Quo Vadis Medical Healing

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Editors

Quo Vadis Medical Healing

Past Concepts and New Approaches

Springer

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Preface

"Healing in Medicine" – the subject of this volume evolved in part as the continuation of an earlier gathering in 1999 in Berlin, when an interdisciplinary group of scholars came together to discuss some of the medical issues confronting us at the brink of the new millennium (now as *Medical Challenges for the New Millennium: An Interdisciplinary Task*[1]). Already during our earlier meeting it became clear that the question "what do we mean by medical healing" poses similarly profound challenges that are, once again, best addressed by an interdisciplinary group of scholars.

At first sight the answer to the question "what do we mean by medical healing" appears to be straightforward. However, to know what "medical healing" means implies knowledge or at least some cognizance of the assumptions that underlie our understanding of "health," and, concomitantly, how we define well-being and its opposites, illness and disease. Or to use the words with which Galen opened his *The Art of Medicine*: "[M]edicine is the knowledge of what is healthy, what is morbid, and what is neither; it makes no difference if one uses the term 'diseased' instead of morbid. … What is healthy, what is morbid and what is neither – each of these comes in three different categories – of the body, cause, and sign."[2]

Galen's notions of health – and here we come to one of the most central aspects revealed by our volume – were formulated within a cultural context which had a fairly cohesive and widely shared worldview that provided both Galen as well as his "elite" audience with rather clear and thus relatively easily communicated ideas about health and morbidity. Yet even Galen, operating in a far more homogeneous cultural universe (in which, for example, a person's dietary regime but also the place where he came from and resided formed part of "medicine") than we do today, contradicted his own definitions of health and morbidity on a number of occasions. Many of his contemporaries, especially his medical competitors, disagreed profoundly with his definitions: then as now, in other words, health and healing, and what we mean by them, are both culturally determined yet also individually and physiologically specific.

Since Galen, much, of course, has changed. Today, health, health care (business, wellness, recreation), and medicine (especially research-driven scientific medicine) have become, at least in part, separate entities with different institutions, budgets, marketing philosophies, and "corporate cultures." What has remained relatively

unchanged since the times of Galen, however, is the fact that what healing is and how to achieve it is not the same for everyone. The place where one lives still matters today – health and healing do not mean the same from continent to continent. What it means to be healthy and especially to attain or maintain health differs depending on the developmental state of the country in which one resides, developing or developed, and does not mean the same even within such "contexts," i.e., there are profound differences among the respective states of the USA or in the different member states of the European Union. Even within the nation state, rural versus urban residence and cultural patterns will determine approaches to health care. A country's and a person's wealth, legal framework, medical traditions, prevailing religious foundations, in short, its cultural constructs are all determining factors of what healing and health mean in practice. Globalization may work for Coca Cola, but it stops short in the arena of medical healing.

If, as has always been the case, one person's "poison" is another person's "cure" – the Greek term *pharmakon* aptly means both – then what are some of the factors that influence our notions of health, healing, health care, medicine, and medication, in Western developed nations and elsewhere? Watson and Crick's discoveries 50 years ago have opened recent avenues (and in few cases the reality) of "healing" on a molecular level, tailor-made for each and every one of us. The sometimes virulent debates regarding stem cell research, pre-implantation diagnostic, "cloning," genetic engineering and so on are well known to all of us, as are the profoundly different reactions of ethics panels, researchers, health advocates, and legislators not only between, but even within countries.[3] Related issues are the market forces and financial considerations undergirding notions of health: What drives pharmaceutical research? Who makes decisions regarding the fate of cures or at least the containments of illnesses that affect millions, but where effective medication has been difficult to develop, inefficient to produce profitably, or hard to patent securely? Why aim for the development of highly costly treatments for conditions that affect only a few thousand but which guarantee a high return on investment? What does a venture capitalist want to see before investing in a biomedical start-up, and why? What are the "ethical" costs of investing millions of research dollars into drugs that are a necessity for few but a "lifestyle" enhancer for many?

Both Viagra as well as fertility treatments (and thus the hotly debated "raw-materials" that are their byproduct) may be seen as such "lifestyle" cures. They do not, arguably, treat diseases affecting many thousands, as does, for example, malaria, yet they are by now standard aspects of health care, not least because they affect another issue that is central to our debate: quality of life. As we all know, of course, healing, health, and quality of life and their inverse are – again – individual and subjective, yet at the same time and in no small part also culturally determined. What is "quality of life" and who should have the authority to decide its relevance for each and every autonomous "patient"? And, intrinsically related to these questions, what role does pain play for us today? Do we have clinical definitions of pain that work as well as our various legal ones? Historically, pain and suffering played a central role in Western (Christian) culture, but what exactly was that role? Has the role of pain and suffering changed, and if so where and how? To what degree is the

recourse to religious heritages justified when answering questions related to modern ethical challenges surrounding notions of health, be it the evaluation of pain, the use of stem cells to ameliorate suffering, or the delay of AIDS vaccine trials? In short, what does medical healing mean for us today? We believe that a comprehensive approach to these issues, one that takes into account the historical, scientific, corporate, and legal dimensions of healing offers much in the way of fruitful and multifaceted analysis.

This volume brings together chapters on, and discussions of, these and similar topics that took place in the course of a symposium at Schloss Elmau, Bavaria, in May 2003. We are very grateful to all the participants in our symposium, both the presenters and our audience, for their enthusiasm and personal initiative. Special thanks are due to Dieter Müller-Elmau and his staff, who welcomed us at the lovely Schloss Elmau, an ideal setting for intensive yet enjoyable debates. We further wish to express our thanks to AstraZeneca for their financial support. Dr. Anne Berghöfer and Tatjana Ossowski were invaluable in their help with the organization of the symposium and the compilation of this volume. Springer (formerly Kluwer Academic Publishers) once again provided their expertise and guidance in the production of this book.

Susanna Elm and Stefan Willich

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2. Galen. The art of medicine (Kühn I 307–308), transl. P.N. Singer, Galen. Selected works. Oxford 1997, 345–346.
3. See, for example, the differing legislative approaches in California and on the US federal level regarding stem cell research; or the related articles in the *FAZ* (e.g., February 19, 2003) which features series regarding genetics and related topics, reflecting widely divergent opinions from theologians, ethicists, geneticists, etc. See also Paul and Nettesheim in this volume.

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Part I
Philosophical and Ethical Foundations

The initial chapter provides an ethical framework for health care from a political perspective. Annette Schulz-Baldes from Zurich University Centre for Ethics describes different strategies to address the scarcity of resources for health care and analyses respective of ethical and economic consequences. She argues that the future of health care will be more or less political depending on the management of rationing decisions. In the following chapter, Thomas Heinemann, who holds joint degrees in philosophy and medicine, offers definitions of the terminology of healing, curing, and health and their ethical and medical implications, and discusses the reciprocity between the concepts of disease and of medical action.

How Political Is the Future of Health Care? Allocating Scarce Resources in Liberal Democracy

Annette Schulz-Baldes

1 Introduction

Medical progress has radically changed human health. Today, we can cure more diseases than ever before. The number of centenarians has never been higher, and premature babies can be kept alive after less than 25 weeks of gestation. Physical and mental abilities are being enhanced beyond natural boundaries. Moreover, genetics makes it possible to predict disease decades in advance. In the future, we may even be able to clone human life.

Science and cutting-edge technologies have not only changed the limits of what is possible, but also caused health systems' costs to skyrocket, thereby putting us and future generations at risk. These trends raise questions the disciplines of science and medicine cannot themselves answer. Should we employ all technical means to create, select, prolong or predict human life? Who should have access to costly and possibly risky new technologies when not all can for economic reasons? This chapter will discuss to what extent answers to these questions will have to be political, i.e. based on negotiation, bargaining and preference aggregation rather than moral argument. Most of us have strong intuitions against simple preference aggregation (i.e. majority rule) when existential interests and fundamental moral values or principles are at stake. We think that good moral reasons, not voting, should govern decision-making about these issues. However, when reasonable people disagree about what counts as a good moral reason, the line between ethics and politics can become blurred. Using the example of allocating scarce resources in a liberal democracy,[1] I will try to demonstrate that the procedures we choose for limit-setting decisions will largely determine the extent to which the future of health care will be political rather than ethical. I will argue that decision-making procedures which are informed by conceptions of a good life are likely to yield more ethical outcomes.

[1] I will focus on democratic and industrialized countries although it seems obvious that health care in developing countries will be among the prime challenges in the twenty-first century. I will also disregard the impact of "external" factors on health care, such as the international spread of disease (i.e. the anticipated pandemic influenza), the global trade in human body parts (i.e. the international circulation of human cell and tissue products), medical 'tourism' (transplant 'tourism' being the most controversial form), and so forth.

S. Elm, S.N. Willich (eds.), *Quo Vadis Medical Healing,*

2 The Future of Health Care (Part I): Scarcity of Resources

Scarcity of resources will significantly shape the future of health care in industrialized countries as medical progress and demographic changes are pushing health care expenses upward. With more and more sophisticated diagnostic and therapeutic interventions available for more and more patients, both the frequency and the costs of medical care will continue to rise. Health expenses correlate with the proximity of death (Zweifel et al., 1999), and consequently, costs increase in aging societies.

The scarcity of resources is amplified by decreasing revenues for public health care spending. Low mortality rates at all ages and the simultaneous decline in birth or fertility rates have led to societal aging and a subsequent decline in income for traditional 'pay-as-you-go' social insurance systems. It is projected there will be more Italians, Germans and Japanese over 80 than under 20 years of age by 2050 (Center for Strategic and International Studies, 2000). More people will therefore be dependent on the income of fewer workers; aging may additionally hamper economic growth. And since aging is a global phenomenon – in fact, many developing countries are aging now at much faster rates than industrialized countries – immigration will at best mitigate the societal effects of aging (Center for Strategic and International Studies, 2000). Already today, what can be done medically cannot be financed solidarily. This trend will acuminate in the future.

3 How Should We Address the Scarcity of Resources for Health Care? The Case for Explicit Rationing

There are five basic strategies to address the scarcity of resources for health care: Society can let the market balance health care costs (Strategy I), preserve a publicly financed health care system by rationalizing services (Strategy II), increase funds for health care (Strategy III), or introduce measures for implicit (Strategy IV) or explicit rationing (Strategy V) (Marckmann, 2007). The following discussion will demonstrate that there are both economic and ethical reasons to reject the first four options. From an ethical perspective, explicit rationing should be embraced under reasonable resource constraints.

3.1 Strategy I:A Free Market for Health Insurance

The market leads to the efficient production and distribution of goods and services in many areas of cooperative activity. It functions without coordinated procedures for the allocation of goods and services, provided that free competition, accountability and informed consumer choice are guaranteed. Because non-market distributive procedures are complex, costly and potentially divisive, in addition to potentially

restrictive when it comes to the autonomous choices of individual consumers (and patients), there seems to be a *prima facie* case for a market solution also in the health sector. Why not let the market match patient preferences to different health insurance packages?[2] Both economic and ethical arguments speak against this solution. Compared to the purchase of other goods or services – for example, a car or a laundry provider – uncertainty about one's future health needs is significant even in the wake of new technologies such as comprehensive genetic testing. Moreover, information about the outcome of different health insurance packages is often insufficient in countries without universal access to health care (Daniels and Sabin, 1997). Since the informed consumer (patient) choice and accountability conditions are unmet, a free market for health insurance would not function properly from an economic perspective.

Furthermore, it would not be justified from an ethical perspective. Justice gives us social obligations to protect the fair opportunity range of all citizens so that all can participate in the political, social and economic life of their society (Rawls, 1971). Health care – which comprises medical as well as long-term care and preventive health measures – protects an individual's fair share of the normal range of opportunities. It is one precondition for people to choose among the life plans they can reasonably pursue, given their talents and skills, and the society in which they live. Providing health care is therefore one way of meeting the social obligation to protect the fair opportunity range of all citizens (Daniels, 1985).

In a free market for health insurance, however, individual ability to pay would determine access to health care. Only those who could purchase insurance would be able to protect their normal range of opportunities. And because ability to pay is significantly determined by the natural and social lottery – the skills, talents, and socio-economic conditions a person is born with essentially depend upon luck – a free health insurance market would undermine fair equality of opportunity and hence be unjust. Both economic and ethical reasons speak against a similar market.

3.2 Strategy II: Rationalizing Public Health Services

A public, and thus solidarily funded health care system, is therefore needed to protect the fair opportunity range of all citizens.[3] So how do we address the scarcity of resources in a public health care system? An obvious strategy would be to decrease

[2] I do not consider the option of a free market for health care services, since it would clearly violate the informed consumer choice condition. Many patients who find themselves in acute need of medical insurance are unable to compare different health service offers and cannot make a rational decision about these offers.

[3] There is no room to detail the extent of coverage in a public health care system here. It should be mentioned, however, that the 'fair equality of opportunity' approach does *not* necessarily imply universal coverage – contrary to a widespread intuition – and is indeed compatible with a tiered health care system (Krohmal and Emanuel, 2007).

spending by rationalizing services. In fact, today's health care is inefficient in numerous ways: Some health interventions are ineffective altogether; effective interventions are being provided without the right clinical indication; effective care exists at lower costs; and more effective treatment could be provided for the same costs. The potential for rationalizing services is therefore large. However, it is questionable that tapping this potential will in fact decrease health expenditures. Measures to rationalize health care require a solid basis of clinical evidence, which is itself costly to attain and often reveals a need for better care rather than a potential to save in costs. Furthermore, rationalizing usually mandates expensive structural changes in the health care system (i.e. a better coordination of ambulatory and hospital care or more emphasis on preventive medicine). But even if savings outweighed expenses, the effective cost containment would probably be limited given that costly medical practices and demographic changes will probably cause increased health expenditures. It seems unlikely that rationalizing health care will be sufficient to address the scarcity of resources for health care – even though there may be other reasons, not grounded in economics, for making services more efficient. For example, the principle of nonmaleficence requires health personnel to omit ineffective interventions and to provide care with the fewest possible diagnostic and therapeutic interventions.[4] The expected economic impact of rationalizing health care, however, is at best weak.

3.3 Strategy III: Additional Funding for Public Health Care

Additional funding for public health care would be another obvious strategy to offset the scarcity of resources for health care. However, several arguments speak against it. First, although medical progress has improved thousands of lives, many innovative medical interventions have a diminished marginal utility. For example, some oncology treatments could arguably be characterized in this way. When the cost of care becomes disproportionate to the gain in medical benefit, additional funding is no longer cost-effective. Medical progress is a leading cause of increasing health care costs, and simply pouring more money into marginally better health care is not an economic solution.[5]

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[4] A thorough ethical evaluation of measures to rationalize health care is not the goal of this chapter. Nevertheless, the reader should note that a focus on efficiency implies a bias for interventions that are suited to provide 'solid' clinical evidence (ideally gathered in randomized-controlled trials) and in addition risks neglecting equity considerations in the provision of health care.

[5] This argument presumes that the primary purpose of a public health care system is to provide care, not to advance science. Were a rigorous distinction between research and therapy to be implemented, additional funding for research – both public and private – would be necessary to maintain medical progress. The present argument may also be oversimplifying from a macroeconomic perspective, as the provision of medical services and related industry account for increasing percentages of employment in many industrialized countries.

Second, health care is not the only determinant of health. Although social determinants of health are poorly understood, empirical evidence shows that our physical condition is influenced not only by access to medical prevention and treatment, but also by the cumulative experience of social conditions over the course of our lives. Absolute and relative socio-economic status has a significant impact on individual health (Daniels et al., 1999). Measures to reduce social inequalities – for example, better educational opportunities – may well be more (cost-)effective than excessive investments in health care.

Third, because public budgets are finite, additional resources for health care imply cuts in public funding for education, protection of the environment, poverty relief, homeland security, and so forth. Even though activities in these areas could be seen as more or less instrumental for health, physical well-being is not the only good individuals or a society would want to pursue. However important health and health care are, other social goods exist and should be pursued (i.e. education). Furthermore, preserving and restoring health is not sufficient to protecting the fair opportunity range of all citizens. A society that maximizes health care but has no resources left to provide fair opportunities for education, for example, is not just. It would not comprehensively preserve the ability for its citizens to participate in societal life as normal collaborators and competitors.

There are no natural limits to health care spending. A society has to decide how much of its public resources should be devoted to health care, based on value judgments about health (and other goods), but also based on empirical facts such as medical and economic development. Excessive additional funding for health care, however, is neither an economic nor an ethical option.

3.4 Strategy IV: Implicit Rationing in Public Health Care

If rationalizing health services cannot adequately contain costs and additional funding for health care is neither an economic nor an ethical way to address existing scarcities, we are left with two ways of budgeting finite resources: implicit and explicit rationing. Implicit rationing uses incentives for providers and patients to save costs at an institutional or individual level; explicit rationing sets priorities for areas of medical activity or medical interventions within the health care system. Both forms of rationing are problematic since they limit access to health services that are expected to have a positive impact on people's longevity or quality of life. However, the costly medical progress and demographic changes leave no viable alternative. Rationing in health care has become a practical necessity.

Implicit health care rationing is present in most industrialized countries today. Even those countries or states that embrace explicit rationing – for example, Sweden, Norway, the Netherlands, the United Kingdom and the State of Oregon in the United States – have implemented some instruments for implicit rationing. The goal of these instruments is to change the behaviour of providers and patients through financial incentives. Restricted budgets, diagnosis-related groups in hospital