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Guest Editorial

A Right to What?: Toward Adequate Minimum Standards for Personal Health Services

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THE GOAL OF HIGH-QUALITY HEALTH CARE for all who need it has been elusive. Striving to attain it has been frustrating. Vast resources have been allocated to health care, but they have not yielded satisfying social benefits. We lack alternatives to current public policies that would improve the general level of services without incurring prohibitive costs. Such alternatives might result from a shift in emphasis in discussions of public policy for personal health services. Rather than argue about what should be

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provided as a right, we could set standards for services at a level less than the best but adequate to maintain our notions of a decent society. Instead of seeking political and professional consensus about what health care is ideal, we could work instead for agreement about what services are both tolerable and affordable.

An adequate minimum, as we use the phrase, is a set of services that would be guaranteed to everyone. The services that comprise this minimum standard would be subsidized, in whole or in part, with public funds. Services in addition to those guaranteed as a minimum could be purchased with private funds. If, however, there is ever a publicly-supported adequate minimum level of service, there would surely be considerable pressure to subsidize services above that level. The debate about this additional subsidy would address not only levels of service but also which services should be universal (freely available to all citizens) and which should be particular (available only to individuals afflicted by relative poverty or by categories of disease).

Most public officials and health professionals distrust the concept of an adequate minimum as a focus for public policy. Some do not want to advocate less than the best conceivable services because it would then be easier for people to accommodate to inequity. Others, emphasizing operational issues, find it difficult to describe the content of an adequate minimum set of services—particularly to decide what should be left out.

Without social goals beyond the minimum standard, any floor would be shabby, unstable, and inequitable. The ideal standards articulated in most discussions of rights to care describe what is achievable without regard to limits of resources. The minimum standard, on the other hand, is a guide to the allocation of scarce resources. That is, the minimum standard provides a measurable and immediately achievable way to articulate public commitment. The degree to which public goals are achieved should be measured by criteria derived from *both* minimum and ideal standards.

The important conflict is not between minimum and ideal standards. Rather, it is conflict between *any* standards and the present open-ended situation. Services are now produced mainly in response to the reimbursement policies of third parties. As a result of historical accretion, the play of interest groups, and the lack of alternative public policies, ever-increasing quantities of service at higher costs are produced without careful regard to efficacy.

Current Guarantees: An Intolerable Minimum

What health services are ***guaranteed*** to anyone in the United States at this moment? What do we feel compelled to provide to an individual merely because he or she asks for help? We know that the answer to this question varies: by region, age, sex, sometimes ethnicity, occasionally personal appearance, time of day, and, frequently, luck. But we do not know precisely enough what the variation is, and what it would cost to improve the services regarded as minimum. We need to know the worst the system provides, why it is tolerated, and whether it can be improved, before we can make the concepts of entitlement and rights to care a practical goal of public policy.

By focusing on the minimum obligation to every person, both what it is and what it could become, we identify the ***public*** interest in personal health services. Americans have never equated public and private interest in health services. Most of us expect to purchase more care than public policy guarantees to us. Yet we have gradually come to expect more from the public sector. Although there has never been strong sentiment in this country for removing services entirely from the price system, there has been a gradual increase in the amount of service most Americans believe ought to be guaranteed.

Attention to an adequate minimum should not cause us to abandon the goal of improved health care for everyone. We have a class system now; the important question is how to modify it. There is little risk that the minimum level of service we are prepared to tolerate would become the best that we provide. Professional and technological achievements in combination with private anxieties and resources would raise aspirations. Once a minimum is established, the inequity that remains would be evident. Reasonable long-term goals of public policy would be to both raise the minimum and increase the number of people getting more than the minimum level of services.

Minimum Standards: A Familiar Tool

We have considerable experience with public policies that create minimum standards that improve and are also exceeded by more people over time. Such policies have given us minimum wages and

school-leaving ages. A recent instance is the poverty floor developed in the 1960s on the basis of research and analysis conducted since the turn of the century. The poverty floor was a statement of what was tolerable in politics and to many professionals. Like any other minimum standard, the poverty floor was dependent upon other goods and services society provided. The problem of life on a minimum income would be very different if society provided no schools, libraries, health care, or subsidized housing. Similarly, the problems individuals have coping with the personal health services we currently guarantee would be different without schools, food stamps, fast police cars, and hospital emergency rooms. Moreover, the poverty floor, like other minimum standards, defined adequacy without consulting the people directly affected by public policy. What is tolerable to politicians and professionals is not necessarily what consumers prefer.

The poverty floor was, however, simpler to describe than the adequate minimum level of health care. The poverty floor addressed relative wealth and measurable consumption. In contrast, the minimum level of care would deliberately avoid the controversial tasks of defining adequate health and listing covered benefits. The worst income we will tolerate can be described in four digits, plus allowances for dependents, and compared to other people's incomes. The worst health care we would tolerate, however, can be described at present only as general entitlement to services and compared only imprecisely with the care received by more fortunate people.

Because of our experience with floors for poverty and education, the phrase, "adequate minimum health services," has different meanings for different people. For some, the floor is a fiscal issue, a way to assign and limit costs. Others see it as a strategy to guide the allocation of services; to ration and redistribute scarce resources. Still others want a publicly-guaranteed minimum as a standard to measure the effectiveness of the health system. In addition, a floor would be a useful tool to describe and evaluate changes in services and their utilization over time.

Attributes of a Minimum Standard

A minimum merely defines the least that is guaranteed to everyone. It does not prescribe what people ought to have, or how they should

get it. Rather, the minimum describes the least that will meet the public obligation.

A minimum standard of services must meet a variety of tests of adequacy. Such a standard must meet *both* the public's aspirations for care and health professionals' tests of efficacy. Moreover, tests of adequacy must also address the health of populations and the behavior of systems. All this is much easier said than done.

Indicators that describe adequacy from various points of view are commonly used for educational services. High schools, for example, are judged by the incidence and prevalence of such conditions as college-going and dropping out, by athletic and musical achievement, and by criminal offenses among their students. The effectiveness of colleges is measured by, among other things, the performance of students on standardized tests, their admission to professional schools and occupations, and by their lifetime earnings. Similarly, a hospital can no more be described satisfactorily by its size, equipment, and staff than can a high school by the size of its gym or the teacher-to-student ratio, or a university faculty by the number of its research grants or the average number of hours in a teaching load. Minimum standards that permit the satisfactory measurement of performance would be essential to sound policy.

Standards must address more than access to services. The success of public policy to reduce barriers to care in the last decade precipitated much of the current controversy about the amount of national income absorbed by the health sector. However, we never made an explicit social policy about the level of services to which access would be guaranteed. When the amount of public expenditure for health services became politically intolerable, services were eliminated or eligibility requirements were raised. Instead of setting standards, describing the worst we would accept and accommodating to it temporarily, we excluded people from services in a haphazard way that varied widely for different parts of the country.

Public policy for an adequate minimum level of health services has several guiding premises. The first premise is that if governments define the humblest entitlement the public interest will support, the power of private purses would permit the expression of a wide variety of personal preferences. Moreover, a floor would provide the psychological and economic security that would encourage people to press for higher standards. A final premise is that in the past minimum standards have risen over time. Changes in society and the

economy will most likely force the standard of health services upward in the same uneven but steady way that poverty and educational standards have risen over the past half century. Moreover, the expression of private preferences may stimulate the minimum standard to rise, just as the poverty level has been pressed upward by consumer aspirations.

An Adequate Minimum as an Interim Goal

The policies that would create and monitor an adequate minimum level of personal health services should be described and advocated as a social goal. Americans should have a right, not to such vague benefits as "health" or "health care," but to guaranteed services that are available without regard to private means.

The concept of an adequate minimum standard makes heavy demands on policy-makers. It should be a public obligation to guarantee the availability of adequate services. Once this level of services is guaranteed, it would be logical to then ask what more is achievable. We believe that an ideal level of services for any American except the wealthiest can only be achieved *after* there is a guaranteed adequate minimum for everyone.

Finally, it is fanciful to set public standards for health status until there are publicly-accepted standards and subsidies for health services. Although services are only partially responsible for health status, they will continue to be the central concern of most consumers, professionals, and public officials.

The research community can help to define the minimum level of services, and once minimum standards become public policy, measure their effects. Only the political community can remove the stigma attached to the concept of a floor, however, by transforming it into a decent and equitable standard.

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