

Nothing is to be preferred before justice.

—Socrates

Justice and Fairness

Mandating Universal Participation

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Convictions about justice are a deep and persistent force in health care. It seems distinctly unjust and unfair, for example, that one victim of a disease dies or is permanently impaired and financially devastated, while another with the same disease is readily cured and lives financially unscarred.

Yet convictions about what is unjust do not necessarily steer us quickly toward universal access to basic care. Beyond political and economic self-interest, conflicts between justice and allegedly competing values like liberty may intrude. Also, there are different senses of justice itself, varying widely across the moral and political spectrum. Those who think it unjust that one person can be ruined by an illness that leaves somebody else, who has greater resources, unscathed, are looking to a relatively egalitarian sense of justice. That sense pushes toward universal access and its equitable financing. Some libertarian views of justice, on the other hand, contend that those who have no contractual or special relationship with the unlucky victim of disease—and have not themselves exacerbated her plight—have no obligation to assist her.

Despite these complications, several claims about justice and fairness may be based broadly enough in U.S. moral and political culture to guide society's debate. A case for mandated universal coverage built on seven such claims is outlined below, followed by a discussion of how such a policy embraces the values of liberty and justice.

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Why Mandated Universal Coverage Is Just and Fair

We have already collectively decided to prevent hospitals from turning away the uninsured. In such a context, allowing insurance to remain voluntary is unfair to many of the insured. The obvious way to alleviate this unfairness is to mandate insurance.

Since 1989, by federal law (the Emergency Treatment and Labor Act), hospitals have been prohibited from refusing acute care to those who cannot afford to pay. Consequently, \$100 billion of care is annually “cost-shifted” onto patients who can pay, almost all of whom are insured. This shift raises the average annual health insurance premium roughly \$1,000 for every insured family. Some of the uninsured are working families and young singles; when they need emergency care and get it at little cost, others who are economically similar but have chosen to insure end up invisibly footing part of the cost. Arguably, those uninsured who so benefit without bearing any share of cost are unfairly free-riding. Only two actions can avoid this: either repeal the rescue requirement on hospitals, or mandate insurance. Few support the former, so let's face the matter and mandate insurance.

A mandate that everyone be insured is unfair unless insurance is affordable, but in any multipayer system, affordability requires both income-related subsidies and restrictions on the behavior of insurers.

Given the cost of even basic insurance, many people of modest means who do not qualify for Medicaid cannot reasonably afford insurance without a subsidy. In addi-

tion, insurance will not be affordable for anyone who already has health conditions likely to require higher-than-average annual expenditures unless insurers are prevented from carving out their favored clientele by means of preexisting condition exclusions and “risk-rated” premiums.

Unless insurance is mandatory, it is unfair to bar insurers from using preexisting condition exclusions, waiting periods, and risk-rated premiums.

Feasible access to insurance for the people who most need it suffers greatly when voluntary insurance that permits the healthiest to go without coverage gets combined with wide latitude for insurer strategies to recruit optimal subscribers. The effective path to access, however, is not merely to bar insurers from using such strategies. To do so would expose them to potentially lethal economic risk (through “adverse selection”). It would also raise premiums for healthy young people, who in turn would be even less likely to insure; thus the number of uninsured might actually increase! People who want to postpone insurance, thinking its expense to be a poor bargain given their current good health, should not be allowed to pick their time to get insured. To receive benefits in times of crisis, people need to pay in all along.

Justice between the well and the ill requires that they share most of the financial burdens of illness, as well as insurance.

Mandating insurance together with sharply restricting insurers’ practices is not only practically necessary to achieve access. It also fundamentally aligns with justice between the ill and the well. Some principle of just sharing between them emerges from widely held convictions about the importance of assuring equality of opportunity. One attractive version of such a principle is that the financial burdens of medical misfortune ought to be shared relatively equally by well and ill alike, except when people can be reasonably expected to minimize those burdens by

their own choices—by avoiding overeating that exacerbates (or even creates) diabetes, for example. It follows that the cost of insurance should seldom depend heavily on a person’s health conditions.

We can’t have it all: setting hard priorities among different health care services (“rationing,” if you will) is not unjust or unfair to patients who would have regarded such limits as wise and prudent prior to becoming ill.

Everyone has reason to worry about the expenditures providers and patients will run up. Once insured—and once ill—patients will want to get and providers will want to provide all the care that has any prospect of net benefit, regardless of how small the benefit is, or how expensive its cost. Every system of insurance thus needs to police the care it provides, restricting care at the margins of (low) benefit and (high) expense. Call those limits “priority setting,” “practice guidelines,” “rationing,” or whatever: they are absolutely necessary to

control costs in a system of insured care. They are not unfair to patients just because the patient might have benefited from the marginal care withheld. If knowledgeable subscribers, in selecting insurance beforehand and having to pay for it with premiums or taxes, would have decided that such care was not worth its higher premium cost, then subscribers’ own values are the source of the limitations that define “wise and prudent” insurance.

Justice does not require universal access to all care, but only to “basic” care. Justice can tolerate additional, more expansive tiers of health care for those who choose to pay for it with their own additional means.

From whose perspective—the relatively wealthy subscriber, or the person of more modest means—should the decision about the boundaries of

wise and prudent insurance be made? Arguably, the person of modest means. The first demand of justice in health care is for universal access to care that has been proven effective and whose expense-to-benefit ratio is not so high that it leads thoughtful, middle-class subscribers to pull it from the package they are willing to fund. The compelling obligations of those who are well to help fund care for the sick, and of the relatively wealthy to help fund insurance for the relatively poor, stop at this line. People can continue to argue about whether health insurance should be more insulated than this from variations in affordability, but in a society committed to only modest measures of income redistribution generally, collective action will be out of balance if it guarantees everyone access to care above this line. Of course, some will wish to include greater coverage, including unproven care of highly speculative benefit. So be it: they are free to buy up to it with their

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own devices. Keeping the package of basic care relatively lean and thus affordable to subscribers and sustainable for taxpayers will never be easy, and pressures from particular interest groups will often need to be resisted.

Financing insurance through the current taxable income exclusion for employer-paid premiums is highly regressive and hardly just. If purchased insurance continues to play a major role in health care, a less regressive, fairer subsidy for access is required.

Currently, roughly half the population is insured through employer-sponsored plans, whose premiums are excluded from the employee’s taxable income. This roughly 40 percent tax subsidy (when the employer’s and employee’s FICA and Medicare taxes are included) is distinctly regressive, benefiting those in the higher tax brackets the most. Such a structure

for the society's primary incentive for purchasing insurance is hardly fair. A second questionable aspect is the subsidy's lack of any limit on the premiums excluded; cost control in health care is thus discouraged, and general affordability aggravated further. Even if health insurance remains significantly based in individual or employer subscription, a capped tax credit is fairer. It would also likely be more effective in persuading lower-income employees and low-payroll employers to insure.

How Mandated Universal Coverage Supports Liberty

Some claim that individual liberty and responsibility conflict with both universal access and any form of mandatory or societal insurance. Mandating insurance may be just and fair, but it certainly appears to limit liberty, and whatever relatively uniform level of "basic care" is used to define universal access rides roughshod over the often very different views individuals have about what health services merit funding. The challenge in countering such a view is to consider liberty in its fuller context, as bound up with responsibility—where both are connected to justice and fairness:

- Lack of access to basic care severely undermines people's ability to be responsible for themselves and their families. Untreated illness has this effect, and so does the financial hardship (even bankruptcy) often caused by uninsured medical expenses.

- The prevention of unfair free-riding—a driving force behind the move to mandatory insurance—is itself based in the value of individual responsibility: no one should get to ride the system without contributing to its upkeep.
- The principle of just sharing between the well and the ill is key to the argument for universal access to basic care, but it is grounded on convictions about equal opportunity for human well-being. That focus of justice on equal *opportunity*, not on equal well-being itself, inherently includes liberty and responsibility. The enterprise of achieving justice is therefore not a matter of "leveling," but of expanding and energizing.
- Even limitations on covered services—that curse of health care politics, "rationing"—may at bottom be tied to the concept of liberty, insofar as these limitations reflect our liberty as citizens to determine what and how much will be spent on health care, using *our* values.

Arguments for universal access and mandatory insurance that invoke justice and fairness can thus be based in fundamentally liberty-friendly values. There is broader room for moral and political agreement than at first meets the eye.

★ Policy Implications ★

- Insurance for basic care must—at least eventually—be mandatory and universal.
- If the system retains employer or individual premiums, they must not be significantly higher for people who are likely to be chronically ill than for those who are likely to be well.
- Guaranteed, universal access should be to a limited scope of care that is of proven effectiveness and reasonable cost-effectiveness. Costs must be controlled, even if this requires setting priorities and excluding some kinds of care. People should be at liberty, however, to buy more inclusive insurance.
- Both single- and multipayer systems can be just. Any multipayer system will have to set a common framework for basic insurance and sharply restrict insurers' efforts to recruit the most profitable subscribers. Financial incentives should promote fair competition both among private insurers and between private and public insurance.
- The current tax subsidy for private insurance—the uncapped exclusion of employer sponsored premiums from taxable income—should be changed to a subsidy that is less regressive and more effective at controlling costs. ★