The Medical Care Crisis: Seeking a Jewish Approach

By David A. Teutsch

Success inevitably leads to new challenges. Not that many years ago, the best available medical care more often than not failed. Today, advances in technology, genetics, pharmaceuticals and virtually every other part of medical science have revolutionized health care. For most people, the result of this extraordinary array of advances is both better quality and greater quantity of life.

Unsurprisingly, providing this rapidly growing set of services has become more expensive. Currently, health care consumes 14 to 15 percent of the Gross Domestic Product (GDP). As the quality and quantity of health care and the resulting costs of providing it have increased, health insurance costs have similarly increased. This is no big surprise, as insurance premiums must cover the increased costs of medical care provision.

Some see large malpractice settlements as a problem because of their impact on malpractice insurance bills and, consequently, on health-care costs. Others have noted that our porous social safety net results in people without health insurance having very limited access to medical care. As the number of people without health insurance grows, emergency rooms often become the primary source of medical care for individuals. This is both unnecessarily expensive and inadequate, in that emergency rooms do virtually nothing about preventive care.

Health-care Policy as a Jewish Concern

In what sense is health-care policy a Jewish problem? Several answers are immediately apparent. First, it is a problem that affects Jews — some are uninsured, some pay a great deal for insurance, some work in the health-care industry, and all are affected by how the health-care industry works.

Second, Jewish tradition recognizes an individual and collective duty to help people heal. In contemporary society, we depend upon secular institutions, in whole or in part, to fulfill that duty. Thus, as Jews, we have a moral concern about health-care public-policy issues as well as about how the medical system operates.

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Third, we have concerns for the dignity of everyone in our society. How the medical system operates provides a core experience for how we see our own dignity as well as that of others.

Identifying Indicators

Given this reality, what tools can we discover within Jewish tradition that may provide a basis for a distinctly Jewish point of view? This is a tricky question, because any time a "pick-and-choose" method is employed, it can simply be an elegant way for justifying one's biases, assumptions, or already-formulated conclusions. There are no simple, clear precedents within the *halakha* that those who do not consider themselves bound by the *halakha* would consider directly compelling or powerful.

With this caveat, I nonetheless want to mine Jewish tradition for values and concepts that are resonant, and can provide guidance.

Since the Jewish community will shape public policy by itself in this area, and since the public-policy questions are extraordinarily complex, the suggestions below should be taken as indicative of an approach rather than as embodying an entire analysis. How medical schools function, how medical research is conducted under not-for-profit and for-profit auspices, how the complex system of regulatory societies, state and federal law, hospitals, nurses, physicians, and others interact is enormously complicated. Changing any part of the funding system — governmental, insurance-based, individually paid, and other third-party reimbursed — will have ramifications throughout the medical system. These can only be considered when looked at with great care from the point of view of medical economics, sociology, moral concerns and service delivery.

Public Health

The *kehilah*, the structured and self-governing Jewish community of pre-modern times, had public health responsibilities. Its obligation to provide sewers, bridges, and other facilities for public safety is clear from a number of sources. One of the public considerations for the *kehilah* was its obligation to provide a physician. Thus, there is within Jewish tradition the notion that at least some basic level of medical care should be available to every member of the community.

Interestingly, physicians would not work exclusively for the *kehilah*, but would earn most of their income from fees for direct service to individuals. The community would provide funding to the physician to provide basic services to those who could not afford to pay. For the physician, this resulted in a two-tiered system. Health care was provided on request to those who could pay for it, and only minimal health care was provided to those who could not.

Such a two-tiered system can exist in the United States, as well. Most recently, it has been instituted in the state of Maine. In that system, those who pay privately or through health insurance receive whatever services are paid for in that way. The state provides a

minimum-care safety net for those who could not otherwise afford care. A well-designed system of this type provides not only emergency care and hospitalization; it also provides preventive care, which in the long run actually saves the health-care system money. Public health care either provides funding for people to go to private physicians or it funds clinics where routine medical care can be provided. Such a system does not necessarily mean inferior medical care; it only means less medical care. For example, the public insurance system will not pay for plastic surgery in cases that are purely cosmetic. It does not provide funding for optional services not essential to good health.

While some efforts in this direction have run into trouble, that does not indicate a flaw in the basic idea but rather in the methods selected for implementation. Oregon, for example, instituted a system that ran into severe financial problems because it did not achieve a workable balance between the amount of state funding and the number of services provided. Such systems confront us with extremely challenging moral and prudential choices. Our desire to avoid them, however, is not a justification for failing to provide basic medical care.

Malpractice Settlements

There have been many public discussions about what to do about high malpractice settlements. Some analyses indicate that the cost of malpractice settlements actually has a relatively small impact on the cost of medical care. Nonetheless, these very public events tend to undermine our perception of how the system works. The issue of whether to cap tort settlements has to do with how we weigh the balance between the public's good and each individual's good.

We understand malpractice settlements to be about several different things: damages for real hurt to the individual harmed, punishment to the wrongdoer, and the creation of an incentive for physicians to do the best they can. However, huge settlements do not necessarily improve physicians' attention. In fact, they are more likely to create too great a degree of caution, with physicians generating extra procedures and tests, instead of acting fully in the patient's best interest.

Anyway, most physicians will do everything they can to do what they perceive to be best for the patient. Malevolent or careless physicians are unlikely to avoid self-destructive behavior. Therefore there is no reason to think that the public gains from these very high tort settlements.

The public does have much to gain by increased toughness in licensure procedures and supervision of physician error. All too often, medical societies protect doctors in marginal cases rather than sternly disciplining them. The pressure of peers can play a critical role in improving medical care.

Jewish tradition recognizes that the community has the right to cap the size of tort settlements for the public good. Whether this should be undertaken or not is a complicated question, but there is certainly a precedent in Jewish

sources for considering tort caps as an option.

Regulating Costs

The health industry is an extraordinarily complicated and interactive entity. Professional networks, large institutions, government, insurance and pharmaceutical firms and other companies all play important roles. Consumers usually have very imperfect knowledge about fees, which does not usually play a major role in their selection of a particular hospital or physician beyond making sure that their insurance is valid in a particular place.

These are conditions where market forces are unlikely to produce a level of competition that will bring prices to the lowest acceptable level. Achieving the lowest acceptable level of pricing might have an unmeasurable but significant impact on the quality of care. Even if we could achieve it, that might not be a desirable goal. Given that reality, the regulation of costs will take place outside of having the individual simply comparison-shop based on prices for similar services. Other methods must be used to control costs.

The efforts of health maintenance organizations to set hospital and physician fees have had very mixed success. Similar efforts by Medicare and Medicaid have also come with huge problems. Nonetheless, the question of cost is worthy of our attention. In terms of the benefits gained from the medical industry, we might well decide that spending 15 percent of the GDP in order to achieve our current astoundingly high-quality medical care is a perfectly reasonable price to pay. Even so, how to maximize the efficiency of the system without undermining its effectiveness remains an important question.

Health-care Education

Health-care education is one of the key elements in reducing costs in the health-care system and improving its effectiveness. One challenge to the Jewish community is to determine how synagogues and other Jewish institutions can play a role in providing health-care education. Sometimes, this is more obvious: One example is the need to do genetic counseling in the case of genetic defects that are common primarily to Jews. It seems reasonable that other, more general forms of health-care education should take place as well. Basic issues in health-care choices and ethics are critical to moral Jewish living. Furthermore, public discussions in the Jewish community of health-care policy can have a positive impact on governmental and industry choices.

One precedent from Jewish tradition that could prove valuable here is the notion that the government (*kehilah*) has the right to make decisions about how to manage costs. This does not solve the problem. In many ways, it actually creates new problems. But it opens one important avenue toward thinking about how the very complicated system of individuals and institutions involved in health care can be handled in order to assure efficient, fair, and reasonable financial arrangements.

Rationing

It is clear that every country rations health care. If that were not the case, people would avail themselves of almost infinite amounts of medical care. Placing costs on medical care is one easy form of rationing. When we know that it will cost us $10 every time we call the doctor, we do not call as often. Insurance companies' decisions not to cover certain procedures — whether because they are cosmetic or because they are experimental — are another example of rationing to control costs.

We make decisions all the time about how to balance safety against expense. Speed limits and the bumpers on cars are examples of that. Jewish tradition attempts to find such a balance as well. For example, the Torah requires that a roof that can serve as a deck must have a parapet around it. The rabbinic discussion about how high the parapet must be clearly indicates that it needs to be an effective barrier without being so high that someone couldn't still fall over the top of it. Thus, the rules require the homeowner to reduce the risk but not to eliminate it.

In the case of medical care, it is clear that for the system to remain affordable, some kind of rationing needs to take place. Since there must always be some rationing, it would be unreasonable for us to get up on our moral high horse to yell "Foul!" in every instance. The question is not *whether* we should ration but *where* and *when*. How do we do it in a fair way that takes into account the extraordinary competition for resources? The potential need is infinite. We can not afford to provide all the medical care everybody wants, any more than we can provide prime cuts of meat at little cost to all those who would like them.

Taking Personal Responsibility

Many public-health issues are affected by what individuals and groups do. Individual choices around smoking, healthy eating, drug use, alcohol consumption, and sexually transmitted diseases all have a profound effect on the individuals' own health as well as on the costs to the medical system. How much we sleep, whether we exercise and how well we tend to those around us will all have significant impact on our longevity, productivity and health-care costs.

Those who strongly or frequently abuse their bodies will probably be much less positively affected by better health-care access than those who tend to themselves with greater care. Nevertheless, most of us would not want to say that medical care should be restricted to people who have taken really good care of themselves. Not only would doing so be unfair, it would be extraordinarily difficult to administer, though some steps in this direction may be possible. For example, it may be reasonable to create a health insurance surcharge for those who smoke.

Sometimes, such factors must be considered, as in cases of rationing organs. People who are poor health risks because of poor self-care inevitably must be put farther down on the organ recipient list than those who con-

tinue to take good care of themselves and who would therefore be likely to live longer.

Principles for Distribution of Care

If it is to be done fairly, rationing must be based on a system of principles and values. Several principles emerge from our tradition. One is equal respect for all persons. Another is *pikuaḥ nefesh* (saving a life), a principle that says that we ought to do all we can to maximize the length of life. In addition to these concepts, there is also the idea that the *tereyfah* (one who has an injury or illness that will certainly lead to death) has less of a claim on medical care than others whose lives can be preserved if there are insufficient resources to treat both.

Values like *k'vod habriyot* (human dignity) mean that we ought to try to honor the wishes of individuals, including their own understanding of what is best for them in preserving a balance between their quality and quantity of life. *Ḥesed* (lovingkindness) and *briyut* (preserving health) are also values worthy of consideration.

These ideas do not lead to an exhaustive system, but they certainly do point in the right direction. When we also consider the tradition's willingness to support capitalist principles, in which people can buy what they can afford and others are willing to sell, we may have more of a capacity for proceeding toward reasonable procedures than may at first be apparent.

There are other methods of distribution that have in various times and places been utilized by Jewish tradition. These include *yichus* (social status), social need, productivity for society, level of learning, queuing and the relationship to the rescuer. How these might apply in some situations is a question that deserves much more substantial treatment than can be undertaken here.

How do we balance *tzelem Elohim* — the idea that human beings have infinite worth because they are created in the image of God — with the reality of finite resources? That is a question that plagues us repeatedly. We might say that it is an unavoidable part of the human condition.

Regardless of the fact that we cannot finally reconcile these two, we must keep that profoundly troubling question before us as a guide. It prevents us from swerving away from the constant moral challenge that the questions surrounding medical care raise for us. If indeed we keep asking the questions and strengthening the dialogue about them, we can then reasonably hope we will make decisions that reflect our best moral and prudential judgments.