STRATEGIC HEALTH POLICY INTERNATIONAL

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Questions About Covenants in Health Care Today

When I speak about covenants in health care, audiences have questions. For me, this is the best part. I like engaging with others to explore the ideas. Each one has challenged my thinking about the topic.

Why address international issues? Aren't our own issues compelling enough?

I get this question often. Initially, I focused only on issues we faced in the U.S. Then, our national consciousness changed when the World Trade Center towers fell to the ground.

I believe it important to deal with the global issues and problems of the developing world for two reasons. First, we need to place our own problems, opportunities, and assets in a broader perspective. Second, which is even more important, I want to drive home an important point—that we, here in the U.S., may live in privilege, but we do not live in isolation.

Addressing infectious diseases makes that point most clearly. The chapter on drug donations calls for an evaluation of the values we hold as human beings and as Americans, whose wealth relative to the rest of the world gives us the ability to help others. Considering clinical trials alerts us to the problems of victimizing research subjects—too often for our benefit. Helping others in dire need allows us to reconnect with our humanity and the importance of compassion. Helping those around the world sensitizes us to the needs of the poor at home.

Lending our assistance and donating our technologies to those abroad satisfies the needs I believe we all have to view healing as a gift to be shared, not a commodity to be bargained. In our sharing, we will realize our prosperity. It is an inroad to creating global health, peace, and prosperity. To help is not just good will, it is good health, good business, good policy, and good politics. It is good for world peace. It is good for global prosperity.

Finally, I fear that health policy in the U.S. today is in danger of devolving into tactical elements of program operations, capitated lives and budget requirements. The health care enterprise is much more complex, multifaceted, demanding, and global than the current and most pressing concerns of an annual budget battle. Unless we address these longer-term and more global issues today, the problems brewing outside our borders will become domestic crises, and we will be unprepared to address them.

Why aren't there more prescriptions and specific directions?

By definition, only the parties to the covenant can work out the specifics. I've been about as specific as I can in what I've written and in what I talk about. I've outlined who the parties to various covenants might be and have pointed them in a direction. Only they can determine if they want to walk the path. Once underway, they'll decide how fast to progress and whether to detour from the route. Taking the first steps will not be easy, but the next steps will be even harder and no observer can second-guess the results.

It is along the way in the covenant relationship that the toughest questions must be addressed. These are the questions that we have avoided so well in the past several decades. They are questions of reciprocity and responsibility: If a patient can sue insurers or managed care providers for failure to provide care (e.g., experimental therapies not covered by contract), can insurers or managed care sue patients for failure to follow medical advice? If patients do not take their medicines or change their lifestyles, should insurers or managed care be responsible for covering the cost of the more expensive diseases that will result? If employers cover the cost of a flu shot, can they deny sick leave to employees who choose not to be immunized but then get the flu? If the nation allows its citizens to carry guns, can insurers levy a surcharge for the likelihood of higher emergency room costs in areas of high gun ownership? In other areas of our lives we pay—financially—for the consequences of our choices. If we change an airline ticket, arrive late to get our children from daycare, check-out of hotels early, or fail to show up for restaurant reservations, we incur financial penalties. Should it be any different in health care?

Talking about covenants is easy. Living covenants is not. At this point, if all I can do is to define the shape of the table at which all the relevant parties to a covenant can sit, and propose a paradigm and a vocabulary for the first discussion. That may be enough for now. To do more at this time would be to prematurely suppose an outcome that only a covenant can determine. Worse, it might even frighten some people away.

Why so many questions and so few answers?

Few health care problems and policy issues have clear answers or easy resolutions, and I can't imagine that the next several decades will be any easier for any of us—healers, patients, or communities. Today's health policy, which is so dominated by the economics of care, could benefit from an infusion of new ideas to frame our analyses. This is an offering of that type. I wanted to bring a new perspective, some structure for analysis, a vocabulary for negotiations, and some tools to help.

Health care could also benefit from an infusion of new questions. It is not only the answers to questions that are important, but the questions themselves. Some say, in fact, that the right question is more important than the right answer. Ancient wisdom says we can afford to be inefficient if we are working on the right question. Stephen Covey's work on effectiveness is built, in part, on a similar notion: that it is of little value to focus on how fast one can climb a ladder, if that ladder is leaning against the wrong tree.

I applaud everyone in health care, e-commerce, and telecommunications working to create efficiencies. Their work deserves support, encouragement, and reward. Squeezing the cents from the dollars is a good thing. Squeezing the soul from the system of care is not. I'll continue to pose the questions that get to the soul of healing.

Will health care in the future be consumer-centric? Is covenant-centric going against the tide?

First of all, I'd like to get past calling patients "consumers." Doing so might well help us improve the "friendliness" of our services, but patients are not just consumers, they are more than that, since healing relationships are covenantal and therefore sacred. The terms are problematic here, and I struggle with what to call patients because "patient" did not seem right either. "Patient" does not account for the healthy person before their illness struck, before their encounter with our health care system, caring for themselves. People? Individuals? Persons? Consumers? I gave up and returned to "patient".

That being said, yes, I believe health care of the near future will be consumer-centric, but I hope it does not end there. Consumer-centrism is most likely a phase of our development and it may be a healthy transition away from "any-color-as-long-as-it's-black" delivery of health care. I hope that it will only be a phase and that we transition beyond it. Health care will benefit from consumers with the incentive to care for their health and the personal skills to do so. Healers and communities can and should help them do that, and doing so may be the most important covenant-focused activity that healers and communities can fulfill in the near future. Healers and communities should avoid strengthening the dependencies that have been created over the past 50 years in this country, however. A consumer-centric attitude should transition towards interdependence among consumers, communities, and healers. If health care of the future is only consumer centered, lacking in covenants of obligation among the parties involved, the many challenges we face now will become serious problems, and the many opportunities before us today to solve problems won't be realized.

Why all the emphasis on spirituality? Are you advocating more of it within health care?

This book did not start out to be a discussion of spirituality in health care. I stumbled into them during the course of my research. No one could have been more surprised to see the wealth of information available and the ties between healing and spirituality—right down to the root of the words that we use. After some thought, I had to admit it: health and disease are still mysteries, still fraught with powerful and unknown forces that we, as patients, want controlled for our benefit. Being modern and scientific has not changed that. Even modern genomics and high-science medicine has not eliminated the mystery of disease and death. If anything, it is all the more mysterious and frightening, and hence, all the more a subject we should discuss openly.

I am not at all opposed to today's standard medical practices and have been the beneficiary of some of the best this nation has to offer. It is not this book that is out of balance in addressing spiritual issues in a policy context, however. In my view, the current practice of health policy and medicine is out of balance with what patients expect. After thousands of generations of linking healing and spirituality, I am convinced that it is so in-bred that we take it

for granted. We may not ask for it, but it is something we want. Deny it to us and we'll feel it missing.

The fundamental underpinning of a covenant is a sacred relationship. As patients and as healers we want it within our healing enterprises. I hope that this work will encourage us to reinvigorate the language and the practice of covenants. I also hope that we'll decide it's worth paying for—which, in my opinion, it is.

How can you expect that we can do what you advocate when all of our policy discussions are political debates? How can we get Congress involved?

We should talk to each other, not to Congress, about what ails us in health care. It is my observation that we turn to Congress reluctantly, and in anger, when the relationship between us breaks down, and we want the Congress to impose controls to fix the "other guy." I was in the audience at one of the farewell addresses of Congressman Barber Conable, at his departure to head the World Bank. "Do not expect us to lead," he announced. "We were elected to represent, not to lead. In that regard, we will have to be dragged kicking and screaming into any issue we deal with." Reluctant congressmen, dragged into issues after years of local constituent anger and hostility, are not in the best frame of mind for crafting a health care future. Perhaps if we talked to each other, we could sort out our needs, our wants, and our differences of opinion. This means that every encounter, every phone call, and every e-mail becomes an opportunity to deal with someone else in the covenant. Take those opportunities. In those instances where Congress is already involved, let's at least advise them to avoid rash solutions and eleventh-hour compromises that please no one. Doing the first will take our time; doing the latter will require our restraint. Doing both is absolutely essential.

Everyone else is addressing trends from another perspective. They say the reason we are in crisis is demographics, costs, or greed. Why are you taking such a different tack?

Yes, my approach is different, and it focuses on the nature of the relationships we have with each other as we approach health and healing. I think we've made several mistakes. First, we forgot that patients were also citizens and had recourse to their governments for relief when they did not like the care they received. We let them approach government for solutions, while we in health care paid too little attention to government as it emerged as a potent force in national health care planning, management, and payment. With government investment came government micromanagement.

Second, we allowed contracts to replace the traditional covenants. Doing so, we not only abandoned democracy, we abandoned covenants.

Third, we allowed the nation to develop an antipathy to profit within the health care sector. This was very foolish. We are an otherwise capitalist culture and we need investors willing to risk their capital to improve heath knowledge and systems—and young people willing to incur hefty six-figure debt to complete medical and post-doctoral training.

Fourth, we failed to understand the inter-relatedness of health and disease across national borders. We did not recognize that diseases from other parts of the world—intentionally or accidentally—could arrive in our land, and that the resources we had developed to safeguard our own health should be used to protect ourselves by protecting others as well.

Focusing on covenants dos not minimize the contributions of other health policy analysts, I just see our problems, and the roadmap to their solutions, in a slightly different way. We need their perspectives and analyses to address the dilemmas we face today. Neither of these approaches—the traditional or the covenant—is sufficient; both are necessary.

How can covenants help the uninsured in this country? Aren't doctors and managed care just shirking their responsibilities to make care available to them?

This is my favorite question. It may be my next book. It is such an immense topic that it deserves a book, or several! Some of the best minds in the country are struggling with this issue, and they have my respect. I hope they are prepared to fail, because, in my view, the current paradigm of health care financing provides them with few opportunities for success. Today's policy and political leaders—along with healers, employers, and health plans—are confronting the challenge of retrofitting new, escalating, unrelenting demands into old laws, regulations, and systems. It's a tight fit for a swelling foot in a worn-out shoe. The employer-based and tax-funded insurance systems have matured into no-fault financing systems precisely at the time when employment patterns changed, science produced cures, and consumers aged and emerged as politically savvy, demanding change agents. My friends in the health care financing battles will make incremental changes, but they will not have the wherewithal for true reform unless the underlying relationships among the parties to the covenant engage each other first in the ways I have proposed.

In the meantime, it is my view that the healers in this country are already doing their part by providing a substantial amount of care to the uninsured. Whether they are physicians, nurses, institutions, or pharmaceutical companies, their products and services are available for free and at reduced charges for those who cannot afford them. Even those healers who work in medical advertising provide free services. They develop and air public health service messages. Providing care for those who cannot afford it is within the covenants that shape healing practices and, in my view, healers have done their part within the covenant.

It is time now to address similar covenant-focused questions to patients and communities. Should patients who can afford coverage but decline to get it be required to do so? Automobile insurance is required in most states; should health care be required as well? Can patients who engage in high-risk lifestyles that drive up costs be required to change their behaviors? For example, should high-calorie, high-fat processed foods be taxed like cigarettes are taxed and for the same purpose—to reduce consumption, to fund health messages, and perhaps to fund health care that treats diseases associated with obesity? Should those who demand cost-increasing health care mandates be required to find funding sources in some other pocket than their own? Legislating that our healers provide care to Medicare and Medicaid patients at lower rates and without patient subsidies is driving some healers away from treating government-funded patients

altogether. Is this what we want? All-or-nothing care? Should every new mandate that increases the cost of coverage be matched with a patient- or community-focused responsibility that will create savings in some other part of the employer or managed care budget?

It seems to me that the uninsured challenge us with questions about what we value in this country, how health care stacks up in that value equation, and what kind of responsibility we feel to ourselves and to others as a result. It is clear to me that we value health and health care, and well we should. I have seen health care systems on five other continents, and this one (even at its worst) is by far the best. We value health and health care above many other things in our lives, and we want everyone to enjoy its benefits as well. We value it so highly that we believe cost should never be a barrier to receiving care. When cost is a barrier, we believe that health care should be free—a gift, if you will. This is not a new idea. Health and healing have always been a gift, from the deity, as the early chapters in this book describe. Our attitudes are no different than those of our ancestors; our behaviors, however, are different. Inherent in the gift-giving of a covenant tradition is the proscription to be a giver as well as a receiver. In the ancient tradition, the Israelites received gifts as a part of their covenant and were then enjoined to preserve their own health, protect the health of others, and give to others in recognition of what they had received. Therein lies a message for all of us today.

I may sound like a broken record here, but caring for the uninsured is a responsibility of the patient, the healer, and the community. Patients should do their part through healthy lifestyles, practicing prevention, and securing coverage when it is offered to them. Healers should do their part in providing free and reduced-price care. Communities should do their part by supporting free and reduced-price clinics, whether through tax dollars or philanthropy.

What I fear most today, in our political climate, is that communities will band together and use legislation or regulation to set prices, require free care, and shift the patient's and community's responsibility for financing even more of the care to the healers. If the community wants all of its members to receive care, the community should be willing to step forward and pay for it, not legislate healers to do it for them. Medi-Cal, on behalf of taxpayers, pays a physician $43.25 to fix a broken arm, while veterinarians in the state get $500-$800 for repairing a dog's broken leg. It seems to me that's a misplacement of payment priorities.

Isn't "concierge" or "boutique" medicine a clear violation of the healing covenant?

"Concierge" or "boutique" medicine is a term used to describe an emerging clinical practice model. In these physician practices, patients pay much higher fees—ranging from $4,000 to $20,000—to physicians, who care for far fewer patients and are therefore able to provide a higher level of service. Patients get access to cell phone numbers, have home visits and examinations, are accompanied on visits to specialists, and are offered other amenities. In other segments of the economy, there is nothing usual about paying more for a higher quality of service or for more personal care. In health care, however, this type of service has been criticized as contributing to two-tier medicine in a nation that abhors class distinction. The phenomenon has been described variously as a response to market forces, as physician greed, and as the

natural outgrowth of clinician dissatisfaction with the constraints of practicing under managed care and government-restricted payment schemes.

Concierge, or boutique, medicine is not a violation of the healing covenant. Covenants, after all, are created by the parties involved. In typical style, the "senior" party—the physician—is offering this relationship to the "junior" party—the patient, specifying the nature of the care and the cost of that care. It is not clear from press reports of these practices if the covenant reflects a true obligation on the part of patients at all, or if it is merely additional services of the grant-type of covenants I have outlined in this book. For example, if the physician uses the additional fees as an excuse to create even greater dependencies, then neither the patient nor the healing relationship will mature. If, on the other hand, the physician educates and empowers patients to make better decisions on a day-to-day basis and creates interdependencies, then a truly mature healing relationship can evolve. That will be good for the healer as well as for the patient. Healthier patients will be more productive employees. It's hard to argue against something that is so good for so many people, including those who are not funding the higher level of care. The real objection, it seems to me, stems from those who want similar service but are unwilling to pay for it. Their objections are not persuasive to me.

Do people have a right to health care?

I get this question after nearly every presentation, probably because the notion of "rights" is promoted in health care reform proposals today. To begin, I'll distinguish between "healing" and "health care" because those terms are often used interchangeably when this question is posed. "Healing" is what we seek when we see a physician, take a drug, or enter a surgical suite. Will we get "healing?" Perhaps. Is it our right to have it? No. That's a strong statement, but I can find no historical or covenant rationale for saying "yes." In fact, "healing" is a gift and, as such, must be freely given by the giver; it cannot be legislated as a "right." The giver cannot be forced into giving, and particularly in the case of healing, with its tradition of emanation from the divine.

Physicians, surgeons, and pharmaceutical companies in a covenant model are aligned with healing forces beyond themselves and are frequently operating within the many mysteries of life—in fact, within the greatest mysteries of life and death. To assume that even with modern science they can vanquish still-unknown sources with regularity is naïve. When we do not secure the healing we want we sometimes believe that it is because our healers have withheld their technology or skill from us, and we claim our right to more. We believe so strongly that healing is our right, we will go to a great extent to get more access to health care in order to get it, including through litigation.

What about "health care?" Is "health care" a right? Is receiving any or all of the health care that we want—or even need—a right? Again, I can find no justification for that.

Historically, it was the king or the employer who recognized that a healthy workforce was a productive workforce, and so provided health care for the economic benefits that would result. In today's health care system, with large and growing numbers of uninsured and

underinsured this is an increasingly important question, particularly as we shift the responsibility for funding care to providers. In my view the best way to answer a question is with a statement and another question: Whether health care is a right is a question we can all answer. For me, yes, it is a right. In order to secure it, as an employer, I provide insurance for my employees; as an individual, I manage the insurance benefit wisely; as a taxpayer, I contribute to the federal and state programs that fund care; and as a philanthropist, I provide additional funds for programs that care for the needy. Are you willing to do the same? If so, then by your own actions you, too, demonstrate in the best possible ways that health care is a right.