title. Daniel Callahan (1990a) has advocated the "rationing of medical progress," meaning the deliberate curtailment of certain forms of applied medical research (e.g., artificial hearts). Aaron and Schwartz (1990) have recently re-described rationing as "the denial of commodities to those who have the money to buy them." John Kitzhaber, architect of the Oregon Medicaid priority-setting project, often argues that Medicaid programs "ration people" by changing eligibility standards so as to

disenroll some beneficiaries. Even more far afield, a correspondent to the *American Medical News* advocated that we "ration back prosperity to the people of this country. . . ." (Brindle 1989)

How *should* the word "rationing" be used? The answer, we believe, lies in considering how the word might be made most useful to the resource allocation debate. On the one hand, if we abandon the original connotations of scarcity and fairness, what shall we call situations (e.g., organ transplants) where genuine scarcity in fact exists -- along with an equitable plan for dealing with that scarcity? On the other hand, the notion that rationing is potentially unfair and discriminatory, or at the very least something to be avoided if possible, seems indelibly ingrained in the collective consciousness of American society.

We believe that the best solution is to restrict the use of "rationing" to something close to Relman's definition: the withholding of services acknowledged to be beneficial, based on ability to pay. Such withholding is potentially far more common and problematic than are the isolated areas of medicine (e.g., organ transplants) to which the traditional meaning of "rationing" can be legitimately applied.

We do not, however, believe that the withholding of care must be "deliberate and systematic," as Relman would have it. Simple toleration by society of inequitable barriers to effective care should also qualify as rationing; otherwise it would be too easy for society to say that it simply "cannot" produce an equitable situation, and that the situation is, therefore, not deliberately brought about. ("Inequitable barriers" here refers primarily to restrictions on access due to wealth or insurance status, but could be extended to race and other socio-demographic factors. Geographic distance ordinarily would not count as an inequitable barrier, any more than the reduced availability of police and fire protection in rural areas is today considered unfair to the people who choose to live in the country.)

Another important consideration with respect to defining "rationing" is that withholding care acknowledged to be beneficial is potentially avoidable through the identification and elimination of useless or "marginal" care. Robert Brook and Kathleen Lohr (1986) have estimated that 30% or more of the health care services currently rendered in this country might safely be forgone, and that elimination of this subset of care could permit society to save enough money to avoid the need to ration effective health care. Subsequent studies (Chassin et al. 1987, Winslow et al. 1988, Brook et al. 1990a, Chassin et al. 1989) and a recent review of available literature (Brook et al. 1990b) tend to confirm Brook and Lohr's view in this area. Nevertheless, whether or not the elimination of unnecessary services would save enough money to provide