

Ends and means: the goals of health care

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Pluralistic societies, reflecting diversity and a love of freedom, have characteristically been wary of efforts to achieve agreement on goals and ends. Often enough, this wariness occurs even in ethics. Yet if ethics is to make a serious contribution to health policy, it must focus its attention as much on the substantive ends of medicine and health care as on the moral means of attaining them. The current ends of medicine and health care ensure not only that health policy will face intractable resource dilemmas and economic unsustainability, they ensure no less that the prevention of illness and the care of the sick will have no reflective goals. In particular, if justice is a primary aspiration for health care, then what kind of health care will be most conducive to making that possible? A health policy such as we have now, which has indiscriminately declared all-out war on death and disease, cannot be a sustainable policy.

To speak at all sensibly on a topic as sweeping as "the goals of health care" requires beginning at the beginning and working out from there. And a common way to start such a venture is to define one's terms. Yet while it is possible to have endless debates on most of the terms used in this chapter, I will simply stipulate my meanings, hoping that they come reasonably close to common usage (Nordenfeldt, 1999).

The goal of health care is that of health. The means to pursue health are

socioeconomic change, medicine, and public health. Socioeconomic conditions are important for the preservation and improvement of health and should surely enter into any broad scheme of health care, but I will touch upon that topic only lightly here, defining health care for the purposes of this chapter a little more narrowly: Health care consists of the organized methods used by a society to promote the health of its members, ordinarily encompassing the fields of public health and medicine. A society's health policy will be the organization of those methods into some overall financial and distributional structure designed to pursue the general goals of health care and, ultimately, of health. Health might best and most simply be defined as an individual's experience of well-being and integrity of mind and body. It is characterized by an acceptable absence of malady and consequently by a person's ability to pursue his or her vital goals and to function in ordinary social and work contexts. This definition puts to one side the famous World Health Organization (WHO) definition of health as encompassing "complete social well-being," an implausible and hazardous health care aim.

The WHO definition would, in principle, make medicine and health care responsible for all human welfare. That is an impossible task for them, and, even worse, it invites distraction from the wide range of causes of social ills such as poverty, injustice, and poor government.

My definition is also meant to make room for age-relative standards of health, out of a recognition that, with aging, there will be a decline in many physical and some mental capabilities but that a person can be considered in "good health" for his or her years despite that decline. It would make no sense to have the same health expectations for someone 90 years of age as one would have for that same person at age 9. To do so would be to act as if the process of aging simply did not exist.

Why should we give any special thought at all to the goals of health care? Don't we already know what they are? Not necessarily. It is reasonable to expect that the next few decades will witness enormous gains in biomedical knowledge and technological development. These gains will force a reexamination of many, if not most, features of current medicine and health care, including the priorities among its goals. They will also force a scrutiny of the penumbra of issues and assumptions surrounding them—namely, our understanding of health, the role of medicine, the extent of the social obligation to provide health care, and the place of health in relation to other social goods. Shaping the contents of a health policy that embodies the shifting priorities and often subtle changes in the interpretation of health-care goals will raise many inescapable ethical problems.

I begin, then, with three premises. First is that the ends of health care ought to be as much a part of the ethical enterprise as the means chosen to achieve them. Second is that the ends of health care should embody some

larger view of the human condition and the place the pursuit of health should have in promoting human welfare. Third is that, while pluralism and a diversity of visions should command respectful deference, it will be important to achieve at least a rough political consensus on the appropriate goals of health care, without which there can be no effective policy.

My purpose is to lay out the ingredients necessary to devise morally defensible goals for health care and then use my own approach as one illustration of the way content may be given to the framework I have set forth. If I am minimally successful, I will have presented a plausible general direction in which to proceed in thinking about goals. If I am maximally successful, my specifications for giving the general framework some detailed content might just seem plausible, as well.

While I will attempt to show why a discussion of goals is insistently necessary now, mention should be made of some problems in pursuing the subject. A perennial problem seems to be the American temperament, which is much more comfortable in fashioning health policy, or any kind of policy, using the language of management techniques and economic efficiency, of money and incentives, and of practical matters of making policies work, than with the articulation of clear health-care goals.

A second problem is that the Supreme Court has historically resisted reaching final decisions about constitutionality, preferring to resolve legal crises at lower levels. So also, analogously, there is resistance to public debate about the meaning of life and death, of suffering, of the definition of health, and other old, complex questions that run as deep, often underground rivers through all health policy. Those topics appear to make many people nervous. They are perceived to be too religious, too philosophical, too general, too controversial, too boring, or too abstract. Nonetheless, those risks have to be run with health care, and I will do my best to avoid the twin dangers of other-worldly abstraction, on the one hand, and a tiresome array of distinctions and qualifications, on the other.

SOME NECESSARY DISTINCTIONS

Some preliminary distinctions are necessary, not all of which I will follow through on in detail, but all of which need to be mentioned as part of the larger task of defining the goals of health care. I begin by defining my topic more precisely: It is to specify the goals of health care, the relationship of those goals to the fashioning of the goals of health policy, and the way ethics might best fit into such deliberations. Why not, however, simply specify the goals of health policy? Now for the first distinction: It makes no sense to talk of the goals of health policy without, as a prior step, taking on

the goals of health care; and, for that matter, going one level deeper and asking what we should mean by *health* and why it is an important human good.

The second necessary distinction is this: When we speak of health care and its ends, should those ends be determined by an inductive effort to discover the de facto ends of American health care—what we do as opposed to what we say—or should we move at once to the normative level, aiming to determine what those ends ought to be? A direct move to the latter level, which might initially seem most obvious if ethics is the focus, runs the risk of ignoring deeply imbedded tacit values of health care that remain forceful because of the various reinforcements they provide for the more explicit values.

A third distinction is that between the goals of medicine and the goals of health care. Medicine is the historically prior institution, and its goals in practice determined for many centuries what health care became available (and long before the concept of health care was devised). With the advent of a public health perspective much later, and then of organized social and political systems designed to improve health by deploying both medicine and public health, it became possible to speak of health care as the generic category for all efforts, medical and otherwise, to protect and foster good health. Nonetheless, even if medicine can now be subsumed under the broader category of health care, its scientific knowledge and ability to determine (usually, if not always) the biological pathways of disease give it a central role in health care. Medicine remains the fundamental discipline of health care.

The most recent addition to this array of nested concepts has been that of the socioeconomic determinants of health and illness and their implications for the improvement of health (Evans et al, 1984). They should surely be understood as demanding a role in health policy, even though they are outside health care systems as customarily understood.

A fourth distinction turns on the debate about whether medicine as a profession and discipline has inherent ends endemic to its practice or whether it is a social construct, ever open to reconstruction (Pellegrino, 1999). It is surely the case that, almost by definition, the provision of health care is a social practice, and the policies that shape those practices are social constructs. Many ways of organizing health-care systems exist, and, in that respect, they are malleable political artifacts. Yet this malleability might complicate our search for health care ends. For, if we think of medicine as having inherent ends, then we have one type of institution, with more fixed goals, placed inside another type of institution, a health care system, with variable and readily reconstructed goals.

The fifth and final distinction is that between our current and future con-

cerns regarding health-care allocation. We need to consider how to divide the scientific and technological knowledge, skills, and therapies now available to health care and those that could and should be made available in the future through biomedical, behavioral, and socioeconomic research. Research produces those goods (to speak generically) that have the potential not only to change health profiles in the future, but also, as an indirect consequence, to change cultural concepts of health and the role of medicine. It also has provided different understandings of the ends of health care and its shaping policies.

MOTIVATING INQUIRY INTO THE GOALS OF HEALTH CARE AND MEDICINE

Why is a reconsideration of the goals of health care and medicine now necessary? The likely impact of new biomedical knowledge and technological innovation, already mentioned, is surely one reason, but there are others as well. Most health-care systems in the world are facing steadily heavier economic pressures, forcing a variety of reforms that require (usually covert) rationing and other restrictions on the provision of health care. A turn to the market is one consequence in many places, and a consideration of priority-setting is still another (Callahan, 1999). Changes of the kind just described can affect the formal goals of health care (e.g., a strong market approach can make choice rather than health the aim of a health-care system), while a move to setting priorities will set up a hierarchy of subgoals within some general framework of goals.

The goals of health care need reconsideration, then, because of the part they play within the broader goals of health policy. A market approach in health policy will have a potent impact on the doctor-patient relationship, as will any rationing policy that forces physicians to deny some forms of medical care to their patients. The rise of chronic disease as a corollary of aging societies requires a reexamination of the relative priority to be given to curing and caring in research and resource allocation. The fact of aging societies and the possibility of competition among different age groups for scarce resources suggest an urgent need to ask whether the goals of medicine for the elderly should be the same as those for the young, with policy age-blind in its resource allocation.

The growing attraction of a medicine that could enhance human capacities and capabilities rather than simply restore or maintain some traditional level of health obviously raises questions about what the most appropriate goals are for health care (Parens, 1999). The so-called medicalization of many problems once considered nonmedical, such as substance abuse (explained

only in part by a possible biological basis to addiction), leads to the question of the scope of medicine in responding to human suffering not obviously biological in origin, and that question, in turn, forces consideration of the scope of health care. Changing cultural attitudes toward the reduction of health risks and constant improvement of medical outcomes aiming for a kind of medical utopia are no less important in motivating a fresh inquiry into goals.

A final motivation for a reexamination of the goals of health care would be to take better account of the increasing knowledge of the socioeconomic determinants of health. As matters now stand, medical treatments and cures are sought for many health conditions that might be greatly reduced by such nonmedical strategies as improvements in education, employment, and the environment. The traditional medical goal of treating the sick would remain, but a greater emphasis would fall not only on public health but also on improving those social conditions known to affect health. The aim would be (as it has been put) to intervene in the "upstream" sources of disease and illness and, by changing them, avert the need for medical interventions "downstream" (Daniels et al, 1999).

SPECIFYING THE GOALS OF HEALTH CARE

Having provided that set of prefatory clarifications, I believe the best place to begin an examination of the goals of health care is with the goals of medicine, for not only do those goals have historical priority, they have also focused on those conditions of an individual's body and mind that have occasioned the abiding interest in health. Accordingly, I will begin with the goals of medicine and then expand those goals to encompass public health. Together, they encompass the goals of health care. The borderlines among these different focal points are not clear cut, however, and I would not want to be understood as suggesting anything close to air-tight compartments. Like all typologies, this one is meant to put the world into some kind of order; and the world, as always, is not nearly so accommodating as are our invented categories.

Medicine as a discipline arose in response to the finitude of the human body. It is a body subject to disease and illness, to aging and decay, to accidents and frailty. Along with the maladies of the body, there are an array of mental and emotional aberrations capable of producing miseries competitive with those imposed by a dysfunctional body. It is at least imaginable that one or more, or many more, of these bodily and mental burdens can and will be cured or effectively relieved in the future, but it is only in the realm of science fiction that there could exist bodies or minds totally free

of such maladies or their threats. It is thus the broad aim of medicine to find ways of dealing with those maladies, by cure or amelioration.

To specify the goals of medicine is to seek the right fit between (1) the human desire to avoid illness, suffering, and death and (2) the capacity of medicine as a combination of science and clinical skills to do something, within the boundaries of its professional competence and integrity, about those evils.

There are a variety of possible ways, of specifying those goals, but I will here draw upon a three-year project of which I was a part and whose purpose was to specify those goals (The Hastings Center, 1996). Our method was to examine the historical goals, to identify present practices that embodied different goals and practices (we identified at least 40), and then to seek a plausible blend of the old and the new. Characteristically, the goals distilled by this process were, in keeping with the most ancient traditions, focused on the care and treatment of individuals, not of populations. Indeed, the continuity with the past was most strikingly singled out by the absence of population-oriented goals in contemporary expressions of appropriate goals. I will now turn to the four goals that emerged from our examination as the most plausible, reflecting both the past and the present.

The Prevention of Disease and Injury and the Promotion of Health

While it is sometimes thought that this is a relatively modern goal, the writings of Hippocrates give it a strong place, one that was carried down through the generations, though with varying degrees of intensity. Its purpose as a formal goal of medicine is to serve the overarching good of health, recognizing that it is as valuable to prevent threats of illness as to relieve those threats once they manifest themselves.

The Relief of Pain and Suffering

Typically, the first manifestations of physical or mental disease are physical pain and psychological distress, often to the point of suffering. Pain and suffering are not identical, since each can exist without the other, but they commonly move in tandem. It is pain and/or suffering that usually brings patients to physicians and, if nothing else can be accomplished, their diminishment or relief are basic goals to be sought.

The Care and Cure of Those with a Malady and the Care of Those Who Cannot Be Cured

This goal is stated in the form of a tension embodying two ideals. One ideal, more modern than ancient in its feasibility and intensity, is to find the bio-

logical or other cause of pain and suffering and to eliminate or otherwise neutralize that cause, that is, to cure the patient. The other ideal is to provide comfort, rehabilitation, or other means whereby an illness or disability can be tolerated and the highest possible degree of accommodation with ordinary functioning achieved. A tension exists between these two ideals because cure cannot always be achieved but ought always initially to be sought, and must, when not found, give way to the ancient caring function of medicine.

The Avoidance of a Premature Death and the Pursuit of a Peaceful Death

This goal also is expressed as a tension, here between the aim of preventing a premature death in an individual and the realization that, since death comes eventually to everyone, the physician should strive to make that death as peaceful as possible. The tension comes from the uncertainty, intensified by contemporary medicine, of knowing when death should be accepted. Technological progress has rendered the line between living and dying ever more tenuous, in great part because a growing number of ways exist to give a critically ill patient a few more hours, or days, or weeks of life. The ideal of prolonging life and the ideal of a peaceful death are both strong. The difficulty, which shows no sign of abatement, comes in knowing when to invoke one rather than the other.

SETTING PRIORITIES AMONG THE GOALS

While much more could be said of each of these goals, three comments are in order, each in answer to a question. First, should there be a context-free set of priorities among these goals? Second, are there some de facto biases in the current priorities given to the four goals? Third, what are some of the obstacles and threats to devising a reasonable set of priorities in different historical contexts?

While it might seem attractive, and even necessary, to set permanent priorities among the goals of medicine, that effort turns out to be generally unwise. Health promotion and disease prevention make little sense as goals for patients who are terminally ill, nor is cure a meaningful goal if a patient is well. Instead, while it can be said that the goals of medicine as specified above are ultimate, their deployment in particular historical contexts is best understood as proximate and contingent.

The question always to be asked is this: What is the appropriate priority with this patient at this time? There are a number of advantages of this approach: It forces a careful examination of individual patient needs, it al-

lows for a change in goals as the patient's condition changes, and it helps to neutralize the constant and familiar hazard of rote, or automatic, treatment patterns that would otherwise be offered regardless of patient needs. Even the goal of relieving pain and suffering, which is important for all patients, could admit of a temporary lower priority in the case of a treatment that would bring time-limited pain for an eventual health gain (such as a bone marrow transplant that aimed to preserve life).

The same way of thinking is appropriate for specifying the goals of health policy, in particular that of determining the most pressing health needs at the present moment even while being ready to change those goals when the circumstances change. A century ago it seemed self-evidently valuable to go after those infectious diseases that randomly killed children and young adults in large numbers. A reduction in mortality was appropriate as the highest goal when most people died before reaching old age. But that aim has been virtually achieved, and different priorities in setting goals are gradually becoming appropriate in most developed countries.

On the matter of de facto biases, a major complaint is that health promotion and disease prevention have systematically been given a place of low priority both in the care of patients and in setting research priorities. The chief culprit has been a bias in favor of cure, which has too often been seen as the highest goal of medicine in most circumstances. It is a bias that has led to a disproportionate amount of money being spent on biomedical rather than behavioral research, on the one hand, and to an emphasis in clinical practice on treatment rather than on patient education, on the other. An obviously important aim of setting proximate, context-dependent goals for medicine would be to counteract outdated goals and open the way for new priorities. The recent effort to give palliative care new force and sophistication is an example of this possibility.

Politics and Priority-Setting

While it might seem obvious that the setting and prioritizing of goals would be a wise move as part of setting health policy, some subtle and not-so-subtle pressures mitigate against doing so. The least noxious of those pressures arises from the play of politics and pluralism. It is better, many believe, to leave deep and possibly divisive matters safely buried away. Pragmatic concerns frequently engender resistance not only to the setting of formal goals but also to any concrete attempt to prioritize them. For many, particularly legislators, it is the give-and-take of politics, full of bargaining and compromise, that appears an attractive, less theoretical way to fashion policy. The setting of priorities means, moreover, that there will be winners and losers—but it is important for the legislators that this reality be obscured to

take the sting out of the losses and to act as if the winners are not taking something from the losers.

Admittedly, I speculate here, but that seems necessary in the face of an international pattern of great interest. Despite considerable public and legislative interest in recent years, only in the state of Oregon has a priority-setting policy actually been put into effect; otherwise, it has remained just talk, provocative enough, but still just talk (Ham, 1997). At the same time, while there has of late been a greater interest in a population-based public health approach to setting policy, it is rare to see this approach coupled with any proposal to give an individual-based, biomedical approach a lesser place. It is, in a word, uncommon for reform recommendations that call for a greater emphasis on a fresh health-care strategy to be coupled with an equally strong emphasis on cutting back more established approaches. Reform is not looked upon as a zero-sum game, even though it often must be.

If the political willingness to call for a more precise definition of goals and a prioritizing of them is rare, still other threats exist to a serious discussion of goals. A setting of goals is clearly easier in small, relatively homogeneous societies than in those that are large and pluralistic, and it is considerably more possible when there is a centralized governmental control of policy—that is, in a closed system. Indeed, in a society such as the United States, where there is a mixed public and private health care system with no central authority, the explicit setting of goals is nearly impossible except at the most local level. I say “nearly,” for it is possible, on occasion, to achieve a political consensus on policy and to thereby set some new directions, as happened in 1965 with the passage of Medicare and Medicaid. In that case, the aim was to provide coverage to the elderly and the poor. As such, this aim did not involve changing any traditional goals of medicine. Instead, it formally introduced into American health policy the goal of special care for the poor and the old.

It has not, however, been possible to significantly push health policy much beyond the 1965 level. While there are many reasons this has not happened, I stress three in particular: (1) the important and growing role of the market, which plays to individual preference and works against strong and universal goals and policies of any kind; (2) the unabated drive for constant biomedical progress and technological innovation, which turns any and all research interests into goals; and (3) the concomitant increase in health care costs that the combination of progress and market forces brings about, which are typically responded to with managerial and economic techniques, not a reconsideration of goals.

While those developments logically speaking, might seem ideal circumstances in which to press forward the question of goals, in practice they make it difficult even to open such a discussion. Consequently, the fitful

drive for universal health care has stalled once again. If that drive can be stimulated again, an articulation of the goals of health care will become imperative: aims and priorities will have to be set, limits fashioned, and the relationship of health to other public goods reexamined.

The Goals of Public Health

Together with medicine, public health is the other principal ingredient of health care. Are the goals of public health different from those of medicine (Institute of Medicine, 1988)? The answer is yes, even though overlap occurs. The characteristic mark of public health is its interest in population, not individual, health. While a population perspective is hardly indifferent to the health of individuals, its focus is on overall trends of mortality and morbidity and their causes. Epidemiology is the key discipline for the measurement of those trends, while a number of other disciplines work to assess the causes and outcomes of health-related activities. Traditionally, public health has focused its efforts on disease and infection surveillance, food safety and sanitary conditions, and, more recently, health promotion and disease prevention.

While health promotion and disease prevention have always had a place in medicine, it is nonetheless true that most of medicine's goals and its common practice focus on dealing with those who are sick or injured. Public health does not attempt to find cures for disease, though it often works with those who do. Public health has no equivalent to the caring function of medicine, which includes providing assistance and palliation to those whose sicknesses or disabilities cannot be cured. Public health has no place in the recent efforts to improve palliative care and end-of-life treatment.

Yet by looking to the health of populations instead of care at the bedside or in the doctor's office, public health is a necessary and invaluable partner in health care. Its goals complement those of medicine. No less importantly, if public health does its work well, it can help society reduce its burden of sick care. For example, an effective immunization program or an anti-smoking campaign can make a great, and often greater, contribution to the goal of health than can the provision of good medical care. The fresh emphasis on health promotion and disease prevention in primary care medicine, helped along by managed care, shows that this perception, while hardly new, is finally beginning to take hold. By asking the question of what health and social practices will make the greatest statistical improvements in mortality and morbidity rates rather than in individual benefits, a population perspective focuses a wide-area lens on health, and that is invaluable. The combination of the medical lens, focused on the individual, and the wide-area lens, focused on populations, constitutes the realm of health care.

I have suggested that while there can be universal and timeless goals of health care—if only because the body and the mind have needs that cut across all cultures and eras—health policy requires the setting of proximate goals. This means giving a more specific meaning to the general goals, specifying some subgoals, and setting priorities among them. I will put to one side the important political question of the procedures by which those proximate goals should be set, other than to say they should be accomplished by democratic procedures by a populace well informed about the health needs of the community. I will instead propose some ways in which the setting of goals can and should be tied intimately to ethics, reducing the possibility of a sharp gap between the ethics of ends and the ethics of means. I offer three policy directions toward that end bearing on the needs of subgroups in the population, on the enhancement of population health, and on the promotion of equitable health care.

Goals That Are Responsive to the Needs of Population Subgroups

For the purposes of policy, it is valuable to understand the full population of a society as made up of various subgroups, each of which will have some overlapping but also some different health-care needs. A basic respect for persons and a sensitivity to the variability in health needs of different population groups connects health-care goals and ethical demands. The most useful way to classify the subgroups is three-fold: by virtue of age, by virtue of economic status, and by virtue of racial, ethnic, sex, or other important social characteristics. To show how this might be done, I will paint only with the boldest strokes.

Age should make a vital difference in the understanding and prioritization of the four goals of medicine sketched above. Health promotion and disease prevention should have the highest priority with children, and here the role of public health measures and socioeconomic conditions is crucial. The point is to get children off to the best start possible, which will serve not only their childhood welfare but their welfare for rest of their lives as well. The cure of disease becomes comparatively more important in adulthood, when it is important to keep workers and parents alive and well-functioning for their own sake as well as for the well-working of their society. With the elderly, cure as a high-priority goal should give way to an increased emphasis on the relief of pain and suffering, rehabilitation, and palliative care in the face of chronic, ultimately fatal disease. Of course, it does not matter (for the aim of my argument) whether the reader agrees with my particular choice of goals for each age group; the point is to establish sub-

goals for each group based on a combination of health needs and social considerations.

The economic characteristics and disparities of different social groups is another obvious criterion for the establishment of subgoals. Money matters. It is not so much that poor children necessarily have health needs radically different from those found among more affluent children (low birth weight, for instance, will be found in both groups), but that their needs are more demanding and widespread. While health promotion is equally important for both groups, a stronger curative emphasis may be needed to compensate for poor socioeconomic conditions afflicting some groups. A similar kind of analysis may be appropriate in responding to racial, ethnic, and sex differences, shifting priorities to take account of different needs.

In each of these cases—age, economic status, and racial/ethnic/sex differences—the aim is to fashion goals that avoid setting inappropriate goals for different groups; that shape the goals to meet the special needs and social situations of different groups; and that seek to avoid, in the setting of goals, an exacerbation of existing health problems.

Goals That Enhance Population Health

The bias of American health care has been toward individual health. That bias is compatible both with the Hippocratic tradition, which puts individual patient welfare as its highest goal, and with American individualism, which is uncomfortable with most value systems that stress the common good. But ethics ought to encompass the welfare and vitality of entire communities as well, if only because the general welfare of a community influences the general welfare of each of its individual members. An excessive individualism fails to take account of the social life of communities and the interdependence of individuals. It has long been known that it is not high technology, cure-oriented medicine that best promotes population health. Instead, public health measures and socioeconomic improvement accounted for most of the reduction of mortality over the past century. That knowledge should lead to an obvious conclusion: goals and priorities oriented to population health should, in general, have the highest place in health care, in research, and in health policy. Yet this has not happened and may never happen. Measures that improve population health will not improve the health of everyone. Many people will get sick anyway, and for that reason ordinary medicine devoted to the cure of the sick and the relief of suffering will always play an important role. There is probably a basic, not fully resolvable tension here: population-oriented strategies have the compelling logic of likely success and overall health improvement in their favor, yet individual-oriented medicine, aimed at dealing with people who are sick, responds best

to people's greatest fear, which is what will happen to them when health runs out, as it always does sooner or later.

As mortality declines for younger groups, it makes sense to shift the main goals of health care from their present de facto priorities, which are now heavily oriented toward cure. It is not that cure is irrelevant any longer; far from it. However, a persistent priority of cure leads to a medical perfectionism with diminishing health and economic benefits. By contrast, a shift in goals toward, first, improving the quality of health of the young and reducing their morbidity and disability burdens and, second, greater health promotion and disease prevention would aim to have people reach old age in the best possible physical and mental state. The viability of the idea of a compression of mortality depends on strategies that also have the advantage of benefits prior to old age.

Goals That Facilitate Equitable Health Care

There is widespread agreement that health care should be equitable, even if there is considerable disagreement about the best political and economic means of achieving that aim. Yet remarkably little notice has been taken of what is, I believe, a fundamental condition for future health-care equity: that the kind and quality of available health care be economically affordable. The current pursuit of unlimited medical progress, regardless of its potential cost, is in direct conflict with that condition. It has led to ever-increasing health-care costs and ever-higher aspirations for good health.

I offer as a primary example of this threat to equity the rising costs of pharmaceuticals. They are proving to be one of the main contributors to rising health-care costs. That rise is exacerbated by direct advertisements to consumers, by the development of expensive drugs that have only marginal health benefits, and by the argument on the part of pharmaceutical manufacturers that high costs are necessary to provide money to continue high-quality research. The inevitable result, it should now be obvious, is a steady growth in the number of uninsured individuals (traceable, in great part, to rising insurance costs), a steady rise in co-payments for drugs, and the inability of many people to pay for prescribed drugs. The trail to this result leads back, I am convinced, to the high priority given to individual health care and, consequently, the lower place given to health promotion and disease prevention. The research money invested in neonatal intensive care units, for instance, would be better spent (as has long been argued) to improve prenatal care to mothers. The money invested in expensive heart surgery for the elderly might better be invested in programs for the young designed to reduce heart disease, and so on.

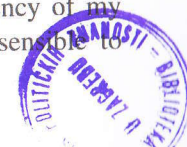
My approach to the goals of health care has been dominated of late by

the idea of developing sustainable medicine and health care (Callahan, 1999). By "sustainable" I mean health care that is economically affordable in the long run and equitably available to all. Our current health care is neither. It is gradually becoming unaffordable, as biomedical progress develops ever more costly treatments, and inequitable, in that rationing is imposed, but imposed on the poor and near-poor, not on those able to buy health care out of their own pockets. When the de facto ideal is unlimited progress and cure is the highest goal, then an ethic of equity is rendered almost impossible. Infinite aspirations cannot be met with finite resources, and the problem is present not only in the United States: The same forces are putting great pressures on the Canadian and western European universal health-care systems to reduce their benefits and to privatize parts of their systems.

The ultimate cause behind these pressures is not, as is commonly assumed, inefficiency (though there is still plenty of that), but instead a set of health-care goals that invites non-sustainability. They are, most notably, the goal of constant, unlimited, and open-ended progress combined with a focus on individual health benefits. Health policy reforms that look only to the mechanisms of policy are bound to fail without a parallel, overlapping reform of the goals of health care. And those goals must be reoriented in the direction of methods to help hold down costs, moderate desires for constant progress, and focus on population rather than individual health.

If sustainable health care were to become a high-priority policy goal, then it might be necessary to qualify the stress I have placed on determining goal priorities by determining the most urgent health care needs for any given historical moment. There are, in fact, two goals that would seem to command a high priority in almost every circumstance—health promotion and disease prevention programs for children and the relief of pain and suffering. The former seems to be required in order to start people out in life with the best possible health prospects, which will have long-term and life-long benefits, and the latter because medicine and health care will always fail at some point to provide cure or relief from illness. It is typically pain and suffering, the palpable symptoms of physical or psychological problems, that bring people to health care; it is the relief of those symptoms that has a prima facie claim upon resources. As with all matters of health care and health policy, then, balance must be sought, and the setting of priorities in the goals of health care will have to balance the claims of the moment against the long-term need for sustainability and the equity that would come with it.

There is obviously plenty of work to be done here and room for many arguments, but I will be satisfied if I have established the cogency of my main convictions. The most important is that it is no longer sensible to



distinguish between the ends and means of health care. If equitable access is an aim of health policy, as it should be, it can only be brought about by devising goals of health care that make such access possible or (more minimally) that do not put obstacles in its way. If the improvement of the health of the population as a whole is the principal policy aim, as it should be, then it is a mistake to allow individual benefit to remain the test of successful policy and for the provision of high-technology, acute care medicine to remain as the highest de facto goal. If, finally, there is to be any hope of weathering the long-range health policy problem of aging societies, then it will be necessary to devise goals of health care for the elderly that are different from those of younger age groups; and then to put in place policies for the young that will help bring them into old age in good health.

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Justice, health, and health policy¹

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Much thinking about ethics and health policy focuses on issues of access to medical services and the special problems created when we must limit access to potentially beneficial services as a result of resource limitations. This narrow focus is the result of many things—the widely held belief that it is medical care, especially new medical technologies, that are primarily responsible for population health, the prominence of health expenditures in the budgets of developed economies, and the enormous demand for medical services created by the medical and health promotion industries. Our goal in this essay is to put other issues on the ethics and health policy agenda and to broaden the perspective of those thinking about health policy in light of increased understanding of the social determinants of health. We argue in what follows for a broad view of ethics and health policy.³

THE NEED FOR A BROAD VIEW

To bring ethics and health policy together, we need a broad view of what justice requires society to do in the promotion of health and the provision of health care. Such a broad view, of course, involves surveying the familiar terrain of medical care at the point of delivery. We must consider how ef-