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INTRODUCTION

As the United States debates whether and how to install a national health care system with universal access, it becomes even more important now than in the past to control costs. Some commentators have proposed that overt rationing is too demoralizing to cherished values, that it demeans the preciousness of each individual for the sake of saving money and attending to other projects. The Oregon legislature, however, has rejected such reasoning with its program to expand Medicaid eligibility while using an explicit priority system to ensure, not only that expenditures do not grow out of control, but also that money is spent as wisely as possible.

The Oregon Health Plan has come in for both criticism and defense in a rapidly growing literature on Oregon's approach, a literature we need not cite here but which is well-covered by the papers that follow. We begin this special issue with an essay by Paige R. Sipes-Metzler, Executive Director of the Oregon Health Services Commission. Sipes-Metzler, whose agency was charged with the development and now implementation of the Oregon Plan, provides readers with an overview of its tortuous origins and its current state as of the date of implementation of the Plan, February 1, 1994. Sipes-Metzler also responds to some of the criticism directed at the Plan, and anticipates some of the additional critiques to be found in other essays in this issue.

Mark A. Hall raises a number of questions about rule-based rationing – a form of rationing he finds implemented in the Oregon approach. He argues that rules are too imprecise to resolve the highly individualized complexities of specific health care situations, and grapple with the intricacies of modern medical science. He urges an internalizing of cost constraints by health care providers as a better way to deal with the cost-containment problem. One difficulty noted by Hall is the classic public

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aversion to explicit rational analysis of "tragic choices," an issue already mentioned above, introduced into the literature by Calabrese and Bobbit. This concern is a theme that appears in several of our papers in this issue, and is one of the foci of the following essay by James Nelson.

Nelson asks why the "grassroots turn," as exemplified in the discussion in Oregon leading up to the Health Plan's condition-treatment pair rankings, seems so attractive. Part of the answer, he believes, is that there is no theory of just rationing available. At the same time, a type(s) of procedure consensus seems to be emerging that may offer a means of outflanking this theoretical impasse. In his reflection on the value of an explicit public debate about health care rationing, however, Nelson cautions us to take the Calabrese-Bobbit position seriously, though critically. (In his criticism of the Calabrese-Bobbit position Nelson cites some of the earlier work of another one of the authors in this issue, Leonard Fleck.) Nelson's conclusion is that rationing is inevitable, and that more attention needs to be paid to the articulation of a theoretically based approach in terms of which we might deal more adequately with these deep and contentious problems.

Actually enacting rationing under such an egalitarian system, however, may be more challenging than it first appears. Lars Hansson, Ole Frithjof Norheim, and Knut Ruyter point out that in Norway, a nation committed to just such a single health care system binding all citizens, it has been difficult to draw the limits essential to containing the costs of an ever-advancing sophistication of medical care. Oregon's system is attractive insofar as it seeks to ensure good basic care while drawing clear limits. Certain problems, however, need to be remedied. It does not account for severity of illness, a factor that is not taken into account simply by looking at the costs and effectiveness of various treatments for various maladies. Further, by focusing on only 709 illness or injury conditions, the Oregon system ignores variations among individuals with each treatment/condition pair. Hansson, Norheim, and Ruyter propose amendments that might mitigate these problems.

In support of Oregon's basic concept, Leonard Fleck argues that rationing is utterly unavoidable, and that explicit priorities and resource restrictions created by public participation are far preferable to covert mechanisms. A philosophically defensible, politically realistic approach to rationing would have us collectively create a priority system binding upon all of us. Where everyone

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equally must abide by prospectively established limits, we may find that the consequences of rationing are unfortunate, but they will not be unfair.

In the final analysis, this issue of The *Journal of Medicine and Philosophy* is only partly about the Oregon Plan. No matter by what mechanism we universalize health care access, the United States must address the nigh-well impossible question of how to limit our expenditures. And this, in turn, requires us all to face the Oregonians' question whether such limits should be drawn publicly and explicitly, or whether they are best left to the more quiet informality of the clinical setting.

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