EDITORIAL

Health Care Under New Constraints

Talk of recession abounds. The 'fat years' appear to be over for the health system as well. Even in countries that until now had no socialized medicine or where even a public insurance system was not subject to very strict economic control, the state sees itself compelled to resort to more or less drastic cost-cutting measures. This experience is that much more painful since, at the same time, medicine is constantly offering new, more complex, and therefore more costly methods of treatment. Of course, this development cannot take place without affecting the way in which sickness in general and individual patients in particular are treated. But since the 'health' care system, as is made clear by its name, is not merely concerned with sickness and the sick, it cannot be guaranteed that there will be no effects on the management of health in general and the healthy in particular. What might this mean for the near future?

As far as the financial consequences of limitations on services are concerned, the effect on hospitals is, of course, most apparent. As very few of these institutions are able to operate self-sufficiently, most are dependent in one way or another on public or private subsidy. Therefore, doing without expensive equipment, reliance on less expensive medication, and other cutbacks in hospital services are inevitable when these subsidies are reduced. This has repercussions on the sales and earnings of pharmaceutical companies and manufacturers of medical equipment which, in turn, may lead to the reduction of resources available for the research and development of new medications and procedures. Not even medical personnel are immune to the effects of financial cutbacks. Positions vacated by departing personnel may be left unfilled and dismissals may even be necessary. As a result, either hospitals must admit fewer patients, or the same number of patients, attended to by a smaller staff must make do with less intensive treatment. The number of doctors in private practice must also decrease, or individual private physicians must be satisfied with fewer patients and a correspondingly reduced income.

Surely, this description of the situation offers no new insights but is included here in view of a consequence that appears to me to have been the subject
of too little attention and analysis: namely, the ethical and legal implications of constraints in the overall health care system on the individual doctor-patient relationship. Of course, this paucity of research cannot be remedied by a single editorial, but this opportunity can be used to articulate several of the questions that must be addressed: To what extent and in what way must economic factors now be accounted for in the individual doctor-patient contract from the moment it is established? Of what financial limitations must the patient be informed? What is the future of a physician's duty of care if the physician cannot prescribe the medically indicated and least risky procedure but rather is forced knowingly to choose a less costly alternative that is less promising for the patient and perhaps more risky? To what extent can the doctor shift to his insurance carrier financial responsibility for any resulting harm to the patient? And to what extent may the insurance company shift responsibility to the overall health care system, which contributed to the creation of the vicious circle by withholding the necessary funds in the first place?

Here, at very latest, arises the question of ultimate political responsibility for a health care system that is no longer prepared to finance all the elements necessary for effective treatment and care. The answer to this inquiry is not least dependent upon the view of mankind and conception of society upon which a health care system — more or less consciously — is based:

If the individual sick person is primarily concerned with his own welfare, he will — regardless of the possibly similar treatment needs of other patients — agitate for the best possible medical care. And if need be, he must be prepared to cover the lion's share of the ensuing costs himself. If his health and sickness remain 'his own business', he cannot expect society to expend resources on him over and above his own precautionary financial contribution. On the other hand, he cannot be forced to make preventive financial contributions and in no case can he be made to help pay for the care of other patients. The possible disadvantages are obvious: objective inequality in preventive and remedial care as well as the danger of subjective dissatisfaction among those who would prefer not to be reminded that the inadequate care they receive when they are ill is due to their own inadequate precautionary behavior or insufficient investment in health insurance.

However, perhaps the basic assumptions of this 'individualistic' model are fallacious because it views man onesidedly as an individual whereby, because of his very nature, man should not be viewed as anything other than a member of human society and a connecting link between his predecessors and posterity. As a result, he is not only the embodiment of an 'individual' but also embodies a 'social' and 'intergeneration' being. If, however, one takes this quasi three-dimensional existence of man seriously, there are significant