Medicaid Reform through Setting Health Care Priorities

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I. INTRODUCTION

The face of American health care has changed since the creation of the two largest government funded health programs, Medicare and Medicaid, two decades ago.\(^1\) While the change in the structure of the health care system is hardly attributable to the development of these programs alone, both have contributed substantially to the creation and the amelioration of the major structural problems in health care delivery in this county. In addition, whatever positive cultural benefits those programs have provided, they have carried with them one overwhelming defect. Like a particularly virulent virus, they have infected the English language with obscure and untreatable words and phrases which has added to the mystery and impenetrability of the underlying substantive law. The Medicaid statute has been described as "[b]yzantine" (by Justice Powell),\(^2\) "a morass of bureaucratic complex-
ity" (by Chief Justice Burger),\(^8\) “almost unintelligible to the uninitiated” (by Judge Friendly),\(^4\) “an aggravated assault on the English language, resistant to attempts to understand it”\(^8\) and a “Serbonian bog”.\(^6\) While it is the Medicare statute that requires us to say “utilize” when we mean “use,”\(^7\) and which has compounded our discomfort by creating the word “utilization,”\(^8\) the Medicaid statute is arguably even worse. Is it better to be a “Pickle Amendment eligible”\(^9\) or an “optional categorically needy?”\(^10\) Whichever choice is preferable, if we wish to set health care priorities for that category, we would be engaged in “prioritization.” At least this confusion serves one purpose in this area: the obscure language of the law does adequately reflect the arcane and complex structure of the substantive law itself. One appropriate title for this paper could be “Prioritizing Healthcare: Is Either of These Really a Word?”

Alas, of course, both are. This brief paper will describe the way Oregon proposes to modify its Medicaid program through prioritization (i.e., setting treatment priorities).\(^11\) It will then discuss the effect the proposal will have on those who depend upon Medicaid for health care and the effect the proposal will have on our national debate over our health care system.\(^12\) This paper will also list the legal arguments that are likely to be raised against the Oregon proposal,\(^13\) and then review the more important policy argument against the proposal.\(^14\) Finally, this paper will suggest that the real problem with the proposed Oregon system is not that it is unfair to poor people, women, minorities, or others, but that any priority list that generalizes from condition-treatment pairs necessarily overgeneralizes, that the range of cost-utility ratios for any condition-treatment pair varies so widely that the application of a state formula is bound to fail, and that the nature of an appropriate doctor-patient relationship requires that the doctor treat a flesh and blood patient, not some cardboard cutout “average” patient

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8. See, e.g., id. See 42 U.S.C. § 1396r-4 (Supp. 1991) for a particularly obscure use of this new word.
9. Don’t like the sound of this? How about living in a “209(b)” state? For a description of this unusual status which is possible in only 14 states, see Health Law, supra note 1, at 568-69.
11. See infra notes 36-59 and accompanying text.
12. See infra notes 60-62 and accompanying text.
13. See infra notes 63-77 and accompanying text.
14. See infra note 78 and accompanying text.
with the same condition. The solution to these problems, however, is not to abandon the setting of treatment priorities. Instead, the solution is to evaluate conditions and treatments in terms of the more general goals of medicine, and, then, with much less categorization, to set priorities so that those goals can be best achieved.

II. Medicaid

The Medicaid program is a state administered program designed to provide medical assistance to the indigent. While the programs vary from state to state, the structure of the programs is relatively similar: when a person eligible as a Medicaid client obtains covered services or goods from an eligible provider, the state reimburses the provider an amount determined through a state statutory or regulatory process. If the state program is consistent with Title XIX of the Social Security Act (the Medicaid statute), the federal government reimburses the state government some percentage of its expenditures. The federal government's reimbursement of the state ranges from 50% to 80% depending upon the financial condition of the state. The richer the state is, the smaller the federal reimbursement it receives. California and Massachusetts each have a 50% reimbursement, while Mississippi is over 70% reimbursed. This year Oregon receives 62% of its Medicaid expenditures from the federal government.

Some classes of indigent (the "categorically needy") must be made eligible for Medicaid for the state to seek federal reimbursement. These "categorically needy" include those who are blind, disabled, or receive old age assistance under Social Security and who otherwise meet need criteria, as well as those receiving aid to families with dependent children (AFDC), the basic state welfare program. The "need" eligibility for the AFDC program is established on a state-by-state basis by each state, with the amount of income that qualifies a family for state medical assistance often being far below the federal poverty line. In addition, states may choose to make other "optionally categorically needy" or "medically needy" groups of people eligible.

15. See infra notes 79-83 and accompanying text.
16. For a good general overview of the operation of Medicaid, see HEALTH LAW, supra note 1, at 565-67. See also 3 Medicare and Medicaid Guide (CCH) ¶¶ 14000-15660, and Medicaid and the Elderly Poor, supra note 2.
17. See 42 CFR §§ 435.1-435.136, 436.1-436.118. See 3 Medicare and Medicaid Guide (CCH) ¶ 14231. For eligibility criteria generally, see HEALTH LAW, supra note 1, at 568-70. See also 3 Medicare and Medicaid Guide (CCH) ¶¶ 14231, 14251, 14271.
18. For example, in 1990 to qualify for AFDC in Oregon a family had to earn less than 58% of the federal poverty level. Several states had even lower levels of eligibility.
for Medicaid benefits. The federal law requires that the various groups covered by a state Medicaid program be given certain designated kinds of services. For example, the Medicaid program must include inpatient hospital and physician services, at least for the "categorically needy." The state's Medicaid program may, in addition, provide a wide range of optional services to those who are eligible. Under federal regulations issued pursuant to the statute, it is impermissible for a state to deny to an eligible person any necessary medical treatment because of that person's medical condition.

Those persons who qualify for Medicaid—the very poor receiving some Social Security benefits or AFDC—have access to virtually all medically necessary services. Indigents who do not qualify—single or married adults without children, whatever their income, and families with income above the state eligibility limit but below the federal poverty line—do not have access to any reimbursed care. Illustrative of this disparity is the determination by one federal court that an alcoholic cannot be denied a liver transplant under a state Medicaid program, and another court that a state Medicaid agency must provide sex change surgery because it is medically necessary for those Medicaid eligibles who are true transsexuals. Contrarily, the Medicaid ineligible must forgo not only sex conversion therapy and a liver transplant, but also an appendectomy needed for appendicitis or antibiotics necessary to control an infection.

Of course, states could overcome this conundrum by increasing the number of Medicaid eligibles. Unfortunately, since its creation in 1965, Medicaid has grown from a friendly pet of state legislatures into a voracious budget eating monster. It now usually receives the largest or second largest state appropriation, depending upon the state's formula for funding education. In the words of Oregon State Senator

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20. Id.
21. The categorically needy must be provided the following required services: inpatient hospital service (for other than mental disease), outpatient hospital service, rural health clinic and ambulatory care service, laboratory and x-ray services, physician's services, nurse-midwife service and pediatric and family nurse practitioner services. See 42 U.S.C. § 1396d(a)(10) (1990); 3 Medicare and Medicaid Guide (CCH) ¶ 14511.
22. 42 C.F.R. § 230(c) (1989) states:
The Medicaid agency may not arbitrarily deny or reduce the amount, duration or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.
25. In Massachusetts, for example, it accounts for $1.8 billion, "far and away" the largest item in a state budget of $12 billion. Stein, Sacred Cows, Boston Globe, Aug. 27, 1989, at A-1. For a sense of how long this has been true, see Pear, Many States Limit Medicaid Programs, N.Y. Times, Dec. 17, 1984, at A-1, col. 5.
Kitzhaber, a physician and the originator of the Oregon Medicaid reform plan, Medicaid is “the Pac-Man of state budgets.” During an era when state legislators have been busy reading lips, there has been little interest in increasing the pool of poor people who are eligible to receive state reimbursed medical assistance.

In addition, there is an underlying presumption that the poor who are not covered by Medicaid manage to find health care services anyway, even if they are inconvenienced by the form and location of the services to which they may have access. In fact, this presumption is probably wrong. There is little reliable evidence that suggests that the uncovered poor get adequate health care. Emergency rooms are now obliged to provide emergency care to all who appear at their doors, at least under some circumstances, and some communities have limited alternative health care systems for the indigent. By and large, though, there is no reason to believe that these Medicaid ineligible indigents receive any other form of health care.

III. THE OREGON BASIC HEALTH SERVICES PROGRAM

Frustrated by this everything-for-eligibles and nothing-for-ineligibles dichotomy, the Oregon state legislature has proposed the Oregon Basic Health Services Program. While the Medicaid reform aspects of the program are only a part of a scheme that would encourage Oregon employers to provide adequate basic health services to their employees and create an uninsured risk pool for others, it is the Medicaid reform which is the most significant. The Medicaid reform

27. See Pear, supra note 25.
28. The source of this presumption is unclear; perhaps it stems from a romantic notion of the charitable foundations of our current health care system. In any case, it is a presumption that is the indulgence of the insured. It is most surely not the experience of those who are presumed to partake of this mysterious source of gratuitous care.
31. Various local and county indigent funds provide very small amounts of gratuitous care in non-emergency circumstances. In addition, some institutions built with Hill-Burton funds may still be required to provide small bits of uncompensated care. 42 U.S.C. §§ 291-300o (1986). Those remaining Hill-Burton obligations will soon be fulfilled.
32. The basic program is contained in Oregon's Senate Bill 27 (1989). This bill became law in 1989.
33. Oregon Senate Bill 935 (1989), providing for affordable insurance plans, tax credits and other incentives for small employers to provide adequate health insurance for their employees. This bill became law in 1989.
34. Oregon Senate Bill 534 (1989), providing for guaranteed health insurance at 150% of an average premium. This bill became law in 1989.
program is designed to provide only the most cost effective medical treatment (and no other treatment) to all of the poor—a change from the current system which provides all treatment to those people, like families receiving AFDC, who are categorized as the most deserving, and no services to others. Because this rationing plan would violate some parts of the federal Medicaid statute, Oregon cannot implement it and continue to receive federal funds unless it gets a program waiver from the Health Care Financing Administration. This waiver is now in draft form.

The first challenge for Oregon was to determine who would receive assistance under a new, broader (even if less comprehensive, in terms of service) Medicaid system. This was any easy question for the Oregon legislature which concluded that every person under the federal poverty line was to be eligible to participate. A more difficult question was the source of the revenue to pay for this expansion of Medicaid eligibility. Originally, the intent was to take all of those currently in the Medicaid program, add to that group all other Oregonians below the federal poverty level, and provide them all of the most cost effective medical services. Ultimately, the most politically powerful forces—the elderly, for example, and long term care facilities—managed to get themselves excluded from the revised version program. The political strength of the elderly lobby was demonstrated in other states as well. For example, in Colorado an act very similar to the Oregon Basic Health Services Act which did not exclude any category of Medicaid recipient from the priority process was unsuccessful. Thus, those who qualify

35. The waiver may be issued under section 115 of the Social Security Act, 42 U.S.C. § 1325(a), if the Secretary of Health and Human Services determines that a demonstration project will promote the objectives of the Medicaid program. Because those objectives remain quite obscure (beyond, very generally, providing health care to the poor), there remains uncertainty about whether the Secretary should grant the waiver in this case. Of course, independently, there also remains uncertainty about whether he will. The Secretary has very wide latitude in deciding whether to grant a waiver. See Crane v. Mathews, 417 F. Supp. 532 (N.D. Ga. 1976).
37. Senate Bill 27, as originally proposed.
38. Senate Bill 27, § 3 (1989), which exempts:
   (1) Nursing facilities and home-and-community-based waivered services . . . .
   (2) Medical assistance to the elderly, the blind, and the disabled or medical care provided to children [under certain circumstances];
   (3) Institutional, home-and-community-based waivered services or Community Mental Health Program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol- and drug-dependent persons; and
   (4) Services to children who are wards of the Children's Services Division . . . .
for Medicaid because they receive old age assistance and those who need long term care (and some others) will continue to get all necessary medical treatment through Medicaid in Oregon. Others, mostly those who qualify for Medicaid by virtue of their receipt of AFDC, will receive only the most cost effective treatment. The resources saved by not reimbursing the least cost effective treatments—and any other resources that might be added by the Oregon state legislature—would go to provide the most cost-benefit effective services to the previously ineligible indigents in Oregon. While there is little doubt that a more comprehensive program that applies the treatment priorities to all Medicaid beneficiaries (or all who seek health care within the state, under Medicaid or otherwise) would be a better and more fair program, the significant question now is whether the limited Oregon application of prioritized health services is more fair than the current all-or-nothing system.

The next challenge for Oregon was to develop a list of treatment priorities. The Oregon statute created the Health Services Commission to do this, and this commission set out to create a ranked list of condition-treatment pairs in order of their cost benefit ratio. The idea was to get the most benefit for the money appropriated for Medicaid purposes. In order to achieve this end, the Commission had to make several determinations:

1. The Commission first determined the effectiveness of each treatment for a designated condition; i.e., what was the outcome of the treatment, and how did this compare to the natural course of the condition without treatment? To make these determinations the Commission established 54 separate committees based on medical specialties to review the literature and articulate the consequences of treatment (or its absence) in each case. These committees reviewed 29 possible symptoms and potential functional impairments to determine what the chance of their occurrence would be with treatment and without treatment, and what the duration of each condition would be.

40. There is an expectation that the Oregon state legislature will increase its Medicaid funding by around 10% if it receives a waiver.

41. The members of the committee were given the following written instructions:

This information is being requested to develop the expected outcomes of a given treatment. It is understood that some outcome data may be subjective in nature. A disease may be bimodal with significantly different outcomes occurring dependent on age of onset or vary according to the extent of the disease at the time of presentation (stage). If this is the case, please use two or more lines to define the condition. An attachment sheet accompanies this package to define the major categories to be evaluated. PLEASE THINK OF THE AVERAGE PATIENT THAT PRESENTS WITH THIS CONDITION, NOT THE EXTREMES....

INSTRUCTIONS

ICD-9 Codes and Diagnosis
2. The Commission also had to establish the value of each of the

Please list both the ICD-9 code and a brief description. These may be grouped as much as possible.

CPT-4 and Procedure
Please list both the CPT-4 code used for treatment of this condition and a brief description. Group procedures that are similar in efficacy as much as possible. Please be prepared to identify any ancillary service (such as radiology, physical therapy) that may assist this procedure.

Median Age for This Treatment of the Condition
Please provide a median age for this treatment of the condition. The cohort code listed on the attachment should be used if specific ages cannot be identified.

Probability That Treatment for the Given Diagnosis Will Be Applied
Please provide your best estimate in percentages for the incidence of this treatment for the given condition.

Expected Duration of the Treatment Result
Please indicate the length of time that the treatment result will continue to be effective for the condition. If the beneficial effects persists for the future lifetime of the patient, indicate “LT”.

Outcome Probability
Please provide your best estimation of the percent of the time that certain outcomes would occur five (5) years hence not given evaluated treatment and with treatment. The outcome expectations should not exceed 100% of the population for no treatment and with treatment.

The outcomes are:
1. Death
2. Residual Effects
3. Residual Effects
4. Residual Effects
5. Asymptomatic

The residual effects columns may be used to define health states intermediate to death and the return to prior health. Each column used must contain a single number designating the major symptom and may include up to three alpha codes, each one representing an impairment of physical or social activity and mobility. See attachments for major symptom and physical, social and mobility codes.

Cost
Please give your best estimate of the cost of the condition for the lifetime of the patient without the aforementioned treatment and with the treatment, if you are able.

OFFICE OF MEDICAL ASSISTANCE PROGRAMS, OR. DEPT. OF HUMAN RESOURCES,
Waiver Application for Oregon Medicaid Demonstration Project, April 26, 1990 at Appendix 2F.

The outcomes were to be defined in the following ways:

<table>
<thead>
<tr>
<th>CODE</th>
<th>CLASSIFICATION</th>
<th>MEDIAN AGE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Infancy</td>
<td>under 1</td>
</tr>
<tr>
<td>C</td>
<td>Child</td>
<td>1 - 10</td>
</tr>
<tr>
<td>A</td>
<td>Adolescent</td>
<td>11 - 18</td>
</tr>
<tr>
<td>Y</td>
<td>Young</td>
<td>Adult 19 - 35</td>
</tr>
</tbody>
</table>
potential outcomes. To determine how significant various outcomes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOBILITY SCALE (MOB)</td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td>Did not drive a car, health related; did not ride in a car as usual for age (younger than 15 yr), health related, and/or did not use public transportation, health related; or had or would have used more help than usual for age to use public transportation, health related</td>
</tr>
<tr>
<td>MH</td>
<td>In hospital, health related</td>
</tr>
<tr>
<td>PHYSICAL ACTIVITY SCALE (PAC)</td>
<td></td>
</tr>
<tr>
<td>PW</td>
<td>In wheelchair, moved or controlled movement of wheelchair without help from someone else; or had trouble or did not try to lift, stoop, bend over, or use stairs or inclines, health related; and/or limped, used a cane, crutches, or walker, health related; and/or had any other physical limitation in walking, or did not try to walk as far or as fast as others the same age are able, health related</td>
</tr>
<tr>
<td>PB</td>
<td>In bed, chair or couch for most of or all of the day, health related; or in wheelchair, did not move or control the movement of wheelchair without help from someone else, health related</td>
</tr>
<tr>
<td>SOCIAL ACTIVITY SCALE (SAC)</td>
<td></td>
</tr>
<tr>
<td>SL</td>
<td>Limited in major or other role activity, health related, or performed no major role activity, health related, but did perform self-care activities</td>
</tr>
<tr>
<td>SN</td>
<td>Performed no major role activity, health related, and did not perform or had more help than usual in performance of one or more self-care activities, health related</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>MAJOR SYMPTOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Loss of consciousness such as seizure (fits), fainting, or coma (out cold or knocked out)</td>
</tr>
<tr>
<td>2.</td>
<td>Burn over large areas of face, body, arms or legs</td>
</tr>
<tr>
<td>3.</td>
<td>Pain, bleeding, itching, or discharge (drainage) from sexual organs - does not include normal menstrual (monthly) bleeding</td>
</tr>
<tr>
<td>4.</td>
<td>Trouble learning, remembering, or thinking clearly</td>
</tr>
<tr>
<td>5.</td>
<td>Any combination of one or more hands, feet, arms or legs either missing, deformed (crooked), paralyzed (unable to move), or broken - includes wearing artificial limbs or braces</td>
</tr>
<tr>
<td>6.</td>
<td>Pain, stiffness, weakness, numbness, or other discomfort in chest, stomach (including hernia or rupture), side, neck, back, hips, or any joints or hands, feet, arms, or legs</td>
</tr>
<tr>
<td>7.</td>
<td>Pain, burning, bleeding, itching, or other difficulty with rectum, bowel movements, or urination (passing water)</td>
</tr>
<tr>
<td>8.</td>
<td>Sick or upset stomach, vomiting or loose bowel movement, with or without fever, chills, or aching all over</td>
</tr>
<tr>
<td>9.</td>
<td>General tiredness, weakness, or weight loss</td>
</tr>
<tr>
<td>10.</td>
<td>Coughing, wheezing, or shortness of breath, with or without fever, chills, or aching all over</td>
</tr>
<tr>
<td>11.</td>
<td>Spells of feeling upset, being depressed or of crying</td>
</tr>
<tr>
<td>12.</td>
<td>Headache, or dizziness, or ringing in ears, or spells of feeling hot, or...</td>
</tr>
</tbody>
</table>
might be to Oregon residents, the Commission conducted a telephone
survey of 1001 people in Oregon. They were asked questions that al-
lowed the Commission to develop a quality of well being (QWB) scale
similar to that developed by Robert Kaplan over a decade ago.\textsuperscript{2} On
this scale the various symptoms and potential functional impairments
that were considered as part of the effectiveness study were evaluated
to determine how much each would detract from the value of "perfect
health" to the average Oregonian. For example, those surveyed indi-
cated that if they were unable to drive a car or use public transporta-
tion, but had no other symptoms or limitations, their health status
would be 94.7\% of perfect health. Thus, an outcome which resulted in
the inability of the patient to drive a car or use public transportation
would result in a loss of health of .053. The functional impairment
scores ranged from 94.7\% to 40.3\% (or a weight of -.597) for "in bed
most of day, or in wheelchair not under individual's control." The con-
sequences of various symptoms ranged from -.46 for "has trouble with
the use of drugs and alcohol" to -.08 for "wears glasses or contacts".
Surprisingly coma reduced perfect health by only .117 while trouble
learning and thinking reduced it by .395.\textsuperscript{43}

3. The Commission also determined the cost of each treatment.
Initially, the cost was equated to the amount which the Oregon Medi-
caid program currently reimburses for the designated treatment.

\begin{itemize}
\item \textbf{nervous, or shaky}
\item 13. Burning or itching rash on large areas of face, body, arms, or legs
\item 14. Trouble talking, such as lisp, stuttering, hoarseness, or being unable
to speak
\item 15. Pain or discomfort in one or both eyes (such as burning or itching)
or any trouble seeing after correction
\item 16. Overweight for age and height or skin defect of face, body, arms, or
legs, such as scars, pimples, warts, bruises, or changes in color
\item 17. Pain in ear, tooth, jaw, throat, lips, tongue; several missing or
crooked permanent teeth - includes wearing bridges or false teeth;
stuff\,y, runny nose; or any trouble hearing - includes wearing a
hearing aid
\item 18. Taking medication or staying on a prescribed diet for health
\item 19. Wore eyeglasses or contact lenses
\item 20. Asymptomatic problem
\item 21. Has trouble falling asleep or staying asleep
\item 22. Has trouble with sexual interest or performance
\item 23. Is often worried
\item 24. Has trouble with the use of drugs or alcohol
\end{itemize}

\textit{Id.}

\textsuperscript{42} For an updated discussion of the bases of this scale, see Kaplan and Ander-
son, \textit{A General Health Policy Model: Update and Application}, 23 \textit{Health Services
Research}, June 1988, at 203, and articles cited there. See also, Kaplan, Anderson,
Wu, Mathews, Kozin and Orenstein, \textit{The Quality of Well-Being Scale: Applications in

\textsuperscript{43} The full scale revealed the following:
Once the effectiveness, symptom and functional impairment scores and costs are established, Oregon can qualify the outcome of each treatment for each condition and establish a value for the consequences of that outcome on the well being of the patient. This combination of the outcomes and their values can then be balanced against the cost of the treatment to render an index number that can then be compared with the index number of every other condition-treatment pair. Because each treatment could have several outcomes, each with its own effect on a patient’s well being, and each lasting a different number of years,

<table>
<thead>
<tr>
<th>Major Complaint</th>
<th>Oregon Score 0 to 100</th>
<th>Oregon Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH (MOB1) Hospital or nursing home</td>
<td>93.7</td>
<td>-.063</td>
</tr>
<tr>
<td>MT (MOB2) Unable to drive a car or use public transportation</td>
<td>94.7</td>
<td>-.053</td>
</tr>
<tr>
<td>Physical Activity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PB (PAC1) In bed most of day, or in wheelchair not under individual’s control</td>
<td>40.3</td>
<td>-.597</td>
</tr>
<tr>
<td>PW (PAC2) In bed or wheelchair but could control</td>
<td>60.4</td>
<td>-.396</td>
</tr>
<tr>
<td>Social Activity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN (SAC1) Need help eating and using bathroom</td>
<td>89.2</td>
<td>-.108</td>
</tr>
<tr>
<td>SL (SAC2) Limited in role activity</td>
<td>93.7</td>
<td>-.063</td>
</tr>
<tr>
<td>Symptom:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Loss of consciousness, coma</td>
<td>88.3</td>
<td>-.117</td>
</tr>
<tr>
<td>2-Burn</td>
<td>62.2</td>
<td>-.378</td>
</tr>
<tr>
<td>3-Sex organs: pain, discharge</td>
<td>67.7</td>
<td>-.323</td>
</tr>
<tr>
<td>4-Trouble learning, thinking</td>
<td>60.5</td>
<td>-.395</td>
</tr>
<tr>
<td>5-Abnormal extremities</td>
<td>73.0</td>
<td>-.270</td>
</tr>
<tr>
<td>6-Back, Joints: pain, stiffness</td>
<td>72.7</td>
<td>-.273</td>
</tr>
<tr>
<td>7-Bladder, rectal: pain</td>
<td>68.9</td>
<td>-.311</td>
</tr>
<tr>
<td>8-Vomiting, diarrhea</td>
<td>61.8</td>
<td>-.382</td>
</tr>
<tr>
<td>9-Fatigue, weakness</td>
<td>70.9</td>
<td>-.291</td>
</tr>
<tr>
<td>10-Cough, wheezing</td>
<td>66.6</td>
<td>-.334</td>
</tr>
<tr>
<td>11-Depression</td>
<td>64.6</td>
<td>-.354</td>
</tr>
<tr>
<td>12-Headache, dizziness</td>
<td>67.2</td>
<td>-.328</td>
</tr>
<tr>
<td>13-Rash: burning, itching</td>
<td>68.3</td>
<td>-.317</td>
</tr>
<tr>
<td>14-Speech problems</td>
<td>80.2</td>
<td>-.198</td>
</tr>
<tr>
<td>15-Eyes: pain, vision problems</td>
<td>73.4</td>
<td>-.266</td>
</tr>
<tr>
<td>16-Skin defects; overweight</td>
<td>77.2</td>
<td>-.228</td>
</tr>
<tr>
<td>17-ENT: dental, pain in ears</td>
<td>76.8</td>
<td>-.232</td>
</tr>
<tr>
<td>18-Medication, diet</td>
<td>86.2</td>
<td>-.138</td>
</tr>
<tr>
<td>19-Glasses, contacts</td>
<td>92.0</td>
<td>-.080</td>
</tr>
<tr>
<td>20-Sleep difficulty</td>
<td>74.1</td>
<td>-.259</td>
</tr>
<tr>
<td>21-Sexual performance</td>
<td>72.8</td>
<td>-.272</td>
</tr>
<tr>
<td>22-Worrying</td>
<td>76.4</td>
<td>-.236</td>
</tr>
<tr>
<td>23-Drugs, alcohol</td>
<td>54.0</td>
<td>-.460</td>
</tr>
</tbody>
</table>

*Telephone Survey Results for Health Values Telephone Survey (Oregon), 3 (1990).*
and because the failure to provide the treatment could also have several consequences, each with its own effect on the well being of the patient for a different amount of time, the determination of the cost-utility ratio is a complex procedure. While the formula has changed occasionally, in late 1990 for each condition-treatment pair, the cost-utility ratio was determined by applying the following formula:

\[ B_n = \frac{C}{\frac{5}{30} \cdot \left( \sum_{j=1}^{30} (1 + \sum_{i=1}^{30} d_{ij} w_j) \right) - \left[ \sum_{j=1}^{30} (1 + \sum_{i=1}^{30} d_{ij} = w_j) \right]} \]

\( B_n \) = the net benefit value ratio for the \( n \)th condition/treatment pair to be ranked. This value will be used in determining the actual rankings of health services from highest (0) to lowest (-infinity).

\( Y \) = the years for which the treatment can be expected to benefit the patient with this condition. This may be the remainder of the patient’s lifetime or some shorter amount of time.

\( p_{i5} \) = the probability that the \( i \)th outcome will occur five years hence with treatment.

\( d_{ij} \) = An indicator variable denoting the presence (=1) or absence (=0) of the \( j \)th health limitation (MOB, PAC or SAC) or chief complaint for the \( i \)th outcome with treatment.

\( w_j \) = the weight given by Oregonian’s to the \( j \)th health limitation or chief complaint ranging from 0=no significant effect to -1=death.

\( p_{i2} \) = the probability that the \( i \)th outcome will occur five years hence without treatment.

\( d_{i2} \) = An indicator variable denoting the presence or absence of the \( j \)th health limitation or chief complaint for the \( i \)th outcome without treatment.

\( C \) = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.

The first run of the 1694 condition-treatment pairs was completed in 1990. By way of example, the run presumed that the condition “diabetic coma” when treated by “hospitalization with insulin” would result in a net improved quality of well being of .773, and this improved quality would have a duration of 40 years. In addition, this treatment would cost $891.34, giving it a cost-utility ratio of 28.84. The condition of fractured/decayed tooth, when treated with restorative service, would only provide a quality of well being increase of .220, and only for seven years. On the other hand, it could be provided for $45.11, and it thus yielded virtually the same cost-utility ratio (29.24) as the treatment of diabetic coma by hospitalization and insulin. Both of these had a much better cost-utility ratio than the treatment of breast cancer with mastectomy, which was determined to provide a .743 quality of well being increase for a duration of 20 years, but at an expense of

\[ 44. \text{ In this equation,} \]

\[ B_n \] = the net benefit value ratio for the \( n \)th condition/treatment pair to be ranked. This value will be used in determining the actual rankings of health services from highest (0) to lowest (-infinity).

\( Y \) = the years for which the treatment can be expected to benefit the patient with this condition. This may be the remainder of the patient’s lifetime or some shorter amount of time.

\( p_{i5} \) = the probability that the \( i \)th outcome will occur five years hence with treatment.

\( d_{ij} \) = An indicator variable denoting the presence (=1) or absence (=0) of the \( j \)th health limitation (MOB, PAC or SAC) or chief complaint for the \( i \)th outcome with treatment.

\( w_j \) = the weight given by Oregonian’s to the \( j \)th health limitation or chief complaint ranging from 0=no significant effect to -1=death.

\( p_{i2} \) = the probability that the \( i \)th outcome will occur five years hence without treatment.

\( d_{i2} \) = An indicator variable denoting the presence or absence of the \( j \)th health limitation or chief complaint for the \( i \)th outcome without treatment.

\( C \) = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.

*Waiver Application for Oregon Medicaid Demonstration Project, supra note 41, at Appendix 2B.*
$5364.40, rendering a ratio of 360.95. In fact, the top ranked condition-treatment pair was the treatment of bacterial meningitis by antibiotics dispensed at an office visit. Others ranking very high were the treatment of crooked teeth by space maintainers, the treatment of infertility by artificial insemination, the treatment of migraine headache by acupuncture, and the treatment of appendicitis by appendectomy. The bottom of the list included the treatment of high blood pressure by diet, drugs and exercise, the treatment of rabies by hospitalization, and the treatment of multiple tooth loss by a partial denture. The treatment of transvestism by behavior and group therapy just barely made the top half of the list while obstetrical care for pregnancy was not in the top 1000 condition-treatment pairs.

Of course, the first run of such an innovative program was bound to have some anomalies. Many of the rankings appear unjustified, and the Health Services Commission is now reviewing them. In addition, the Health Services Commission will be able to modify the rankings through the application of social values. The social values were developed by the 1000 Oregonians who attended 47 community meetings throughout the state during January, February and March of this year. The values that were articulated most frequently at these meetings were prevention of illness and the maintenance of quality of life, while community compassion, impact on society, the maintenance of length of life, and personal responsibility were mentioned far less often.

45. It ranked 19 out of 1694.
46. It ranked 73 out of 1694.
47. It ranked 132 out of 1694.
48. It ranked 396, barely making the top quarter.
49. It ranked 1565 out of 1694.
50. It ranked 1616 out of 1694.
51. It ranked 1671 out of 1694.
52. It ranked 787 out of 1694.
53. It ranked 1040 out of 1694.
54. The Executive Summary of the report of these meetings provides:

This report is a compilation of the values expressed at all of the health decisions community meetings held in Oregon. Some values were expressed more frequently than others. All are included in this report. What values do Oregonians want the Health Services Commission to use in guiding the process of prioritizing health care services? The following are values Oregonians indicated should be considered. (The frequency of discussion of each value is shown in parenthesis).

1. Prevention (very high-all community meetings)
2. Quality of Life (very high-all community meetings)
3. Cost Effectiveness (high-more than 3/4 of community meetings)
4. Ability to Function (moderately high-1/4 of community meetings)
5. Equity (moderately high-3/4 of community meetings)
6. Effectiveness of Treatment (medium high-more than 1/4 of community meetings)
7. Benefits Many (medium-1/2 of community meetings)
When the Commission reorders the rankings based on its correction of
the formula analysis and its social values modification, it will send its
new rankings to actuaries. These actuaries will then determine what
the total Medicaid cost for the proposed eligible population would be
for each condition-treatment pair. The list, with the cost of each item,
will then be forwarded to the state legislature. Finally, the legislature
will determine how far down the list it wishes to go and will draw a line
below the lowest ranked covered service. The legislature, which may
draw the line where it wishes but is not permitted to alter the rankings,
will then appropriate sufficient funds to provide the enlarged pool of
eligibles with all of the services above the line.

Except for those exempted from the new scheme, no Medicaid eli-
gible will receive those services below the line drawn by the legislature.
While there is great disagreement on the propriety of this whole sys-
tem, there is a consensus on the number of people who will be affected.
In 1990, 144,000 current Medicaid eligibles would have been covered
by the Basic Health Services Act, while 116,000 people would have
become newly eligible under the waiver. Thus, 260,000 Oregon Medi-
caid participants would have been subject to the new system of priori-
ties. An additional 52,000 Medicaid recipients would be exempt from
the priority plan. While those exempt constitute only one-third of
those enrolled in the Oregon Medicaid program, they account for a
majority of the current Medicaid expenditures.

8. Mental Health and Chemical Dependency (medium-½ of commu-
nity meetings)
9. Personal Choice (medium-½ of community meetings)
10. Community Compassion (medium low-less than ½ of community
meetings)
11. Impact on Society (medium low-less than ½ of community
meetings)
12. Length of Life (medium low-less than ½ of community meetings)
13. Personal Responsibility (medium low-less than ½ of community
meetings)

Executive Summary, at 5-6.

55. The Health Services Commission completed the new ranking in February of
1991. It rearranged the occasionally surprising computer rankings, in the process re-
ducing the total number of categories from 1694 to 808. Moved up the list were organ
transplants and treatment for pneumonia and tuberculosis. Moved down the list were
terminal AIDS and other untreatable conditions of adults and newborns. The new
highest priority is pneumonia treated by antibiotics; the revised lowest priority is high
tech treatment of anencephaly. See Eagan, Oregon Shakes Up Pioneering Health Plan

56. Office of Medical Assistance Programs, Oregon Department of Human Re-
sources, The Oregon Basic Health Services Program 11 (June 1990).
57. Id.
58. Id.
IV. WHAT THE PROGRAM DOES

The Oregon Basic Health Services Act and its approach to the delivery of health care has several consequences. Most significantly, it moves the focus of discussion from who should qualify for health services to what health services ought to be provided. If the community admits that it must engage in health care rationing, and no one doubts that we ration health services now, this distinction is an important and necessary shift. There is little doubt that if this country ever develops a rational health care system the public debate should center on what kinds of medical services will be provided to everyone, not on who will get all imaginable health services and who will get none.

A consequence of this change of viewpoint is the need to analyze what makes medical care valuable. As long as the focus was only on who received that care, the discussion could be limited to who was deserving. There was no need to ask just what those recipients might deserve. If all Oregonians—or even some Oregonians on Medicaid—are entitled to some kinds of health care but not others, there must be some principled way to determine what kinds of health care should and should not be available. For example, this society will have to be more explicit and open in comparing improved quality of life and increased length of life. While there are those people who object that the Oregon formula for accomplishing this end is too obscure or too artificially precise to accomplish the task adequately, no one can doubt that Oregon is directly confronting the questions that the rest of the country will have to address eventually.

The Basic Health Services Program will also require the legislature to define what constitutes a basic health package that should be available to everyone. When the Oregon legislature meets to decide where to draw the line on the ranked list of condition-treatment pairs, it will be defining that basic health package. While there are those who fear that the legislature will draw the line at the wrong place, or without regard to a real and comprehensive notion of what constitutes basic health care, their real quarrel is with what they believe will be the substance of the Oregon decision, not the Oregon process. Additionally, the Oregon legislature is in a position to increase Medicaid funding, something many people expect, if it finds that such an increase is necessary to insure that all necessary basic health services are included in the package available to Medicaid recipients. In this way the Oregon process is far different from the experiment in setting priorities that failed in Alameda County, California, last year. Most health care providers and community organizations refused to participate in the development of a set of priorities for Alameda County because the county was unable to increase the grossly inadequate Medical funds available for poor patients. Many thought that participating in an overt rationing program for the poor was immoral itself, as would be any community
decision to offer for sacrifice some number of the innocent poor and sick.59

Finally, the Basic Health Services Program ought to eliminate that practice of expensive medicine that is not in the patient's interest but requires that patients be maintained, in the words of Sandra Johnson, as "symbols of the sanctity of life that exist to meet the need of society." 60 These high cost-no utility cases—the Nancy Cruzans61 of the world—are cases in which the vast majority of Americans would want to see treatment eliminated, even without regard to any cost-utility analysis.62 The focus on the what of treatment rather than the who of treatment provides a principled way to overcome the arguments that the Nancy Cruzans must be kept alive as symbols of the delivery of officially adequate health care.

V. LEGAL ATTACKS ON THE BASIC HEALTH SERVICES PROGRAM

There have been several arguments advanced that the Oregon Public Health Services Program is illegal. Of course, it is inconsistent with the regulations issued under the Medicaid statute63 and a waiver of the provisions of that regulation by the Health Care Financing Administration would be necessary for it to become effective. There is currently a debate in Congress about whether the Congress should smooth the way for that waiver by statute, or whether Congress should block any such waiver by statute. The legal battle over the propriety of the waiver will continue in both the Health Care Financing Administration and in Congress.

If a waiver is granted, there is little doubt that there will be an attempt to block the program judicially. Those who wish to block it will depend upon several civil rights statutes.64 First, they will argue that it is facially invalid under the Age Discrimination Act of 1974, which

59. Certainly there may be those who hold this same opinion about the Oregon proposal, even if the Oregon plan includes additional funding for Medicaid.
60. Quote by Sandra Johnson, Interim Dean of St. Louis University School of Law, St. Louis, Missouri.
63. It violates 42 § 230(c), see supra note 22.
64. They may depend on constitutional arguments, too, but without any serious hope of success. Classification by wealth does not give rise to any increased constitutional scrutiny, San Antonio Independent School District v. Rodriguez, 411 U.S. 1 (1973), and it can hardly be argued that there is no rational basis for the Oregon proposal. In addition, the Supreme Court has refused to find that health care is a fundamental right; indeed the Court has determined that there is no right at all to have a state pay for even necessary health care. See, Harris v. McRae, 448 U.S. 297 (1980) (upholding the Hyde Amendment, which forbids federal reimbursement for abortion services). See, also, Maher v. Roe, 432 U.S. 464 (1977).
prohibits programs from discriminating on the basis of age. Of course, the Oregon statute requires that all services continue to be provided to those who qualify for old age assistance, and that only others be subject to the priority limitations. Thus, it will be argued, in violation of the Age Discrimination Act, indigent people over 65 will be entitled to a whole range of treatments, all determined to be cost-ineffective by the state, that will be denied to younger people who otherwise qualify for Medicaid. It is ironic, those who oppose the Act point out, that people with the shortest life expectancy will be entitled to the greatest range of medical treatment. They suggest that the program is thus irrational as well as illegal. Of course, if this argument were a sound one, much of the Medicaid program, which describes categorical need in terms of age (e.g., those receiving old age assistance qualify) is legally suspect. Because age is a relevant consideration in determining the propriety of health care, it seems unlikely that this attack on the scheme will be successful.

The plan may also violate Titles VI and VII of the Civil Rights Act of 1964. While only one in twenty of the non-rationed senior citizens is a racial or ethnic minority, one in five of the rationed indigent children is. This argument is likely to fail under the principle of Washington v. Davis unless those who oppose the plan can show that there was a racial animus in the decision to treat the elderly differently from others who qualify for Medicaid. Again, if the Oregon program fails this test it is likely that any program designed to provide services to the elderly indigent and not to the young indigent would be found to be illegal. While such a development might provide a useful check on legislatures which are heavily lobbied by the elderly, it seems unlikely that the courts would be willing to apply Titles VI and VII in this way.

The next argument that will be raised by those who oppose the waiver is that it violates section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against the handicapped. Because


68. 426 U.S. 229 (1976).


handicapped people (and handicapped children in particular) have a need for expensive and continuing treatment for chronic conditions—exactly the kind of condition-treatment pairs that are likely to be most expensive, and thus likely to be at the bottom of the priority list—the handicapped are more likely to be denied services that are now available than are others with acute rather than chronic illness. Again, the application of the Rehabilitation Act to medical treatment was severely limited in American Hospital Association v. Bowen (the "Baby Doe" case),\(^7\) where a majority of the United States Supreme Court recognized that the health status of the patient is a relevant consideration in making health care determinations, and thus section 504 could not prohibit that consideration when physicians were engaged in making health care determinations. In effect, in Bowen the Supreme Court held that section 504 of the Rehabilitation Act does not protect handicapped people's right to treatment that is directed at the handicap itself.\(^7\)

Several other legal bases for opposition to the Oregon Health Services Act are even less convincing. The anti-dumping provisions of COBRA\(^7\) would seem to remain unaffected as long as hospital emergency rooms otherwise comply with that federal statute since there is nothing in the Oregon Basic Health Services Plan that would hinder them from complying. Similarly, those health care institutions still obligated by Hill-Burton\(^7\) requirements are legally free to meet those requirements without regard to the Basic Health Services Act, and all institutions covered by the Child Abuse Amendments of 1984 (the "Baby Doe" statute)\(^7\) could continue to follow the requirements of that Act, even though they may not be reimbursed by the state for doing so. Of course, they are not necessarily reimbursed for complying with the requirements of that Act now, either. While the Oregon statute would release, from tort liability, health care providers who might otherwise be liable for failing to provide services that were unfunded in the Medicaid scheme,\(^7\) the Oregon statute cannot and does not purport to release those health care institutions from any other obligations they would have under state law, under federal law, or under the accreditation policies of independent organizations. Finally, the argument that the whole program constitutes research on human subjects which requires the consent of those human subjects,\(^7\) if taken seriously, would

\(^{1991}\).

72. Id.
77. Basic HHS Policy for Protection of Human Research Subjects, 45 C.F.R. §§
mean that no demonstration Medicaid waiver program could be undertaken without the consent of all of the participants. This would make innovation impossible and would do away with the very important waiver programs that provide adequate treatment to HIV positive patients and to other patients who would not otherwise qualify for Medicaid, or could not otherwise qualify for Medicaid, or could not otherwise qualify for treatment in the most appropriate venue.

Ultimately, the Oregon Basic Health Services Act, if implemented with a Medicaid waiver, is likely to pass legal muster. If there is any reason to avoid the priority setting process Oregon intends to employ, that reason is found in policy arguments that have been raised before the Health Services Commission, the Oregon legislature, or the Health Care Financing Administration.

VI. POLICY PROBLEMS WITH THE OREGON PLAN

There are several potential social and political costs of instituting a plan that formally rations by service rather than by eligibility. First, as the Oregon and Colorado experiences indicate, the political battle over which groups ought to be included in the priority scheme make the growing intergenerational battle over health care an explicit and frightening one. While politically powerful elderly groups see no problem in applying the rationing scheme to children, it is unacceptable to have it applied to them. The fact that the Oregon program and its Medicaid waiver application are explicitly opposed by the Children's Defense Fund and the American Academy of Pediatrics suggests that attempts to change the current system, which favors the indigent aged over the indigent young, and which favors indigent children over the indigent middle-aged, will give rise to a real age-defined battle among segments of the poor. While our focus may be on the battle between the powerful aged and advocacy groups for children, the certain losers in such battles are those—like homeless single people, who tend to fall into neither category—who will remain entirely unrepresented in the fight among the poor for the nation's health care scraps.

The reason that the American Academy of Pediatrics and the Children's Defense Fund oppose Oregon's Medicaid Waiver Application is that they conceive the program as essentially unfair to poor women and poor children who currently qualify for Medicaid and thus have a vested interest in maintaining their current level of benefits. The very limited amount Oregon spends on health care for the indigent, they argue, should not be financed by rationing only poor women and children.78 Some opponents go beyond this and suggest that any partic-
ipation in a priority system amounts to an admission that our health care system in general, and the Medicaid program in particular, are zero sum games. The solution, they argue, is putting more money into health care for the indigent, not taking some necessary services away from some of them. People who adopt this position argue that it is immoral to participate in such an unfair and inadequate system, and they suggest that the priority scheme gives Oregon a political way out of providing adequate health care to all of its citizens.

This principled position is based on a failure to recognize that states simply are not willing to spend a great deal more on their Medicaid systems; rather, they are looking for ways to cut back on this kudzu of their state budget programs. Principles will not help the poor if those who advance them refuse to apply them outside of utopia. Those who seek health care reform should be obliged to start with the health care system as we find it, because that is de facto the default position—that is what we end up with if there is no reform. Health care in this country surely would be advanced if our medical resources were redirected so that the poor had greater access to them, but to expect this to happen through state legislatures' independent actions to increase their largest budget line item is naive. Advocates of the poor do them no service when they argue that those categorically favored people who now qualify for Medicaid should continue to get ineffective costly treatment even though that means that other equally poor people, and those slightly less poor but still below the federal poverty line, are denied inexpensive but effective treatments.

In fact, the argument that the Oregon proposal is unfair because it
rations the poor fails to consider why a transfer of resources from the favored poor is unfair per se. If the politically powerful and well connected take wealth from the poor and disenfranchised for their own benefit, it makes sense to say that their actions are unfair. That is hardly the case when the poor with relatively effective public advocates—children, for example—are left with marginally less health care so that the poor with no advocates—the homeless, for example—can have access to basic health care.

Of course, some of those who will benefit from the Oregon program—the very poor who do not fit into any Medicaid relevant category—are just as poor as those who now qualify for Medicaid and who will thus lose some marginally valuable services. Others who will benefit—those who have incomes between the current Oregon eligibility level and the federal poverty level—are relatively better off than those who will lose some services, but not in a way that is relevant to the distribution of state health care resources. These uncovered between-the-levels patients have no reasonable possibility of purchasing either health care or health insurance on the open market; by definition they do not even have enough income to afford the bare necessities of life. While their paltry resources may allow them to buy minimal amounts of clothing and housing (and thus it may make sense to keep AFDC resources for others with virtually no resources at all), there is no reason whatsoever to treat them as though they had any meaningful access to health care. In addition, they quite obviously do not have the access to the political process that might eventually gain them adequate health care. Those excluded from Medicaid coverage now have proven themselves politically less powerful—at both the federal and state levels—than those who have been successful in getting themselves Medicaid coverage. It would not be unfair to remove marginally valuable health care services from those with the political muscle to provide the most cost-effective services to other indigents with less political power.

Ultimately, and in part because of the unfairness of the current Medicaid system, introducing new arbitrariness and unfairness is not the greatest problem with state experimentation with setting health care priorities. The real problem resides in the necessary generalization of the doctor-patient relationship and the bureaucratization of the health care system that is required by setting condition-treatment priorities. The real problem is that any system which distinguishes all condition-treatment pairs that are appropriate for medical intervention from those that are not appropriate is necessarily based on the response of an “average” patient with an “average” case of the designated condition if granted the “average” form of treatment. The essence of practicing good medicine, however, resides in recognizing that any particular patient is not “average,” and the patient’s condition is not either.
VII. GENERALIZATION, THE GOALS OF MEDICINE, THE DOCTOR-PATIENT RELATIONSHIP, AND BUREAUCRATICALLY DEFINED TREATMENT PRIORITIES

Ultimately, the most important consequence of the Oregon priority scheme is not that it will transfer resources from comparatively ineffective treatment from poor women and children to comparatively effective treatment for other poor people, or that it will provide Oregon with a way out of providing adequate health care for everyone, or that it will provide a focal point for the intergenerational battle for resources. Ultimately, the greatest risk is that it will bureaucratize medicine by overgeneralizing the nature of the doctor-patient relationship. When a doctor prescribes a coded treatment for a coded condition rather than for a patient with whom she had developed a relationship, the patient, the health care system, and the community are all poorer for it. A system that treats all mastectomies for breast cancer identically may allow doctors to treat an "average" breast cancer case appropriately, but it also forces them to treat many (and perhaps most) real cases inappropriately. It requires the cookbook medicine doctors so much fear and inevitably removes the one-to-one doctor-patient relationship.

No one doubts that the use of antibiotics as a treatment for bacterial meningitis (the top condition-treatment pair in the 1990 Oregon ranking) is virtually always appropriate. On the other hand, when is the application of space-maintainers for crooked teeth or artificial insemination for infertility (both in the top five percent in Oregon) really appropriate? When is the application of a partial denture to multiple tooth loss or an office visit for a superficial wound (both in the bottom five percent in Oregon) appropriate? These are not questions which can be generalized over a whole society because both outcomes and values will vary between persons, even if costs will not.79

In addition, sometimes the best medicine is not the obvious conventional medicine. One primary care physician describes his regular treatment of a severely disabled woman with migraine headaches with her requested drug—tetracycline.80 There is little doubt that the tetracycline is ineffective in treating her headaches, but her ability to obtain and use that prescription drug gives her a sense of control that, in fact, may cure her migraines. Would the intense and sensitive doctor-patient relationship that led to the prescription of the tetracycline be recognized as appropriate under the Oregon system? Alas, almost certainly not.

What should a doctor do if he knows that his failure to treat high blood pressure by diet, drugs and exercise (1565 out of 1694 on the

79. Of course, costs will vary from case to case also.
Oregon list) will lead to major depression which will require outpatient therapy (1185 in Oregon)? What if he believes that that major depression, combined with other factors that are a part of the patient’s life, will lead to a heart attack, which is likely to be treatable with anticoagulating medications, at least if the patient is under 65 (241 in Oregon)? Further, the doctor may realize that the heart attack following the depression will lead to the need of artificial insemination to treat the consequential and psychologically based infertility (a very high 73 in the Oregon scale). Must a sensitive doctor forgo treatment of the high blood pressure, and then forgo treatment of the major depression, and offer only treatment for the heart attack (and the infertility, of course) because the “average” patient would not be driven to depression by his high blood pressure, and because the “average” patient would not be driven to a heart attack by a combination of his high blood pressure, depression, and other factors? The doctor-patient relationship is simply more complex than 1694 ranked condition-treatment pairs can recognize, and reducing it to such a list will lead to soulless medicine.

Is there some way to set treatment priorities without overgeneralizing? Perhaps doctors should be encouraged to focus on the goals of medicine in individual cases rather than on the cost-utility ratio of condition-treatment pairs for mythical average patients. Indeed, the Oregon Health Services Commission Alternative Methodology Subcommittee has now suggested that each of the condition-treatment pairs be categorized into one of twenty-six general categories that more clearly identify underlying goals of medicine. For example, such categories include “preventive care for nutritional deficiencies in children at risk,” “treatment of acute life threatening conditions where treatment prevents imminent death with a full recovery and return to previous health state (e.g., appendectomy, bacterial meningitis),” “treatment of acute life threatening condition where treatment prevents death but without a full return to previous health state (e.g., CVA, gunshot to the head),” “repetitive treatment of non-fatal chronic (with recurrent or continuous symptoms) conditions with improvement in QWB [quality of well being] with short term benefit (e.g., epilepsy, rheumatoid arthritis),” and “comfort care for persons with less than one year to live.”

81. The complete list, released by the Health Services Commission on August 30, 1990, includes, in no particular order:
1. Preventive care for children . . . (e.g., immunizations, well child care) and treatments of those conditions when the major purpose is to prevent chronic ‘disability, (e.g., congenital hypothyroidism, treatment of strep throat).
2. Preventive care for nutritional deficiencies in children at risk (e.g., iron).
3. Preventive dental care for children (e.g., cleaning, fluoride).
4. Preventive care for adults as defined by A, B, and C categories by the U.S. Taskforce on Prevention.
5. Preventive care for adults as defined by D and E categories by the U.S.
Categories address more directly the functions of health care and the values we intend to maintain by providing health care. Of course, the same treatment for the same condition might fit in different categories depending upon the attributes of the patient. Providing nutrition intravenously to a patient with a bowel blockage could fit in several categories, for example, depending on the nature of the patient. Applying these categories would allow doctors to treat patients as human beings rather than merely collections of conditions, and this could preserve the best attributes of American medicine.

Taskforce on Prevention.
6. Preventive care for nutritional deficiencies in adults at risk.
7. Preventive dental care for adults (e.g., cleaning, fluoride).
9. Health education for adults (e.g., smoking cessation, alcohol abuse).
10. Health and safety education (e.g., workplace) for adults.
12. Maternity care (e.g., prenatal, natal, and postpartum).
13. Family planning (e.g., sterilization, termination, education and counseling).
14. Infertility services (e.g., work-up, treatment, and counseling).
15. Treatment of acute life threatening conditions where treatment prevents imminent death with a full recovery and return to previous health state (e.g., appendectomy, bacterial meningitis).
16. Treatment of acute life threatening condition where treatment prevents death but without a full return to previous health state (e.g., CVA, Gunshot to the head).
17. Treatment of acute nonfatal non self limited conditions with return to previous health state (e.g., skin diseases).
18. Treatment of acute nonfatal conditions where treatment will improve QWB without return to prior health state (e.g., burns).
19. Treatment of acute nonfatal self limited conditions where treatment will expedite return to prior health state (e.g., measles, chicken pox, and viral warts).
20. Treatment of a fatal chronic condition where with treatment one would return to previous health state with improvement in life span and QWB [Quality of Well Being] (e.g., major depression, transplants, diabetes, schizophrenia).
21. Treatment of a fatal condition with no improvement in life span but improvement in QWB (e.g., stage IV cancer).
22. Treatment of a fatal condition with improvement in life span with no improvement in QWB (e.g., life support).
23. One time treatment of nonfatal chronic conditions with improvement in QWB (hip replacement).
24. Repetitive treatment of nonfatal chronic (with recurrent or continuous symptoms) conditions with improvement on QWB with short term benefit (e.g., epilepsy, rheumatoid arthritis).
25. Treatment of nonfatal conditions with minimal or no improvements in QWB or life span (e.g., viral pneumonia).
26. Comfort Care for persons with less than 1 year to live.

Minutes, State of Oregon Health Services Commission Meeting, 7 (September 5, 1990).
How would individual cases be categorized in this new scheme, however? Establishing any bureaucracy and formal process to do the categorization is likely to lead to the same generalization problems that create so much difficulty in the current Oregon condition-treatment rankings. Is there some way to serve the goals of medicine and eliminate generally cost ineffective treatment without applying something that looks like a social security grid? In fact, the only cost effective way to do so may be to leave the categorization to doctors, in consultation with their patients in appropriate cases, to be performed on a case-by-case basis. By creating a medical culture that recognizes the limited resources available for the health of the community, and by creating formal and informal peer review mechanisms to help physicians make individual decisions about treatment categories, the community may be able to accomplish much of what the Oregon program would do without sacrificing primary care medicine and the doctor-patient relationship. Of course, using twenty-six categories (the number suggested in Oregon) to identify the uses of health care rather than 1694 condition-treatment pairs, and asking individual physicians to categorize individual patients rather than “average” patients, will sacrifice some apparent accuracy to the uncertainties and idiosyncracies of individual practitioners. Some physicians may move some of their patients from one necessarily ambiguously defined category to another to assure that patient gets health care, for example. Of course, that could happen under the Basic Health Services Program, too. In any case, it may be worth sacrificing some efficiency and accuracy to maintain the authority in the doctor and the patient.

VIII. CONCLUSION

Oregon, through its Basic Health Services Program, intends to ration health care by service rather than by patient status. That program is a reasonable and worthwhile improvement on the current arbitrary system. Most of the legal and policy arguments raised against the Basic Health Services Program are faulty because they fail to recognize that some treatments really are more cost effective than others and that those excluded from the Medicaid system really do not receive even the most cost effective of those treatments. The Oregon system needs refinement, however, to avoid creating a new arbitrariness, one that arises out of the presumption that doctors treat conditions rather than patients.

There is little doubt that state Medicaid systems and, ultimately, all other health care systems, will be required to set priorities. These priorities should be set in terms of the goals of medicine and the treat-

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82. This grid removed discretion from the administrators of the Social Security disability system by requiring the application of effectively irrebuttable presumptions. See, 20 C.F.R. pt. 404, subpt. P, App. 2 Medical-Vocational Guidelines.
ments offered to serve those goals rather than in terms of those eligible for entry into the health care system. The Oregon Basic Health Services Act describes the new health care world, muchachos, and we're in it. Our endeavor ought to be to help fine tune the system so that it maintains the utilitarian benefits it was designed to achieve and also allows medicine to retain the fundamental principles underlying the doctor-patient relationship.

83. To paraphrase B. Traven, muchachos.