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Introduction

As part of the health reform debate that is raging in Congress and the nation at the time this essay is being written in late 2009, frenzied claims regarding the advent of health care rationing continue to be exchanged by the more extreme wings of both major political parties. Politicians and commentators on the conservative end of the spectrum worriedly lament that passage of ObamaCare will usher in a new era of rationing that denies potentially beneficial treatments to vulnerable patients and their physicians, while liberal Congressional and Administration spokespersons vigorously deny those accusations.

Attention has been explicitly paid to the subject of health care rationing in the United States—including the idea of using patients' chronological age as a criterion for rationing—in the ethical and public policy literature for at least a couple of decades (Menzel, 1990; Smeeding, 1987; Symposium, 1992). Responsible commentators have recognized the inevitability of rationing health care in a real world of finite resources and infinite demands (both legitimate and unreasonable), but also have acknowledged the seemingly unmanageable methodological, political, and cultural can of worms that the challenge of rationing opens up (Aaron, 2008; Aaron & Schwartz, 2005).

A major problem with the present (often uncivil) political discussion is that both ends of the spectrum make the same categorical mistake. Conservatives and liberals alike act as though: (1) health care rationing would be a new, previously nonexistent phenomenon; (2) this new phenomenon, if it developed, would be evil; and (3) that rationing can be avoided either by maintaining the health system *status quo* or changing the system radically enough to wring out enormous undiscovered amounts of fraud, waste, and inefficiency. A more honest discussion, by

contrast, would acknowledge that health care rationing in the United States is already a practical reality and can only intensify in the future regardless of the disposition of the current health reform debate (Kapp, 2002; Kapp, 1998). Thus, a more fruitful allocation of intellectual and political effort should focus not on *whether* there will be health care rationing in this country's future, but rather on *how* it ought to be carried out in the most ethically palatable manner possible. A primary responder, for almost a quarter of a century, to the question of how health care rationing should be done in the United States has been philosopher Daniel Callahan.

Callahan's Proposals, Then and Now

Early Arguments

Philosopher Callahan, a co-founder of the pioneering bioethics think tank The Hastings Center (www.thehastingscenter.org), broke new ground in 1987 with the publication of *Setting Limits* (Callahan, 1987). There, he set forth a fairly comprehensive proposal for radically altering the American health care delivery and financing system. The key component of his plan to enhance equal access to affordable care within a universe unfortunately but unavoidably characterized by limited financial, physical, and human resources was the utilization of patients' (or potential patients') chronological age as a categorical eligibility criterion for the receipt of particular forms of diagnostic or therapeutic interventions. Specifically, he proposed the creation and implementation of explicit, official rules disqualifying individuals who had exceeded a designated age threshold (roughly identified as seventy-ish) from receiving (ideally at all, but at least at public expense) certain aggressive forms of medical tests and treatments solely because they were deemed too old. Callahan expanded on this thesis a few years later in *What Kind of*

Life? (Callahan, 1990), in which he derided the popular clamor for medical "progress" by arguing that, although many individual lives might be lengthened and improved by continuing to support medical innovation, the American population considered as a whole was quite healthy enough. His attack on medical innovation as an (indeed, the chief) unacceptable cost-buster was made even more directly in his later book, *What Price Better Health?* (Callahan, 2006).

Callahan's proposals for formal, legally sanctioned, age-based health care rationing schemes inspired a barrage of emotional (and perhaps too frequently *ad hominem*) criticisms from all points on the ideological compass (Barry & Bradley, 1991; Binstock & Post, 1991; Homer & Holstein, 1990). The principled criticisms took several tacks, but most telling were the objections that Callahan's categorical approach to rationing allowed for little account to be taken of individual variations among older persons that might justify differential access to specific forms of medical care in unique circumstances. In Callahan's mind, however, a categorical approach admitting few if any exceptions is precisely the strength of his proposal. In his latest work, *Taming the Beloved Beast*, he reiterates his allegiance to this approach and hones in particularly on his felt need to control the growth and use of innovative medical technology for the Americans population across the board, and for older Americans as a specifically targeted group (Callahan, 2009).

Previous Ideas Repackaged and Renewed

Taming the Beloved Beast is, in important respects, a repackaging and renewal—at his current age of 79 (Callahan, 2009, p. 150)—of Callahan's earlier theses. It has the tone of a decently diplomatic "I told you so more than twenty years ago" lecture to his critics (whom he

labels as "[t]hose obsessed with antiageism" (Callahan, 2009, p. 191)), emphasizing that, as he consistently predicted, health care costs have kept escalating uncontrollably and thereby imperiled sufficient access and reasonable affordability for many individuals. Moreover, as Callahan had predicted and as he now reminds us, other cost containment strategies, such as permitting individual physicians and patients to make ad hoc bedside decisions (Cassel & Brennan, 2007) or relying on the results of comparative effectiveness research to encourage desirable behavior by clinicians and third-party payers (Brook, 2009), have failed pretty miserably.

Callahan here renews his focus on controlling and curtailing the development and dissemination of medical technology, which today is largely at the core of American health care (Cohen & Hanft, 2004) and, most significantly for Callahan, the prime generator of uncontrollable health care expenditures. Technology limitation is his target because, first, that is where the greatest savings can be found and, secondarily, because—according to his reckoning— the yield in terms of demonstrably improved population health from our enormous national investment in the development and use of medical technology has been much too puny. He would limit the negative financial impact of medical technology in two ways: reducing support for applied research designed to lead to new technologies whose subsequent use in clinical practice would have to be paid for, and adoption of express rules limiting or prohibiting the use of certain technologies for older people (for whom technology is often used irrationally (Homburger, 1994)).

Callahan anticipates the complaints of critics that his proposal certainly would have the effect of discouraging future technological advances in health care, largely freezing the *status*

quo as the ongoing state of the art (Charen, 2009). His eager response is, So What? "There is no moral obligation or imperative to continually improve the general health of populations already at historic high levels." (Callahan, 2009, p. 174) Chilling technological advances is precisely the point of Callahan's proposals; keeping new drugs, devices, and other gadgets—no matter how much they might potentially benefit some specific individuals—is the only real way to control overall health care spending. According to him, it would be "foolish to worry about reduced innovation and industry losses. That is precisely what we should hope for. We cannot both hope to manage technology costs and yet, at the same time, bemoan the possibility that it might work." (Callahan, 2009, p. 165). "The greatest problem in the long run will be with our technological successes, not our failures, wonderfully effective, yet horribly costly." (Callahan, 2009, p. 167)

Callahan's social value reformation project is nothing if not ambitious. He asserts unabashedly:

> Whether Americans can be brought to think differently about health, to expect less and to settle for less, and to be willing to forgo some health care they might like, or even need, for the sake of the public good, takes a utopian, or maybe a counter-utopian elixir of hope and imagination. I see no plausible alternative. (Callahan, 2009, p. 154).

Callahan contends, repeatedly, that a meaningful handle on spending for medical technological research and application can only come about through the legislative embrace of a universal, federal government-directed national health system. The key feature of such a system, and the heart of its ability to control the development and dissemination of medical technology, would be an inflexible global budget for health care, coupled with "a presidential declaration of immediate price controls on drugs, devices, hospital charges and those of all medical vendors, and parallel imposed cuts in the fees of medical specialists.. ." (Callahan, 2009, p. 207) Because

this model has thus far proven impossible to sell politically in the United States, Callahan positively swoons over the variations on the general centrally controlled total budget theme that have been instituted in different European countries (Graf von der Schulenburg & Blanke, 2004). He fervently implores a thorough reexamination of the depraved American cultural values of individualism and personal freedom of choice and their replacement by the much superior European (especially continental) values of forced social solidarity and dictated equality of result. "American health care is radically American: individualistic, scientifically ambitious, market intoxicated, suspicious of government, and profit-driven," he disparages. "I put changing those values within health care in the class of a cultural revolution dedicated to finding and implementing a new set of foundational values." (Callahan, 2009, p. 7)

Indeed, for Callahan and like-minded commentators, one of the main salutary effects of containing health care expenditures in the United States would be the freeing up of more money for the government to spend to expand its power in other areas (such as housing and education) of people's lives, per the European example (Kilo & Larson, 2009). This outcome would, for Callahan, contrast delightfully with our current, highly objectionable "affluent, individualistic culture, one economically profligate in so many ways, yet incredibly tight-fisted in others (e.g., taxes), and in love with technology of all kinds." (Callahan, 2009, p. 170)

Callahan quite reluctantly posits a continuing role for the private sector in American health care financing and delivery, but zealously rejects the possibility of any effective contribution by this sector in the cost control endeavor. His description of the duplicity of private insurers and providers of health care goods and services, especially technology innovators, often borders on conspiracy theory. Given his recognition that eliminating the

private sector entirely is not politically feasible, his next-best solution is

> to begin classifying medical industries much as we do some public utilities, that is, as private companies that perform a public good. The latter are lauded for their public benefit but regulated with an eye to making certain that their quest for profits does not harm their important public role. (Callahan, 2009, p. 140)

Callahan is accurate that competition among private health care providers and insurers has not heretofore produced success in containing the steady climb in health care costs. Nonetheless, his rather vehement condemnation of the profit-seeking private sector's perverse conflict-of-interest driven influence on health care costs overlooks three significant factors.

First, he neglects to mention that many aspects of private sector activity in the health care sphere are extensively regulated and that such command-and-control micro-management by government impinges on the ability of a competitive free marketplace to work properly. For him to condemn the private sector as inherently defective when government intrusion shackles it is an unfair criticism; the private American health care industry has hardly been afforded an honest test, at least in the modern era.

Second, when Callahan writes about the shortcomings of non-governmental actors to contribute to meaningful health care cost containment, he speaks only about private insurers and sellers of goods and services. He totally ignores the vital potential of properly incentivized health care consumers as decision makers about their own health care (Kapp, 2009), and the ways in which the consumer role might operate to inhibit the sort of unrestrained health care spending that occurs in typical third-party payment situations that separate consumers from the financial consequences of demanding unnecessary and/or excessive diagnostic and therapeutic interventions. Callahan's intellectual capital is invested exclusively in supposed supply side

solutions that prospectively, externally impose strict constraints on individual choice; we must "minimize the need for directly rationing care [retrospectively} ... by not having technology readily available in the first place." (Callahan, 2009, p. 195) The term *consumer* does not appear in this book's index.

Third, Callahan's broad contention that "[g]overnment does not have an inherent conflict of interest and is thus a better vehicle for health care than is the private sector" (Callahan, 2009, p. 215) is wrong. The hundreds of national, state, and local legislators and regulators who comprise government and are politically accountable to the divergent demands of their collective millions of constituents encounter continual conflicts of interest galore that rival, if not exceed, those experienced in the private sector; moreover, at least in the latter and unlike in the governmental realm, the conflicts are transparent and well-publicized.

Conclusion

Callahan's repetition and reinforcement of the theme that health care costs absolutely need to be controlled, sooner rather than later, to avoid incurring or exacerbating deep and permanent social damage in the United States is one that cannot be ignored. Nonetheless, this need raises a slew of complex and perplexing ethical, cultural, political, and legal dilemmas that both political leaders and followers struggle mightily to avoid (Zelinsky, 2010). Callahan is certainly correct that the claim that we can achieve sufficient health care cost control while simultaneously improving quality and expanding access is an illusion, if not a delusion (Editorial, 2009). "[D]iscussions of the cost problem too often [are] couched in win-win fantasies and hopes." (Callahan, 2009, p. 202)

Terribly, even tragically, difficult choices involving distasteful tradeoffs among competing deeply-held values must be made. As Callahan warns, "[A]ny plausible solution will require pain and sacrifice." (Callahan, 2009, p. x) His proposed scheme for achieving those trade-offs and their ultimate cost control objectives—rationing choices dictated and enforced by central government planners, while ignoring the capacity of informed consumers to direct their own health care in an individually and socially responsible manner—is, in my judgment, seriously mistaken in practice as well as theory. My objections notwithstanding, Callahan has once again offered us a valuable intellectual contribution to a vital topic that needs, before much longer, to progress from debate to action.

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