



FROM BIRTH TO DEATH AND BENCH TO CLINIC

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CHAPTER 18

Health Care Reform

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health care reform

by Norman Daniels and Marc Roberts

Framing the Issue

Health care reform is on voter's minds and back on the national agenda with good reason. Since health care reform efforts failed during the first Clinton administration, the number of uninsured in the United States has surged nearly 50% from 33 million (roughly the population of Canada) to 47 million (roughly the population of Korea). In the same period employers responded to continued inflationary pressures with efforts to restrain health care costs through "managed care" and by shopping for lower cost insurance options. This slowed the rate of cost increase for a few years in the early mid-1990s but did little to deal with the underlying problems. Predictably, high rates of cost increase resumed and continue today.

Not only are U.S. costs increasing, but they are also well above that of any other industrialized country. These costs in turn impose a burden on all segments of society—the individuals who pay taxes and premiums, the governments whose budgets are strained by Medicare and Medicaid, and the businesses whose competitiveness is undermined by high health insurance rates.

The high cost of the U.S. system reflects a variety of factors: very high administrative costs due to our competitive and uncoordinated insurance system, fancy and duplicative physical facilities designed to attract patients, and very aggressive treatment patterns—including the use of expensive high technology—that are a response to the way we pay doctors and hospitals. Recent studies suggest all this is coupled with high rates of medical error and inappropriate treatment decisions, especially in the direction of doing too much rather than too little. Furthermore, the fact that many lack insurance means they do not have access to routine outpatient care and thus wind up in hospital emergency rooms when their conditions worsen. Getting the uninsured routine outpatient care within a universal coverage system might lower system costs once we correct the backlog of untreated conditions. Given documented increases in economic inequality in this country, we are likely to be entering a period of mounting health inequalities.

The result of all this is widespread distress, ranging from corporate frustration over ever-rising costs, union concerns over threats to member benefits, and an increasing number of middle class citizens who find themselves without coverage as business responds to cost pressures by trying to avoid providing insurance

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HIGHLIGHTS

- Reforming the American health care system is a leading issue for voters.
- There is widespread distress about the state of the American health care system that crosses political affiliations and ranges from corporate concern over costs to union concern over benefits. It increasingly affects the middle class, which makes up a growing percentage of the uninsured.
- Health care reform cannot proceed on the basis of economic, political, and clinical concerns alone, but must engage crucial values issues.
- Among the values invoked in remaking the nation's health care system are access, financing, cost containment, and allocation of care, as well as health disparities that require remedies beyond what the health care system can provide.
- Strong support for a universal coverage system comes from a range of widely held views in bioethics, including those focused on rights and fairness and those concerned with consequences.
- Much of the current debate is not between advocates of a totally free market and proponents of a state-run system, but instead focuses on how much of a role the market should be allowed to play in the health care system.

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to employees. With a recession—or a clear threat of one—on hand, many fear a further loss of coverage. Moreover, state experiments at introducing universal coverage have encountered problems of cost and sustainability. In Massachusetts, higher than anticipated enrollments in state-subsidized insurance plans have led the state to seek \$150 million in added revenue, to the point that its legislature is considering a \$1 a pack increase in the cigarette tax. In California, reform efforts have floundered, in part due the same issues. No wonder so many citizens tell pollsters that health care is now an issue of major concern.

Bioethics and Value Choices in Reform

Health care reform is clearly in order, but it cannot proceed on the basis of economic, political, and clinical concerns alone. Crucial values issues underlie all aspects of health care reform. As outlined below, these values are key to answering fundamental questions underlying reform, such as:

- Is unequal access to care unjust, or is it an acceptable consequence of relying on private insurance?
- Who is obliged to pay for care, and how should these costs be distributed?
- What kinds of care are owed to people? How safe must they be?
- Who has the moral authority to make such decisions?
- What is the role of individual choice?

Access. The United States is the only wealthy country that lacks universal access to health care. Yet nearly all Americans believe no one should go without care because of inability to pay, and a significant majority believes we should have some form of universal insurance coverage. Indeed, those without insurance are provided over \$35 billion in medical services each year through various kinds of tax support and cross-subsidy schemes. However this care is generally “too little, too late,” as Institute of Medicine studies emphasize, leading to higher morbidity and mortality and to serious negative effects for families, communities, and society as a whole.

Many ethical views—both those focused on rights and fairness and those concerned with consequences—support universal health insurance. Health is an obviously important aspect of opportunity. And if protecting opportunity is a social obli-

gation, as many Americans insist and various theories of justice claim, then one can make a strong argument for including universal coverage as part of that obligation. Similarly, if treating people with equal respect is a fundamental requirement of ethics, as many believe, the denial of medical care to some in need, while others have access to it, clearly violates that principle.

Those who think the right thing to do is to produce the best consequences can plausibly argue that universal coverage promotes a healthier population and does so more efficiently than our system does now. Another important consequence of a universal insurance system is that it efficiently provides the public good of financial risk protection by protecting people from the poverty that results when families try to meet the medical care needs of loved ones out of pocket. Such a public good cannot be created by a market for insurance alone.

The argument that we should, nonetheless, let the free market determine access to health care is in direct conflict with these converging ethical views and is unpersuasive. First, on the basis of consequences, the U.S. system is simply not very attractive. There is no reason to rely on markets alone when they lead to poor outcomes. In truth, almost all market advocates recognize the possibility of “market failure” and accept that it is justifiable for governments to intervene to modify markets to achieve important social goals. Much of the current debate is not between advocates of a totally free market and proponents of a totally state-run system. Instead, the issue is exactly how much of a role the market should be allowed to play, and with what constraints. In particular, do we guarantee risk-sharing between sick and well and redistribution between rich and poor—both of which some market-oriented schemes, like health savings accounts, would substantially undermine—and if so, how? Of course, any particular universal system might be open to objections on the grounds that it undermines efficiency or quality or inappropriately limits patient or provider choice. But these are not objections to universal coverage in principle and instead lead to the need to examine in detail the likely results of any specific proposal.

A more extreme libertarian view than this general appeal to free markets holds that the property rights of individuals and the basic liberty of free exchange cannot be overridden by tax schemes aimed at achieving the protection of opportunity, equality of respect, or even social welfare. Such a

view is made less persuasive by the fact that it would make almost all modern government impossible! Arguably, it not only misconstrues the more qualified nature of property rights, but it also distorts what some seminal libertarians, like Gilbert Hyack, actually claimed.

Financing. To be ethically justifiable, an employer-based coverage system financed by premiums, such as the United States has, would have to improve access, efficiency, or some other value, such as choice. But our current system creates serious performance problems in all these dimensions, especially with regard to access. Even if all employers were required to provide coverage, it would be difficult to avoid gaps for those who are unemployed or who move. Further, employment-based systems lock workers into jobs they would rather leave, since they fear portability problems and inequalities in coverage across jobs. This makes labor markets less efficient and restricts opportunities for all. Nor is there any evidence to support the claim that the U.S. system of competing private insurance plans provides efficient or cost effective care—not in a system where between 30% and 40% of all expenditures go to administrative costs, and life expectancies are well below those of most European countries, whose spending levels are all significantly lower.

Different types of payment for health care are redistributive in different degrees and ways, and thus raise important questions of equity.

- Systems that rely heavily on out-of-pocket payments, including deductibles and co-pays, are least acceptable on equity grounds. Such payment schemes involve less risk-sharing between the well and the ill and none between income groups. Indeed the rich can wind up spending less since they tend to need health care less.
- A premium-based system like the United States has fosters some risk-sharing between the well and the sick, especially if schemes are “community rated” rather than “experience rated,” so that all in an area pay the same rate. However, this practice is steadily less prevalent in the United States as companies seek to limit their own costs. Actuarial fairness—premiums that reflect the risks of a particular narrow group—is not overall fairness if we believe that all citizens have broader social obligations.
- Payroll taxes, like those that finance Medicare

ETHICAL HEALTH CARE REFORM ON THE CAMPAIGN TRAIL

A universal coverage system is strongly supported by a range of widely held views in bioethics. If properly designed, such a system could avoid many of the problems we face in our current system, and not just its failure to cover all. Unfortunately, the proposals before us, even where they call for universal coverage, fall short of addressing the most serious flaws in our system. An ethically sound proposal would need to:

- Alter the employer-based organization and financing of much of our system
- Address the problem of how decisions should be made about benefits within the system
- Address the many sources of health inequalities in our population
- Improve the equity of financing within the system as a whole
- Improve the quality of care and safety within the system in ways that go beyond the appropriate calls for improved information technology

These requirements do not make a movement toward universal coverage unimportant. But they do emphasize that even if universal coverage is achieved in the next administration, many ethically important issues will remain unresolved.

and Social Security, are more progressive than insurance premiums because people pay proportionally to their earnings (at least up to any income ceiling).

- In many countries general tax revenues are more progressive still—in so far as they rely on income taxes which charge rates that increase as one earns more.

The more progressive the financing stream, the more the burdens of meeting social obligations are put on those who can best bear them. Most European systems are thus more equitable than the U.S. system, which has proportionally more out-of-pocket payments, more private insurance funded by premiums, and less health care financed by payroll or general tax revenues. Indeed, without some important component of ability-to-pay financing, no universal system will be possible, since America's poor are too poor to pay for their own care, and even the near poor will require a subsidy from the rest of us to afford what many would consider morally acceptable levels of coverage.

Cost containment. Since the late 1970s, some

RESOURCES

Web sites

- www.commonwealthfund.org – the Commonwealth Fund. Includes policy updates, charts and statistics, surveys, publications, and an RSS feed.
- www.kff.org – the Henry J. Kaiser Family Foundation. Includes a newsroom, fact sheets, charts and data, surveys, issue briefs, reports and studies, and interactive tools.
- www.allhealth.org –Alliance for Health Reform

Recent news

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- Laura Meckler, “Parties’ Split Most Apparent on Health Care,” *Wall Street Journal*, April 19, 2008.
- Paul O’Neill, “A Health Care Bargain,” *New York Times*, October 16, 2007.
- “The Battle over Health Care” (editorial), *New York Times*, September 23, 2007.
- Steven Pearlstein, “Health Care Reform Needs Holistic Approach,” *Washington Post*, June 6, 2007.
- David S. Broder, “A Route to Better Health Care,”

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have argued that we could not provide universal coverage until we learned how to contain health care costs. Many American efforts at cost containment have implicitly involved “social experiments” that have not been subject to evidence-based or ethical review. In the 1990s many people worried that capitated reimbursement schemes gave clinicians untested incentives to undertreat patients, and the evidence for adopted practices was missing. Currently, advocates of consumer-driven health plans argue that the “felt price” and “increased choice” given to enrollees will lead to lower health care costs and wiser purchases. Here, too, there is little evidence to support these claims, while there is evidence that such schemes are risky for poorer, sicker enrollees.

Proponents of universal coverage contend that a properly designed universal coverage system would obtain efficiencies that could better control costs. Such a system could include the constraints provided by a global budget—one that covers all, or most, health expenditures in the country. There are also potential gains from the concentration of purchaser power to counter the power of providers, better integration of information systems, better dissemination of disease management strategies, and more rational dissemination of technologies.

Contrary to what some think, cost containment is an ethical concern because our current system wastes a great deal, overtreats many people, and swallows up expenditures with very high unit costs for services. If we get better value for health care dollars, we can use our resources to meet more health needs (or other important social goals). So American inefficiency is of ethical concern and not merely a technical policy question. It is ethically important to dispel the myth that the U.S. system is superior to other systems. The outstanding clinical care we offer for the well insured and the well connected does not make the U.S. system superior overall. Any politically acceptable reform to the American health care system will no doubt have to allow for some variations in coverage and perhaps service levels. “Equity” in the American context is perhaps best understood as getting everyone to some acceptable minimum (so-called absolute equity) rather than insisting that everyone have exactly the same opportunity (so-called relative equity).

Deciding on benefits. Reform proposals are often silent on what exactly will be covered and who will make these decisions. Serious ethical issues surround both of these topics. Substantively, the question of whether to cover new and expensive treatments will inevitably arise, especially if

less expensive alternatives are available. We can also anticipate debates about whether certain procedures involve the guarantee of basic opportunity rights (in vitro fertilization, cosmetic surgery, or sex reassignment surgery). General moral arguments are not always easy to translate into the complex specifics of individual patient circumstances, and reasonable people do not always agree on their principles enough to resolve their disputes about coverage.

These substantive ambiguities make the procedures by which benefits decisions are made all that more important. In particular, who is included in the decision-making process, and what methodologies or tools are used in making these decisions? Are they transparent, so that people understand how and why the limits they impose were chosen? A common feature of most proposals for reform in the United States is that little or no attention is paid to questions about how the benefit package will be modified over time (for example, to deal with new and often expensive treatments). We believe it is a

central bioethical concern to focus on the ways in which such decisions can be made accountable to those affected by them.

Health disparities. Access to care is an important determinant of population health equity, but universal coverage is not a cure-all for that problem. We know that significant class and ethnic inequalities persist in universal systems. This does not mean it is unimportant or useless to eliminate inequalities in access to care. Rather it means we must also address the other determinants of health disparities, including inequalities in education, income, job opportunities, and effective political participation. In addition, other factors play a role, including residential segregation and social problems such as drug abuse, domestic violence, and other forms of violence. Unless we work both inside and outside the health sector to address the maldistribution of resources and opportunities that produce health inequalities, we can expect that substantial inequalities in indicators like life expectancy and infant mortality will persist. 🌳