

## First: Cut the Paperwork

In our national debate on health-care reform, an ethical climate is developing that denies whole categories of health-care services to one group of citizens or another. In response to this disturbing trend, a leading group of ethicists and physicians, chaired by the author, gathered to suggest a new moral guideline for health-care reform. In our statement, “Core Values in Health-Care Reform: A Communitarian Approach,” we argue that no one should be denied medical services that can produce health benefits until major savings are gained *first* by cutting extraneous administrative costs.

By this standard, the Oregon rationing plan, which refuses to pay for procedures that have a high cost and relatively low benefit, should be rejected out of hand. Oregon ranks highest among all the fifty states in the proportion of its health-care budget that is devoted to administrative costs. Accordingly, it is only fair to cut the excessive paperwork, nettlesome micro-management, and bloated bureaucracies before eliminating procedures such as liver transplants—as the Oregon plan does—that have proven medical benefits.

The standard reflects a moral dictate developed by the group—“cut patients last”—that has a much wider application than the Oregon rationing plan. While the Oregon plan takes aim at the poor (it applies only to Medicaid patients), others target the elderly. Philosopher Daniel Callahan, Director of the Hastings Center, has long argued that people who are older than 80 should receive only “ameliorative” care (such as pain killers and hospice services) and not therapeutic services (which comprise most of medicine). Recently, he urged that Medicare should include a new “Part C” that would allow those older than 80 to choose between coverage for long-term assisted care *or* acute hospital care. Joseph d’Oronzio, a professor at Columbia University, has argued that those elderly men and women who do not sign living wills limiting their

use of life-support systems be required to pay higher medical premiums. Gregory Pence, a University of Alabama Medical School professor, who also endorsed a rationing plan, has suggested that we tell a 76-year-old woman facing an expensive liver transplant: “For all your children and grandchildren, we can’t spend this much on you.”

These approaches constitute age discrimination, the group of ethicists and physicians conclude. In contrast, we argue that, if rationing must occur, the only standard that should guide rationing decisions is one based on an assessment of the likely success of treatment for those in the late stages of a terminal illness. This principle would be as relevant for a dying young AIDS patient as for some elderly patients. On the other hand, it would not deny treatment to the many men and women 80 years and older who can be restored to a full life.

Most important, before draconian measures such as rationing are considered in what is still the richest society in the world, we should cut those costs that needlessly drain valuable resources. The place to begin is with paperwork, not people. The U.S. spends up to 24 percent of its health-care resources on administrative costs while Canada spends only 11 percent. If we switched to a Canadian-style system, the reduction in paperwork would save more than \$65 billion a year, according to the Government Accounting Office.

Second, if we overcome the political pressure posed by the trial lawyers and allowed differences between health-care providers and patients to be resolved via mediation and arbitration rather than litigation, the national health-care tab would be reduced by \$7-8 billion. Such changes would not only reduce the costs of lawyering but also the billions wasted on defensive medicine.

Third, we should cut out procedures that have no proven benefit. This would eliminate up to 20 percent of current medical procedures and save more than \$40 billion, according to studies by the RAND Corporation. Fourth, drug companies must be stopped from gouging their prices: some experts believe the savings in reduced pharmaceutical costs would net up to \$9 billion.

Our health-care “crisis” prompts people to pursue radical change. But a word of caution is in order. Before we consider options like rationing, we must cut administrative waste, litigiousness, defensive

medicine, needless procedures, and corporate profiteering. More important, if we must ration, age must not be the basis of separate and unequal medical treatment for the elderly or any other group.

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## Applying Federal Laws to Congress

Congress' legitimacy is seriously undercut by the public perception that it exempts itself from the same laws it expects the rest of the country to abide by. Few Americans understand why this should be so. Citizen groups, executive branch officials (including the president), and members alike have decried Congress' exemption from civil rights, employment, and safety laws. The president, vice-president and their staffs are similarly exempted from coverage by the same laws.

There are two issues here. One is whether Congress, sensitive to public antipathy, too eagerly cedes its constitutional responsibilities under the separation of powers under assault by the executive branch and the public. The second, though, is whether Congress uses the excuse of its constitutional responsibilities to avoid living itself under the laws it makes for others.

The rationale for Congress' exemptions can be found in Article I, Section 6 of the Constitution, which states that "for any speech or debate in either House, [members] shall not be questioned in any other place." Historically, the point of contention has been whether the clause protects official actions not directly related to speech and debate, such as the