

# Bioethical Implications of Healthcare Financing Systems

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Healthcare financing systems are a significant force in shaping the bioethical landscape and could become even more powerful in the future. Healthcare reform is a major political issue and discussions of this topic reflect many underlying ethical theories, ideologies, and worldviews. Modifications in healthcare financing systems offer the opportunity of alleviating some existing ethical dilemmas, but could worsen others, thereby shifting one set of ethical problems to another. This paper does not attempt to delve into health care policy minutiae, provide detailed economic analyses, or promote one “best” plan. Instead, it is meant to 1) summarize the current state of the healthcare financing system in the United States, 2) clarify key terms used in the debate about reform, 3) analyze reformers’ basic underlying worldviews and ideologies as they relate to health, human rights, and distributive justice, and 4) evaluate implications of proposed healthcare financing systems in relation to specific bioethical issues.

In this paper, “healthcare reform”, unless otherwise noted, is meant as major change in the system of paying for medical treatment in the U.S. Other aspects of healthcare reform may include modifications in delivery structures, “evidence-based medicine”, tort reform, innovations to reduce medical errors, etc., but these issues are not presented here.

## **I. Healthcare Financing**

In order to adequately discuss reform, one must have a basic understanding of the current healthcare financing system, its chief problems, and the two main approaches to solving these problems. In the current system, there is a patchwork of payers. Payers can be broadly divided into either governmental programs or private insurers.

The federal government directs the Medicare program, which covers everyone over 65 years of age, anyone on renal dialysis, and,

separately, medical services for the military (including veterans). The federal government also partners with state governments to finance programs for the poor and near poor, including Medicaid and the State Children’s Health Insurance Program [SCHIP]. Federal, state and county governments partner to provide various public health services, which may include immunizations, prenatal care programs, family planning services, treatment for sexually transmitted illnesses, home nursing visits, etc. Overall, government is the largest payer for health-related services in the nation.<sup>1</sup>

Most Americans who have private health coverage are insured as a group through their employer, a system that is indirectly government-subsidized, as the employer’s cost for healthcare premiums is nontaxable compensation to employees, and any employee contributions can also be made pre-tax.<sup>2</sup> These insurance plans traditionally take the form of fee-for-service (usually a negotiated fee paid to health care professionals),<sup>3</sup> preferred provider networks (groups of professionals from which a member chooses one or more for care), or health maintenance organizations.

A relatively newer option (since 2003) is the health savings account [HSA] to which employers and employees contribute agreed amounts of funds to be used for health care. HSAs are coupled with a high-deductible or catastrophic health insurance plan. Some persons purchase non-employment related individual health insurance, but these policies are generally more expensive, non-tax-deductible, and have exclusions for pre-existing health conditions.

Persons not covered by any of the above financing systems are the “uninsured”, and they figure prominently in the debate over healthcare reform.

## **II. Healthcare Costs**

The fundamental crisis for the current healthcare financing system is the unsustainable expense. Healthcare expenses now amount to about 15% of the U.S. Gross National Product [GNP]<sup>4</sup>, but it can be shown mathematically that an amount equal to the entire GNP of the U.S. could be spent on reasonable medical care.<sup>5</sup> If Medicare costs continue to rise as projected, they will consume almost 25% of federal tax revenues by 2026.<sup>6</sup> Since Medicaid's inception, it has grown twice as fast as Medicare and is an increasing burden on state budgets.<sup>7</sup> The premiums for private insurance from 2000-2005 increased by 73%, while wages rose 15%. Healthcare is a major expense for employers and decreases their ability to hire full-time workers; many believe it is a major cause of jobs being outsourced overseas.

All experts agree that spiraling increases in healthcare expenses are at least partly due to advances in technology. Another core reason is high demand, driven in part by the fact that most people have access to a wide variety of medical services and technology, while on average paying only approximately 14% of cost out-of-pocket.<sup>8</sup> Economists agree, although with varied terminology, that significantly controlling total costs can only be done by either reducing the consumer insulation from price (i.e., reducing demand by increasing out-of-pocket costs), or reducing access (i.e., rationing of some sort).<sup>9</sup>

### **Reducing Demand**

The RAND study, which continued from 1974 to 1982,<sup>10</sup> showed that even small costs incurred by consumers significantly decreased utilization of health services, with no measurable change in medical outcome. Since that study, most private insurers have used deductibles, co-pays, and co-insurance to decrease utilization. There still is incentive to use medical services, though, as health insurance is a prepaid benefit which retains no monetary value if it is unused. HSAs, on the other hand, require patients to pay a large deductible before the insurer assumes any

costs. Thus, the patient has to weigh the immediate cost and benefit of purchasing medical services against accumulating funds in the account for later use.

### **Reducing Access**

Limiting access to services can be done in many ways and under many auspices. Private insurers may limit members to using only specific healthcare professionals, and at the same time negotiate reduced payment rates to these specific healthcare professionals. Reduced reimbursement incentivizes professionals to see more patients, thus in effect rationing time spent with each patient.

Health Maintenance Organizations [HMOs] and capitation systems of reimbursement<sup>11</sup> control use of medical services through "gatekeepers", primary care physicians who must authorize services and who are financially rewarded for seeing patients faster and less often, and for denying "excessive" or "unnecessary" tests or treatments. HMOs may also use very restrictive formularies (lists of medications allowed under the plan) or limit patient choice of specialists and hospitals. However, HMOs have recently faced declining enrollments and lawsuits due to consumer dissatisfaction with care restrictions.

### **Reducing Costs**

Insurers also decrease costs by denying claims (often by ambiguous criteria), "down-coding" billings (paying less than contract by contesting accuracy of the description of the charges), and delaying payments. Another effective approach to limiting cost is to skew enrollment in their plan towards those persons least likely to become seriously ill.

### **Government's Cost-Containing Strategies**

Unlike private insurers, government programs have had very limited success in use of cost-sharing systems, and they cannot "cherry-pick" the healthier subscribers, so they have tended to rely primarily on policies that limit access. The Veteran's Administration

[VA] system has one of the most restrictive drug formularies in the nation, and a new patient in the VA system can wait up to 13 months for an initial visit with a primary care physician.<sup>12</sup> Medicaid and Medicare have experimented with HMO-type plans and have implemented prospective payment plans that pressure hospitals to make stays shorter.

Their routine cost-cutting strategy, however, has been to reduce reimbursements to health professionals. Payments now are at such low levels, often just at or even below the cost of providing service, that many Medicaid and Medicare patients are unable to find physicians willing to see them—making this the ultimate way to limit access.

Those who are still accepting patients from these government programs are shifting costs to other patients who are privately insured or pay out-of-pocket. It is estimated that 10% of the cost of private health insurance policies are due to this cost shifting. This leads to increased expense for insurance companies, who then pass the increases on to consumers. Each percentage increase in health insurance premiums leads to more persons being priced out of the private insurance market. In turn, each uninsured person in the U.S. then uses an average of \$1000 per year in unpaid medical services, with these costs also absorbed by the taxpayers in various ways.<sup>13</sup>

### **Final Thoughts about Current Healthcare Financing**

The current system is a mixture of numerous private and government insurance programs, each with its own multiple and frequently changing rules, and regulations.<sup>14</sup> Most patients have little understanding of their insurance plan, co-pays, deductibles, co-insurance, caps, exclusions, or the information they receive related to insurance payments. Physician offices and hospitals hire coders, utilization reviewers, billing specialists, consultants, and clerical help—and, in spite of this help, health professionals still spend hours daily completing prior authorizations forms and medical necessity forms, all the while supporting patients in appeals of insurance

denials. This is all done in the context of extensive documentation of patient visits (which must follow specific formats). The money saved in trying to limit services is thus expended in administrative fees, which now consume an estimated 30% of all healthcare dollars.

Meanwhile, total expenditures continue to rise. Those who are insured, whether privately or through public programs, feel entitled to as much medical care as could possibly be effective, and they expect it to be available 24/7, with the best specialists, the most amenities, and no errors of commission or omission. Yet, health outcome measures are not improving, and costs are such that the number of uninsured people is increasing. Changes in the system are clearly necessary.

### **III. Reform Proposals**

The foregoing is a brief and simplified historical overview of healthcare financing in the U.S. What currently exists is, however, the base for all reform proposals and must be understood in order to evaluate the possible effects of any given reform proposal. While many suggestions have been made for minor adjustments to the system, there are only two standard approaches to major reform—those that primarily seek to further reduce consumer insulation from costs, i.e., promoting market-driven changes, and those that seek to give more power to government to determine the most effective use of health-related economic resources, i.e., central control of access.

Reform proposals that primarily promote market-driven changes include 1) unlinking medical insurance from employment, thereby making insurance portable over a lifetime, 2) giving the same tax incentives for individual policies as employer-purchased policies, 3) reducing insurance regulation, such as state mandates for what services policies must cover, 4) expanding and deregulating Health Savings Account [HSA] plans, 5) encouraging innovations such as cash-pay primary care services; paying physicians for care management by phone and Internet; promoting mediation and arbitration in place of medical

malpractice lawsuits, etc. Collectively, these are often referred to as Consumer-Driven Health Plans [CDHP].

Reform proposals that seek primarily government-driven solutions include 1) mandatory insurance coverage regulated by the government or 2) a single-payer system including nationalized health care.

While mandatory insurance coverage is sometimes touted as a type of free-market plan, it requires government tracking of those who do/do not have insurance, government subsidies (which may require means-testing), and federal regulation of the insurance market, including determination of benefit packages. However, even most proponents do not see this as a long-term sustainable solution to the high cost of healthcare, because as more persons obtain insurance, especially those previously uninsured, demand for medical services--and therefore cost—would rise accordingly. For this reason, almost all those advocating this reform note that mandatory insurance is a temporary precursor to some type of a more fully government-administrated system, because government cannot indefinitely sustain increasing subsidies and administrative costs associated with multiple insurance providers.

The single-payer, nationalized, health care system is envisioned by some as a simple insurance plan wherein everyone is covered, and health professional's charges are submitted under uniform billing requirements to a single government-financed entity. This, it is proposed, would eliminate societal inequality in healthcare utilization, physician paperwork hassles, and administrative costs.

Unfortunately, no country in the world has ever actually created such a system. In reality, all policy-makers (for and against single-payer) understand that a single-payer system will mean significant redistribution and rationing of medical resources.<sup>15</sup> Most proposals include regional budgets set by the federal government, similar to the national health services system in Britain or Canada.

#### **IV. Ethical Implications**

A continuing stream of books and papers has been written analyzing, endorsing and/or criticizing different health care reform proposals. Why is there so much controversy? How can one begin to make a good choice when no choice will be perfect? And finally, what might be the ethical implications of change?

To evaluate this for the two major categories of healthcare financing reform, we will look to the underlying ideologies and worldviews embedded in each position. This will be done by considering some of the key terms of the debate, how each side defines and uses them, and then analyzing the ethical principles and theories used to support various proposals.

#### **Health**

Health is broadly defined as a “state of well-being”. The factors that determine health include genetics, environment, personal choices, and access to adequate medical services. Generally, according to the CDC (Centers for Disease Control), each of these four factors equally contribute to health outcomes. Genetic factors include gender, ethnicity, and the individual's genome (i.e. inherited tendencies to disease). Environmental factors include occupational or other risks, stress, family relationships, social support networks, air and water quality, climate, public health efficacy (prevention and containment of communicable disease in the region), and other events (such as natural disasters, war or crime). Personal choices include diet, exercise, risk-taking activities, use of safety precautions, use of tobacco/alcohol/other drugs, and sexual relationships. Use of medical care, which includes preventative and treatment services, comprises the remaining quarter of the factors responsible for health outcomes.

Obviously, there are outside influences that affect several of these categories. Persons with higher income can mitigate some factors more easily than those with lower incomes: they can move to a better area, they can buy better foods, or they can pay for more medical

services. Persons with higher literacy levels can more easily obtain and use information to improve their health. Persons who are deeply religious or spiritual may have more social support, less stress, and fewer tendencies to engage in high-risk “recreational” pursuits. It is apparent that “health” encompasses a wide spectrum of human states, relationships, and activities.

Proponents of market-driven health-financing reform tend to emphasize health in an individual sense, attributable to a combination of unique personal characteristics along with choices made regarding allocation of personal resources. Freedom and the pursuit of happiness are considered a good and a right. As long as someone does not infringe on the rights of others, each person must alone decide how best to balance their resources for health, whether that includes a mammogram, a car with cutting-edge safety features, organic foods, medical insurance with a wide selection of specialists, or any of an infinite number or combination of items related to health. The primary perspective is libertarian.

Proponents of government-driven reform tend to focus on societal health as a whole and the need for equality in access to healthcare. For example the poor or disabled have fewer choices available to them. Health is considered a special good in and of itself, and inequalities in health or health resources should be remedied by society. Some proponents limit remedies to a certain level of guaranteed medical services, while others take a more inclusive approach, attempting to create a “classless” society through “a fair distribution of the social determinants of health”.<sup>16</sup>

In this latter approach, “healthcare” could become a far-reaching social program touching on almost all areas of citizens’ lives. Precedent has already been set as some medical insurance has begun to include payment for gym memberships, personal trainers, acupuncture, and many other “health-related services” desired by consumers.<sup>17</sup> Physicians are expected to address all manner of social problems including domestic abuse, parenting problems, violence prevention, depression

screening, chemical dependency, safety issues, diet, behavioral problems, and more. The psychosocial problems are real and pressing, yet the question is whether they are best addressed by a medical model. Currently, the medical model predominates, as it is socially acceptable to seek medical care, and for the insured, it’s often the least costly out-of-pocket source of assistance.

### **Preventative Healthcare**

A related aspect of one’s views of health is the place of “preventative healthcare”, which is often invoked as a panacea for health in medical financing proposals. This theory proposes that if everyone was evaluated by a physician regularly and had screening and other “appropriate testing” done, illness and disability would be prevented, and illnesses that did occur would be detected early and treated easily, thereby decreasing total cost. This oft-repeated scenario indicates a lack of understanding of the capabilities of the health system.. There are three preventive measures that have been proven highly effective: vaccination, prenatal care, and screening of newborns for treatable genetic disorders.<sup>18</sup> There are also preventive measures that are moderately effective: mammograms, Pap smears, blood pressure testing, and colonoscopies. Other preventative measures are minimally effective or unproven, such as yearly physical exams. Screening itself has some risk, particularly related to “false-positive” results that require more tests, procedures, and additional physician evaluations at additional cost.<sup>19</sup> And while preventing early death and disability are an undeniable good, it actually increases health costs. A good description is that preventative care is a “consumer good”, i.e., gives benefit for a cost, rather than an “investment good” which returns monetary dividends.<sup>20</sup> In the U.S. now, a large part of the escalating costs of medical care are due to the fact that most people die after long-term, expensive illnesses such as cancer, heart disease, and Alzheimer’s instead of more acute conditions.

## **Medical services vs. Healthcare**

It is instructive to note that when persons advocating free-market reforms talk of “health” and “healthcare”, they often talk in the narrow sense of “freedom from illness” and “medical services”. When advocates of more centralized control speak, they most often have a wider vision of “health” as “well-being”, with “healthcare” that brings “health and caring” to society, thus positioning it to solve a wide variety of social problems. For example,

“The health care system must meet the full range of our health care needs. [...] differences in our risks of becoming ill and in the costs of meeting our needs are largely undeserved and beyond our control [...] Unhealthy behavior is often not voluntary [...] By providing for these needs and sharing the burdens fairly, the proposed new system would give us all a new security that our needs and the needs of our family members and those we care for would be met throughout their lives. [...] A common health care system that serves and cares for us all will also help bind us together in a broader national community.”<sup>21</sup>

## **Insured vs. Uninsured**

What does having health insurance really mean? Classically, insurance is a way to spread the risk of major, unpredictable, and infrequent events—e.g. car wrecks, house fires, tornadoes, etc. Private health insurance does sometimes function in this manner for unexpected major illnesses or accidents, but much of the time, it pays for routine, predictable expenses such as well-child care, preventative screenings, eyeglasses, minor illnesses, etc. Health “insurance” in the U.S. could more accurately be called “prepaid medical benefits packages”. Public “insurance” on the other hand is a “free” or reduced-price medical benefit package provided by the government, based on age and/or income. Approximately 85% of all U.S. residents are covered by either private or public insurance. This number is stressed by those who advocate market-based reforms. They

believe that a shift towards true medical insurance (i.e. policies covering primarily large unexpected events) would make coverage affordable for most people.

Those who advocate government-based solutions stress the number of uninsured, consistently equating “uninsured” with “having no access to medical care”. As of September 2008 the number of uninsured in the US is estimated to be almost 46 million.<sup>22</sup> Who are the uninsured? The highest percentage, approximately 25% of the total, are undocumented workers; many others are younger healthy workers who opt out of expensive plans; some are full-time workers in small companies unable to find affordable small group coverage; others are low-paid workers who cannot afford the coverage even if it is offered by their employer; some are unemployed or between jobs, temporarily without insurance; some have chronic illness and cannot find willing insurers; and a few are wealthy enough they don’t feel they need insurance.<sup>23</sup> Many uninsured persons are eligible for government programs, but do not apply until they have a significant medical expense. Many state programs will pay up to three months of medical expenses retroactively, so there is little incentive to sign up before it is needed. Even persons covered for medical expenses under “share” programs, such as Medishare or the Mennonite Church organization, are considered “uninsured”.<sup>24</sup>

Therefore, the uninsured are a diverse group, found along a continuum from those in a very difficult situation to those who are having no problems with health or healthcare financing. Studies have shown poorer health status for the uninsured as a group compared to the insured, but the discrepancies in health status may be significantly skewed by the uninsured who are chronically ill, low-income, and/or recent immigrants.

## **Access to Healthcare**

“Access” is another key word discussed in different ways. Persons opposed to government-driven reforms note that everyone in the US, whether insured or not, has “access”

to the health care system. Emergency departments are required to see all who present, regardless of insurance status or ability to pay. Hospitals routinely provide high technology inpatient care to persons unable to pay. Most physician offices provide care to uninsured patients, give discounts and help them develop payment plans. Pharmaceutical companies offer free and/or discounted medications to low-income persons who need non-generic drugs. Community clinics and charity care are also available in some areas. However, it is acknowledged that the sheer numbers of uninsured financially stress the healthcare system, particularly in locales having higher populations of persons without private insurance to whom the costs can be shifted. In addition, having “access” does not relieve the financial concerns of the uninsured, and piecemeal care often fails to provide continuity, efficiency, or a sense of security in having health needs met.

Persons advocating more governmental oversight often speak in terms of “equal access”, pointing out that the uninsured are less likely to get routine and preventive health care, less likely to have a regular physician, and are often reluctant to seek needed services because of cost. Charity care is felt to be demeaning and unreliable.<sup>25</sup> They believe a government program with central control could financially equalize access to everyone and could also decrease geographic discrepancies in access by mandating locations of providers and services. Another important aspect of the concept of “equal access” is that of rationing access. If access is to be “equal”, it will mean not only raising access for the uninsured to a certain level, but perhaps also reducing access to those who now have more. “We must not recreate a two-tier system [...] If supplemental insurance not subject to budget caps becomes widespread and the source of access to substantial health care services not provided by [the national plan], both equality and cost control will be undermined.”<sup>26</sup>

## **Affordability**

How can society make anything “affordable to all”? Proponents of CDHP usually speak of affordability in terms of reducing cost through competition and efficiency, thus helping more people afford more care. Proponents of government control most often mean that a person’s health care costs should be limited to “ability to pay”. Ability to pay in some proposals is linked to income and in others to total assets.

One suggestion is to equate the purchase of health care services to any other consumer purchase. The [national] insurance coverage would go into effect when an individual or family needed services beyond their ability to pay ... Coverage would thus be income-dependent based on what the consumer could afford. For example, the first dollar of health care costs for a family whose income is below the poverty line is an unaffordable loss; for a millionaire, however, the unaffordable loss might not occur until several hundred thousand dollars of healthcare costs have been incurred. Implementation of this model would enhance the distributive justice model of ethics.<sup>27</sup>

## **V. Philosophies of Justice in Healthcare**

The ethical principle that is most often appealed to in discussion of healthcare reform is justice. Justice, in this context, usually speaks to distributive justice, or the morally correct distribution of resources. Of course, the determination of what is the “right” distribution will have deep roots in the policymaker’s worldview.

A traditional/conservative/libertarian view of distributive justice tends to follow this line of thinking: humans are created equal and have certain rights; these rights include: the right to be allowed to live, to have freedom to make choices, and to pursue happiness without undue government interference. It includes the right to private property and to the fruits of one’s labor. What comes to one by one’s labor is a

commodity which one can sell or trade for other commodities—these commodities are not nebulous “resources”. They are a representation of work, and are the individual’s responsibility to manage—first to meet one’s needs and those of family, then to meet the needs of others in one’s circle of responsibility (parents, religious community, etc), and then to share with the poor. In this view, value is given to labor, freewill, and responsibility. Rights are given to everyone equally, but these are not rights allowing a claim to someone else’s labor. Resources which require effort to obtain are not considered public property, to be redistributed by force from one to another, even if they are vital resources (e.g. food, clothing, shelter, medical care).

In a radical secular version of free market solutions, there is faith that individual choices will always work for the good of all. Ayn Rand’s writings (*The Virtue of Selfishness*) are classic in this regard. Government exists only to protect choice and freedom. Altruism is considered a vice.

In a more typical Judeo-Christian worldview of the free market, resources are God’s, and man is given responsibility or stewardship over the resources in his sphere, which include his financial resources. Because of sinful human nature, wrong choices will be made, people will suffer, and therefore charity is essential. The role of government is debated, but most believe it is legitimate for government to encourage and reward responsibility, to protect the vulnerable, and to assist the poor in various ways-- particularly when non-governmental institutions or organizations are unwilling or unable to do so. However, it is generally accepted that injustice and unfairness will remain a part of life until God’s kingdom is established on earth.

A liberal/progressive/egalitarian view of distributive justice tends to follow this line of thinking: Humans have equal rights to resources considered necessary for life, liberty, and the pursuit of happiness, for otherwise there is no basis for equality. If one person or a group of people has more basic goods than another, it is inherently unfair, and it likely

came about by the oppression or exploitation of those who have less. Those who have less, therefore, have a right to redress, to claim their fair share. When all persons have equality of access to resources--and thus true equality of opportunity--then poverty, sickness, suffering, war, and all types of evil will be eradicated. Humans have the power within themselves to bring about this good life for all.

The concept of “equality of opportunity” is a major underlying ethical argument for universal single-payer healthcare. One of its notable proponents is Norman Daniels, who was a member of the 1994 White House Task Force on National Health Reform and whose writings are widely quoted in literature supporting universal health care programs. He builds his arguments from John Rawls theory of justice as fairness, which provides principles for fair distribution of goods. Daniels argues that health care is a foundational right because it is required to protect equality of opportunity: “Healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens...”<sup>28</sup> Daniels (with Dan Brock) writes “the availability of health care ... affirms our status as full members of society and the moral community.”<sup>29</sup> Therefore healthcare is also a moral right, something that defines our human dignity, so it must not be distributed based on ability to pay. Furthermore, continuing with Rawlsian tenets of justice, no one in society deserves any better health care than anyone else, unless it benefits those who have the least. Daniels writes:

This principle is not a simple “trickle-down” principle that tolerates any inequality so long as there is some benefit that flows down the socio-economic ladder; it requires a maximal flow downward. It would therefore flatten socio-economic inequalities in a robust way...<sup>30</sup>

The political manifestation of this philosophy is most commonly found in socialist or communist societies, where the state is given the power to equalize resources. The individual matters less than the community; the good of

the whole is paramount. Equality does not start with creation by a Creator, but with equality of goods distributed by the state. Rights are positive rights—rights that give claim for goods that require labor (i.e. commodities), and therefore must be taken from another, by force if necessary: “From each according to their ability, to each according to their needs.” (Karl Marx) In proposals for nationalized healthcare, the rhetoric of class warfare is pervasive. “The Ethical Foundations of the Clinton Administration’s Proposed Health Care System” notes “...financing mechanisms should be based on people’s ability to pay and should be progressive, with high-income individuals paying more...” “Health services should reflect only differences in our health care needs...” “...ability to pay should not give some people access to important medical services that others cannot afford.” “Sometimes it is necessary to limit people’s liberty in order to carry out desirable social purposes such as controlled health care costs.” “The federal government acts for us as a nation ... ensuring that the new system [will] live up to all of its guiding moral principles and values.”

There is a Christian progressive/communitarian version of distributive justice that has similar political views, but its ethical basis is a particular interpretation of Scripture and Jesus’ teachings.<sup>31</sup> Followers believe that all resources come from God and that humans are called to live in community, share God’s gifts freely, love one another, and promote justice. According to this worldview, the Kingdom values as practiced by the early church (Acts 2: 44-45) should be the norm for social order. Christians should denounce self-interest and work collectively to achieve these goals in the world. Medical care is considered a primary good, such as food, and a high-priority good requiring equal distribution. “No one has legitimate claim to treatment that is withheld as part of a just rationing system.”<sup>32</sup> “Human dignity can be achieved and protected only in solidarity with others.”<sup>33</sup> It is believed that peace will prevail when all goods are justly

distributed (not only in the US but throughout the world).

Liberation theology takes this even further, asserting God’s “option [preference] for the poor” must be demonstrated in a healthcare system to the extent that the poor should not just receive basic or average medical care, but should be given *better* care than the non-poor.

Obviously, there are modifications at all points along the continuum from a completely consumer-driven, free-market system to a completely government-driven system. All sides invoke utilitarian appeals to support their position, purporting that their proposal will bring about the best outcome for the greatest number. However, here one can see again the underlying worldviews in the debate, those views being the natural inclinations of human beings. Those leaning towards CDHP believe that all humans have a natural tendency to be selfish, to make decisions based on self-interest. Therefore, they believe a well-functioning economy, such as capitalism, should be based on this natural inclination, and allow individual choice and profit incentives. In the end, the outcome of the individual choices will work toward the overall best interest.

The more liberal/progressive view of human beings is that humans are generally good, but individuals can be corrupted by political systems. The best economic result will come from societies that promote equality and caring, and in turn discourage or punish choices based on selfishness (i.e., greed, exploitation, profit). A benevolent government can most efficiently distribute resources to do the most good for the most people. The best outcomes in health for a population will come when experts and leaders work together so as to prescribe countrywide “best practices” and prioritize needs of society as a whole. “From an ethical perspective, resources should be allocated appropriately so everyone can enjoy the best health possible.”<sup>34</sup>

## VI. The Unspoken Agendas

Unfortunately, most public debate about healthcare reform is reduced to “sound bites”, simplistic rhetoric, or utopian political

proposals. It is confusing to hear people from all social classes and walks of life disagree so profoundly on health care policy. One last element is needed to best understand the debate. It is that most powerful bias in ethical decision-making: self-interest. Even though many decry selfishness, it cannot be assumed that they have absolutely no bias about their own health or in the \$2 trillion a year currently spent on medical care in the U.S.

Advocates of healthcare financing reform are many, and most have multi-faceted perspectives. All are or will be patients someday, and all want available, quality medical care for themselves and their families. Those who are well-insured now do not want to lose benefits or pay more; those who are uninsured want healthcare coverage; those with specific diagnoses want benefits that will cover their conditions. Physicians prefer to treat patients without concern about cost. They also want independence in decision-making, minimal paperwork, and good incomes. Most politicians want to support whatever they believe their constituents want.

It seems impossible to predict what changes will occur in the U.S. system in the next few years, but it is highly unlikely that anyone will get everything they want. And most citizens will not even have an idea of what they will get until they have it. Two authors (advising policymakers who want universal coverage) write: “Proposed reforms that make headway ... are more likely to be successfully enacted if they are inherently ambiguous and stress benefits and subsidies rather than cost-constricting regulations or funding cuts. [...] Complexity and ambiguity are necessary...”<sup>35</sup>

It is in this milieu that physicians, ethicists, and other professionals should begin to evaluate how various shifts in our health financing structure may impact clinical ethics. The remainder of this paper is organized by topic, comparing and contrasting the potential ethical challenges in the two primary types of proposed reform.

## **VII. The Physician-patient Relationship**

A U.S. physician’s present primary source of income is through third-party payers, so even in the current system, unless the patient is uninsured, the physician does not work solely for the patient. While the physician and patient generally can make decisions based on the best interest of the individual, the physician is responsible to the insurer for documentation of service, time spent, correct coding of diagnosis, and other proper billing procedures. Whether or not, and how much, the doctor is paid depends on following the widely varied (and frequently changing) rules and regulations of each third party. Criteria for payment may include meeting goals for preventive services, not exceeding minimum intervals for lab tests, prescribing a certain percentage of generic drugs, etc. Periodic chart audits are often done by insurers to reward or penalize health professionals. Patients have no say in this, and must allow their insurer access to all their medical records. If insurance denies payment for a service that the physician feels is absolutely necessary for a particular patient, he can file a request and then, if needed, an appeal with the patient’s insurance carrier. This process, however, is very time-consuming, and usually unsuccessful, so is not done lightly for every patient denied a service.

In CDHP, the physician would presumably work directly for the patient, although in most cases there still would be an insurance agency involved. Currently, most HSA plans are administrated by the insurance company providing the high-deductible coverage. The insurance plan still contracts with health professionals and also has access to health records in order to determine when the required deductibles have been met. Health professionals would have more leeway in setting some prices and would need to be more comfortable discussing--maybe negotiating--prices with patients for non-emergency care. It also seems clear that when patients are paying out-of-pocket, they want more time with their doctor to discuss diagnosis, options and cost/benefits of treatments, or to “shop around”. Physicians would need to become

more comfortable “selling” their basic office services. Ethical issues that will predominate include non-maleficence and beneficence in regards to potential conflict-of-interests. Instead of following insurers’ guidelines (a different sort of conflict-of-interest), physicians would have more opportunity to act as entrepreneurs, directing patients towards more profitable services. This could be a win-win situation if the patient is medically knowledgeable and consumer-savvy, but ethical concerns arise especially in the case of vulnerable patients—and almost all patients are vulnerable in some way.

A second issue is autonomy with regard to patient choices. Should a health professional do anything and everything someone will pay for, or are there some external restraints? On the other hand, how will health professional deal with those patients who have made unwise decisions in allocating medical funds for themselves and their families and have no funds left? Finally, justice needs to be considered. Are concierge practices ethical in any situation? Should the perceived “best” doctors be allowed to charge more than others? Should physicians in underserved areas be allowed to charge more (because they have a local monopoly)? The legal and ethical question of whether patients can sign away their civil rights (i.e. the right to file malpractice suits) in exchange for lower prices must also be considered.

In a government-run system, the health professionals will work directly for government, which poses its own significant ethical risks. While some physicians still envision the utopia of every patient under a single-payer, no worries about cost, treat today and get (well) paid tomorrow, that clearly will not be the case. Others understand that choices will need to be made, and rationing will occur. They even welcome the thought of being relieved of the responsibility of triage and the frustration of poorly managed resources by letting “society” make those choices for them. However, there is no likelihood of “society” agreeing on most decisions to limit treatment options. Major choices about healthcare

priorities are likely to be made by politicians’ budgeting decisions, while day-to-day rationing for individual patients will be left to physicians under the constraints of their regional funding.

Gordon writes that... [Rationing] decisions are so emotionally loaded, that no elected official could afford to claim responsibility for them. Important decisions on who will receive care and how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.<sup>36</sup>

When care becomes “free” to the patient/consumer, yet costs are constrained, the result is predictable: high demand for services resulting in queues, and increased need for doctors to make triage and rationing decisions. Each physician will be in the position of trying to spend the available resources in the best way for all patients covered by the regional budget, as well as (hopefully) working for what is best for an individual patient. He will be pressured by peers, income, and job, to “meet budget”. In this case, the physician-patient relationship moves towards a distributor-user model in which each user (patient) is a cost-center to the distributor. “[P]roviders in a resource-limited system ... face inescapable conflicts among their own interests, those of their patients, and that of society.”<sup>37</sup> Predominant ethical issues will again include beneficence and non-maleficence with respect to conflicts of interest. In the case of CDHP, the physician incentive is to offer more services, whereas in the government controlled system, the incentive is to limit services. While patients may be harmed by excessive medical services, they still have a choice to accept them or not. When they sense that their physician may be limiting options offered, they are likely to be distrustful of recommendations. The relationship could become adversarial. A corollary ethical issue will be truth-telling.<sup>38</sup>

Autonomy in a government system relative to patient choices will be an important issue, albeit with different concerns than in CDHP. In a centrally controlled system, what choices will the patient have? Various national health

plan proposals indicate doctors will be pressured to follow national protocols for patient treatment, and use a limited pharmacy formulary. Patients may not have the option to see a specialist when that isn't indicated by the "protocol". They probably will not have choice in hospitals, and might not have the option of obtaining extra services or products even if they pay out-of-pocket. Perhaps they will not even have a choice *not* to come to the doctor: Presidential candidate John Edwards proposed a plan in which persons would be *required* to obtain periodic physical exams in order to keep their benefits!

Justice and civil rights will be a concern if there is rationing. Under CDHP, money is the asset that allows extra benefits. In a government directed system, it is power, social connections, and prestige (and money indirectly). However, if resources reach a certain point of scarcity, private payment will again be a key in obtaining services. Several countries (including Canada and Britain) now allow private practices outside the government system in order to alleviate queues. Those countries that have not allowed private practices have experienced outside-the-system payments (i.e. "gifts" or bribes) by patients to physicians in order to obtain even the most minimal access to treatment.<sup>39</sup> The effect of a national health plan on civil rights is not clear, but some think it would be difficult for a citizen to sue the government for harm due to rationing, unless a case could be made for unequal treatment under the law. However, others think such cases could be frequent, because there would be inevitable regional differences in how budgets are apportioned.

The ethical health professionals will be required to think through the maintenance of a fiduciary relationship with their patients. They will also need to demonstrate transparency and truth-telling in decision-making, while practicing responsible stewardship, regardless of whether the resources are from the patient or a budget set by the government.

## **VIII. Care for the Poor**

Caring for the poor is considered a major weakness of CDHP. However, there are many proposals to care for them in such a system, including continuing the Medicaid program, subsidizing insurance for the poor--which could be on a sliding scale so that it no longer "all-or-nothing", and HSA to which the government contributes. In the case of generally healthy low-income persons, money that isn't used in an HSA could accumulate as a financial asset to the family.

A government-run health system is generally considered to be of greatest benefit to the poor, but that has not been shown to be the outcome in other countries. Better access and care in a system with central control is still correlated to income, with the key being power, prestige, and social connections.<sup>40</sup> In one Canadian study, the patients most likely to receive preferential access were high-profile public figures, patients who had personal ties to the doctor, and politicians.<sup>41</sup> A 1998 British study by the Department of Health showed that gaps in mortality rates among social classes actually widened over the previous 30 years under the National Health Service.<sup>42</sup> The poor tend to vote less often, and thus have less political power, leading to diminished regional resources for them. Rural areas pay the same taxes for services but are underserved by health professionals and facilities. The poor often lack the social connections to receive preferred care. In addition, access to medical care does not remove other factors which often coexist with poverty and contribute to poor health, including illiteracy, deprived living conditions, stress, etc.

Whichever healthcare system one favors, it seems that healthcare professionals will always be needed to advocate for the poor, and provide charity care for them.

## **IX. Care for the Chronically Ill and Disabled**

Financing care for the chronically ill and disabled, including the mentally ill, is one of the biggest challenges to *all* proposed healthcare systems. Persons who have high

and ongoing medical expenses are not insurable in the current system unless they were already insured at the time of diagnosis. Then in order to maintain their coverage, they must stay employed at the same workplace unless they are able to find new employment with a large company that provides group medical benefits without pre-existing condition exclusion clauses. Many persons remain in difficult work situations for years, unable to move or change jobs, because they need to maintain their health benefits for illnesses they have or have had.<sup>43</sup> For persons who lose their job, or who are diagnosed with a major illness while uninsured, there are few good options other than staying or becoming poor in order to enroll in federal or state programs. Unfortunately, these persons and their families must then continually strive to cut work hours and avoid building assets in order to stay “poor enough” to continue to be eligible for benefits.

Government healthcare delivery programs are already heavily burdened with cost of caring for the chronically ill and disabled, contributing to the economic problems now faced in healthcare. Once a person is in a government program, most of their medical expenses are covered, not just those related to their chronic illness or disability, which multiplies the cost. In addition, those who must reduce assets to receive medical coverage also may become eligible for other state entitlements, again increasing costs.

CDHP proposals could solve some of these concerns proactively, by unlinking insurance from employment and making insurance portable through a lifetime. However, those persons already chronically ill and disabled are a dilemma. They are often not employed full-time, but even if an employer (or the state) helps fund an HSA for them, their medical needs contain fewer discretionary expenses, and they are forced to meet a high deductible year after year. Some could be accepted into large group plans, perhaps with a government subsidy based on their diagnosis. However, it would significantly increase insurance rates if plans were forced to accept, for example,

persons with AIDS or patients on a transplant list.

There are some innovative proposals for the chronically ill and disabled in CDHP plans. One involves “rolling” deductibles, structured so that persons with long-term high expenses pay less in deductibles over time. Another is to develop state plans with structured disability-specific benefits rather than “all-or-nothing” benefits based on income.<sup>44</sup> These would be tailored to specific diagnoses, e.g. supplying dietary formula for persons with PKU, vouchers for glucose testing supplies and diabetes management education for persons with diabetes, or medication and medication follow-up for persons with schizophrenia. Particular benefits could be targeted towards those services that would encourage good outcomes and be unlikely to be overutilized.<sup>45</sup> If benefits were given equally to all with the same diagnosis, it would ameliorate the personal expenses of the chronic illness, make more chronically ill persons privately insurable, and increase incentives to work and build family assets. Finally, HSA funds could be made transferable, even from one family to another, so that persons in a social network have the opportunity to assist each other in difficult medical circumstances.

A national health care plan is the most appealing answer to “insuring” the chronically ill, due to its automatic coverage of all persons without exclusions, but it also has pitfalls. In a federal “mandatory insurance for all” plan, insurance companies would be required to accept all applicants and not be allowed to charge higher premiums for persons with chronic illness or disability (mandatory “community rating” of premiums). This type of plan would inevitably drive insurance premiums up steeply and quickly, as the sickest apply for those plans which provide the most benefits. The federal government would be forced to offer high subsidies to those enrolling the chronically ill. Costs would increase. Regulations would multiply, as legislators tried to hold down costs. In some plans, everyone’s health premiums would be capped based on a percentage of income, so the

government would gradually assume more liability, and be forced to take on more regulatory and rationing power.

Eventually, a single-payer system would probably emerge. Proponents would welcome the chance to more fairly distribute healthcare resources—toward the ill, disabled, and those in most need of medical services; that is the promise. Unfortunately, that has not been the reality in other countries with national health care, for several reasons: First, the overwhelming number of patients seeking services causes waitlists in obtaining care (office, hospital, surgical) for everyone, including the ill and disabled. Physicians in Britain and Canada work fewer hours than U.S. physicians, yet see almost 50% more patients. They have much less time per patient—and disabled patients generally need more time to receive quality care.<sup>46</sup> Second, political rationing decisions will be made by the numbers and there will be more political pressure on elected officials to maintain services for the well majority.

Why do single payers [systems] skimp on expensive services to the seriously ill while providing so many inexpensive services to the marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small number of voters).<sup>47</sup>

The easiest way to reduce cost is to ration high-technology services, limit the number of specialists,<sup>48</sup> and decrease use of new medications—those services that are most beneficial to the seriously ill. Brock and Daniels write “The prime force behind rapid growth of healthcare costs ... is the development and unconstrained dissemination of new medical technologies.”<sup>49</sup> and also “[W]e do not value all health care services equally and so must give priority to services that meet our most important needs.”<sup>50</sup> Whose values? Whose needs? Will the needs of the chronically ill and disabled be a priority for the country?

It is possible that some benefits for the disabled could be politically realized. Those with the most visible, dramatic, and publicly acceptable disabilities would be expected to reap the highest benefits, possibly by appeals through Congressional hearings or a national health board.<sup>51</sup> Many patient advocacy groups are calling for a single payer national health plan, and are already working to position their group’s members for particular benefits in that plan. The American Cancer Society wants cancer screening and treatments fully covered; the homosexual community wants full medical benefits that start with the first positive HIV test<sup>52</sup>; etc. It is not difficult to envision those with, say, muscular dystrophy, spinal cord injury, or multiple sclerosis using their political clout to assure particular benefits from a national health plan at the expense of those with ulcerative colitis, dementia, or chronic depression—even though the latter group represents significant disabilities that affect a greater number of people.

In any system, as costs mount, ethical issues become apparent in caring for the ill and disabled. For example, the abortion rate for disabled fetuses is very high in the current system.<sup>53</sup> Would it be even higher in CDHP plans because of parental concerns about medical bills? Would it be lower if parents were assured of lifetime medical support for their child through a national health plan? Or, when state and federal budgets are strained due to costs, will there be a push for mandated prenatal testing to “prevent” disabilities and pressure parents even more to abort a “defective” unborn child? Is it ethical to allow the disabled to receive disparate services because of more or less assets under a CDHP plan, or should government mandate the same benefits for all? If the program cannot fund the same level of services for all, should resources be rationed based on “quality-of-life”, and if so, who decides? David Thomasma says, “[...] quality of life judgments must be used in a rationing scheme...Normally we try to avoid such judgments, especially at the

bedside. But they are actually an intimate part of the virtue of justice seen as distribution of a good. Quality of life ... means that persons still function as moral persons, able to make determinations about their lives.<sup>54</sup>

This seems to say that rationing or denying services is inherently just if the person is non-communicative, demented, or mentally retarded. An “equality of opportunity” ethic may also be problematic for the disabled, especially if they have no chance of recovery or cure. Citizens must be discerning in their evaluation of a health plan’s proposals for the chronically ill and disabled. Is the plan financially realistic (a question of truth-telling)? Will it protect and assist the most vulnerable (nonmaleficence and beneficence), yet promote choice and responsibility for the competent ill and disabled (respect for autonomy)? How susceptible is the plan to manipulation by special interests (a question of justice)?

## **X. Caring for Children and Adolescents**

Approximately 89% of children are already covered by private or government insurance. Of the 11% who are uninsured, an estimated 70% are eligible for SCHIP or Medicaid, but have not enrolled.<sup>55</sup> In addition, charity care for children abounds, including the newest technology available, in children’s hospitals and research centers throughout the country.<sup>56</sup> As a general U.S. population group, children are among the most medically healthy, with very low morbidity and mortality due to acute illness, thanks to advances in immunization, nutrition, safety, and sanitation. However, there is a great deal of focus in healthcare reform on the need for “health care for all children”.

Most child-advocacy groups, including the American Academy of Pediatrics [AAP] have voiced opposition to CDHP plans, believing that parents are likely to skimp on care for their children in order to save money. Instead, they strongly support single-payer health insurance<sup>57</sup> with a generous standard benefit package to all

children. The benefits given would be determined by pediatric professionals.<sup>58</sup>

A recent AAP publication noted that general pediatric practice has now shifted to the point that 60% of all children’s “health problems” are social/environmental or behavioral concerns such as violence, child abuse/neglect, mental illness, behavior problems, learning disabilities, obesity, substance use, eating disorders, sexually transmitted diseases, etc. (This group of problems is sometimes referred to as the “Millennial Morbidities”.)<sup>59</sup> Many of these problems are those that previously would have been felt to be the purview of parents, grandparents, teachers, pastors and others involved in the child or teen’s life, but the AAP solution is to train pediatricians in medical models that address these concerns. Having the physician become a sort of pseudo-parent seems part of the underlying philosophy of the concept of a “medical home” for all children:

Care is not just about giving immunizations, treating colds, or checking lead levels. It’s about establishing a medical home for children, so that they can develop a trusting relationship with a health care provider. Only then can we begin to make an impact on such life-altering issues as obesity, drug abuse, and teen pregnancy.<sup>60</sup>

To provide funding for this medical model would require significant financial and professional resources, which the AAP says should be met by making the U.S. a more “child-centered” country, i.e. redistributing economic resources for more social and health-related benefits for children and the professionals caring for them.. In return, society is promised that “investing [tax-wise] in children early and often [will] promote their success later in life” and that the spending choices advocated by professionals “will maximize the lifetime well-being of all American children...”<sup>61</sup> In a fall 2007 memo by email, the AAP advocacy arm advised pediatricians on “talking points” for increased SCHIP funding. They said legislators are

concerned about teen high school drop-out rates, so now would be an opportunity to “link” the issue of educational problems to lack of healthcare access: “tell them if children are sick, they can’t learn.”

The Society for Adolescent Medicine [SAM], the professional society for pediatricians who sub-specialize in adolescent medicine, is also at the forefront of supporting a national health plan. SAM believes that all adolescents (starting at age 11-13 years) should have the right to confidential and “comprehensive” care by their physician, including contraception, abortion, gender identity counseling, HIV testing and HIV treatment.<sup>62</sup> For years they have voiced concerns about the difficulties of taking care of teens who are privately insured, because their parents receive the bills or insurance statements,, thus threatening confidentiality.<sup>63</sup> A healthcare plan that allows direct billing to the government would allow teens to circumvent the possibility of parental involvement.

It is most clear in the debate over health care for children that some advocates are pushing not for a healthcare plan *per se*, but for specific social outcomes. Controversial social and ethical policies would have the opportunity to be enacted in one sweeping national financing program, with benefits justified by “science” and recommendations of “medical experts.” All health professionals would then be under pressure to “adhere to guidelines” in counseling patients and families, with possible professional or financial penalties levied against those who act differently based on conscience or even evidence-based medicine.

Politicians working toward single-payer systems generally tend to ideologically agree with sociologically liberal medical experts, but that is not necessarily their entire vision. Those promoting nationalization of health care have admitted that it would be difficult to pass universal coverage all at once. They believe a national plan will need to be phased in.<sup>64</sup> Medicare for the elderly was the first phase, Medicaid for the poor was the second, SCHIP was the third, and full pediatric coverage will

be the fourth. Within this strategy, anyone who voices opposition is labeled as being “anti-child”. Once entitlement programs are in place, people become dependent on them, and they are very difficult to scale back or rescind.

In reality, children and teens in the U.S. have relatively few unmet traditional medical needs, but immense psychosocial needs. How those needs should be addressed is dependent on one’s views regarding the respective roles of physicians, family, and community in shaping young people’s lives. Ethical issues include autonomy (children’s autonomy, teen’s autonomy, and family’s autonomy), and justice in how the entire federal and/or state budget is collected and spent. For example, tax money spent “for kids” may not be a net gain to them if tax burdens require parents to work longer hours, thereby reducing family time.

## **XI. Caring for the Elderly and End of Life Care**

At the other end of the age spectrum is the elderly, who are covered under the Medicare program. Medicare does not cover all medical costs--most notably it does not cover any preventative care--but Medicare recipients are allowed to purchase government-approved supplemental policies that cover co-pays, co-insurance, and some other out-of-pocket expenses.<sup>65</sup> Medicare recipients are *not* allowed to pay (and doctors are not allowed to charge) additional money above the government-set fee for any procedure or benefit that Medicare does cover, even if the service is upgraded in some way and the patient wants to pay. There is an option for the elderly to buy into private fee-for-service insurance in Medicare, which allows premiums and reimbursement to providers to be free from governmental control. Only about 2% are enrolled in this option because it is expensive, but it does open less constrained access to physicians and removes the threat of further rationing of services. However, this opportunity for additional coverage has been debated in Congress and may be eliminated as part of new funding proposals. The criticism of this Medicare option is that it creates a “two-

tier” system for the elderly. More rationing will come as costs continue to escalate, even for those who wish to pay outside the plan.

End of life services are consuming a large portion of the Medicare budget, with about 28% of Medicare spending being for patients in the last year of life.<sup>66</sup> There is ongoing concern about whether these resources are being used appropriately. Since the elderly and their families are not paying for most services, there is a tendency to request or allow “everything” to be done in end of life situations. There are patients with terminal illness being kept alive on ventilators, 90-year-olds having coronary artery bypass and being maintained on renal dialysis, elderly with severe dementia nourished by expensive formulas through feeding tubes, and so on. How do reformers address these issues?

Proponents of CDHP believe that the demand for end of life care from patients and families will become much more reasonable when that care is paid (if even only partially) with private funds. Patients and families will need to balance medical costs with other uses of their resources. Some may write an advance directive insisting no life support under certain situations, so as to preserve their estate. Families may decide to “let go” of a loved one earlier if care is costing \$10,000 a day, or they may elect to forego chemotherapy for a family member who also has Alzheimer’s disease. Obviously, this doesn’t solve the problem of making good ethical decisions. What if the family member doesn’t accept reasonable care solely because of concern about cost? What if an elder’s family exerts pressure not to accept treatment because *they* are concerned about cost? What if the family wants to “pull the plug” when there is still a good chance of recovery because they see their inheritance disappearing? Moreover, what about those who still want treatment, but cannot pay—under what circumstances could health professionals and facilities actually refuse potentially life-sustaining treatment?

In a national healthcare plan, it is unlikely that clear and definitive rationing regulations regarding end of life and quality of life would

emerge due to the political sensitivity of these issues. Even in Britain, political pressure has modified age-related rationing decisions (such as dialysis). Instead, rationing would probably be done through regional budgeting. A cultural bias against the elderly and their quality of life would place the elderly at significant risk for under-treatment.<sup>67</sup> The elderly at highest risk would be those who are minorities, have low social status, disability, and/or no family to advocate for them.

The ethical model of “equality of opportunity” for national health care justifies its potential bias against the elderly by claiming that they have already had their opportunity in life. In paying for care, some believe a younger person should receive priority proportional to age (potential years of life). “Fairness between age groups in designing a health care system is appropriately modeled by the idea of prudent allocation over a life span ... Under some conditions of scarcity, this implies that ‘pure’ rationing by age ... is permissible.”<sup>68</sup> A term promoted in the 1994 Clinton plan was “generational solidarity”, which was mentioned often but only vaguely defined as “sharing benefits and burdens fairly across generations”. The general implication, though, seemed to be that the elderly should give up benefits for the sake of the younger.

Another ethical issue of special concern for the elderly is euthanasia. When private funds are limited, will there be pressure to ask for or accept voluntary euthanasia? In a national healthcare plan, when acute care beds are needed for the acutely ill, but are occupied by the frail elderly, will involuntary euthanasia be quietly practiced? Involuntary euthanasia has been reported to some extent in most European countries that have nationalized health care, and it disproportionately affects the elderly.

## **XII. Reproductive Medicine, Stem Cell Research, and Genetics**

Reproductive technology, stem cell research, and genetic manipulation raise many issues, but have similar ethical concerns in regards to financing. All these technologies are (or predictably will be) very expensive to

develop and to utilize. Who will allocate funding and how will they decide? Who will regulate researchers and practitioners? Who will benefit and who will lose?

Insurance companies in the past have generally refused to cover infertility as an illness or disease, so most people have had to pay out-of-pocket for infertility services. More recently, infertile couples (who are often older and well-educated) have pressured through the political system for insurance coverage. As a result, many states now mandate insurance coverage for infertility. This means every insurance policy sold in those states must pay for infertility treatments, even though the majority of policyholders may not want that expensive benefit.

Genetic and stem cell therapies are generally considered experimental, and not covered under most private insurance. However, if stem cell therapies, and genetic treatment, modification, and enhancement become more commonplace, there is concern that they will only be available to the rich, thereby creating another divide between the “haves” and “have-nots”.

In CDHP plans, insurance mandates would be minimized. In this scenario, infertility treatments and genetic therapies would either be private-pay, or an expensive add-on to an insurance policy. The end result will likely be less of these technological interventions performed, particularly those that are most expensive. On the other hand, in the free market there will likely be less regulation. There could potentially be no regulation for private-pay patients and varied rules via policy coverage for the privately insured (such as for number of embryos transferred per cycle in IVF to reduce the costs for multiple births).

Infertility treatment and/or genetic therapy would be very costly benefits to provide in a national healthcare plan, but one can never underestimate the power of political pressure. In fact, some are already proactively lobbying for national health care specifically in order to make technological advances available. John Fletcher, bioethicist at University of Virginia School of Medicine writes:

Healthcare reform will be necessary to realize savings from cutbacks in other areas of healthcare ... so that these savings can be directed toward a new investment in mainstream medicine with new foundations in genetic knowledge and approaches to treatment.<sup>69</sup>

Fletcher calls for rationing of “technically sophisticated healthcare” through global budgeting, but increased funding for genetic technology under the premise that it will be a type of primary preventative care.<sup>70</sup> He supports embryonic research and fetal research, stating:

“Thus, basic research with human embryos promises to provide answers to close the gap between diagnosis and treatment of genetic diseases. [ ... ] it would be unfair to limit its benefits only to those who could afford to pay... Again, we see how healthcare reform ... ought to precede these scientific developments so that the benefits and burdens of developing gene therapy can be distributed as fairly as possible.”<sup>71</sup>

The ethical advantage to a national plan is that there would be increased regulation of infertility and genetic treatments, with the hope of those regulations being well thought out ethically, and supportable by a majority. On the other hand, there will likely be limits placed on “rights of conscience” by health professionals with minority ethical viewpoints. If there is a national plan, there will be strong legal precedent to require “equality under the law”. For example, physicians at private infertility centers are currently allowed in most States to refuse some patients based on conscience—such as singles and unmarried couples, including homosexuals. They would not have this option under a government-funded plan.

### **XIII. Rights of Conscience**

Rights of conscience are already under scrutiny in many health and medical-related arenas. Many persons and groups believe that they have a right to receive any possible

medical care from any physician, and that religious beliefs [of physicians and others] are “interfering with personal rights” in the U.S. healthcare system.<sup>72</sup>

Proponents of CDHP plans explicitly note that patients should be allowed to choose health plans that exclude services that the enrollee feels are morally unacceptable to subsidize.<sup>73</sup> Also, since health professionals would be more independent, they in turn would be more likely to maintain freedom of conscience to refuse treatment requests that they find ethically objectionable. However, individual cases might still need to be fought through the legal system.

In a national healthcare plan, with all monies for medical care coming from a single source, that source would have the power to set rules for health professionals, with the ultimate control being to deny them the ability to participate in the national plan if they refuse to abide by its regulations (e.g. such as provision of “comprehensive counseling for emergency contraception”, referrals for abortion, IVF services for single women, non-discriminatory hiring of office staff, etc.).

#### **XIV. Conclusion**

The healthcare financing system will determine who makes the ethical decisions in medicine and will heavily influence what decisions are made.

If reform tips to a market-driven approach, issues will center on a consumer-oriented system: how and if to regulate ethically

problematic services or research in the free market; how to maintain ethical doctor/patient relationships instead of a seller/buyer mentality; how to make just accommodations for those with fewer financial resources; and how to adequately protect the many who cannot make their own decisions due to age or infirmity.

If reform tips towards increased governmental intervention, ethical issues will center on political control: who will make rationing decisions and what ethical basis will they utilize; who will be able to challenge those decisions; and who will protect patients who have little social or political resources. There could also be significant concerns for providers’ rights of conscience. Incentives will be different in each system, and therefore opportunities and temptations for unethical behavior will be different. There must always be heightened concern for the potential of devastating evil in a system with powerful, centralized control.

Citizens need to be knowledgeable about the healthcare debate, ask hard questions about specific aspects of proposals, and be able to explain to others the potential ramifications of various reforms. Reform policies will most likely be developed incrementally, yet once enacted will be difficult to reverse. However reform evolves, though, it is best to understand the challenges of a given system as early as possible, in order to be proactive in ethical response.

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#### **ENDNOTES**

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<sup>1</sup> The government directly pays for 45% of U.S. healthcare spending. This does not count the value of tax subsidies, the funds used to provide health insurance packages for federal workers, or the imposed costs of regulations on private insurers. Pipes, *Miracle Cure*, 1.

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<sup>2</sup> This system originated during World War II, when wages were frozen, but employers were encouraged to increase employees' compensation packages by adding healthcare benefits.

<sup>3</sup> In clinical ethics, many eschew the term “provider”, but in most places in this paper, it is the best designation to include not only physicians, but nurses, physician assistants, pharmacies, hospitals, etc.

<sup>4</sup> Detailed U.S. health statistics can be accessed at [www.cdc.gov](http://www.cdc.gov) which is the Centers for Disease Control website. These statistics are widely quoted in policy materials. The numbers are rarely controversial, only their interpretations.

<sup>5</sup> Goodman, Musgrave, and Herrick, “*Lives at Risk.*” 2-4.

<sup>6</sup> Pipes, *Miracle Cure*, 50.

<sup>7</sup> Graham, “Taming the Medicaid Monster”

<sup>8</sup> Porter and Teisberg, “Redefining Competition in Health Care,” 65. Of course, people collectively are still paying all the costs of their medical care in some way, whether that is from lower wages, higher prices, or other indirect expenses.

<sup>9</sup> Kling, *Crisis of Abundance*, chapter 4. This author explains this economic principle very clearly.

<sup>10</sup> Newhouse, et al., *Free for All? Lessons from the RAND Health Insurance Experiment*.

<sup>11</sup> Under a capitated system of reimbursement, the physician is paid monthly “per head” of patients assigned to his practice. The contracts are rather complicated, but the basic idea is that the physician’s incentive is to provide the least expensive care possible to each assigned patient (the best outcome being the patient that is never seen) in order to have the highest profit.

<sup>12</sup> Young, “Changing Economics and Clinical Ethical Decision-making”, 286.

<sup>13</sup> Goodman, et al., see chapter 23.

<sup>14</sup> Medicare policy alone has 110,000 pages of rules and regulations.

<sup>15</sup> Aaron, et al., *Can We Say No?* , 6. The authors explain “the term *rationing* ordinarily does not refer to the inability of some people in a market economy to afford particular commodities. Customarily, it describes the situation in which people who can afford a commodity are unable to buy it because of scarcity, which results because some non-market allocation system—ration coupons or queues, for example—limits demand to available supply.”

<sup>16</sup> Daniels, “Justice, Health, and Healthcare”, 2.

<sup>17</sup> Some of these are financially advantageous for insurance to cover—for example, giving rebates on gym memberships may tend to attract healthier people to the plan. Other coverage may be mandated by the states, often after pressure by special interest groups.

<sup>18</sup> That is why prenatal care for the poor is almost universally available in the U.S., all states have programs that subsidize immunizations, and all states provide universal newborn metabolic screening.

<sup>19</sup> For detailed discussion and extensive references regarding evaluating preventative health services, see Goodman et al., Chapter 12, and Kling, Chapter 3.

<sup>20</sup> Goodman, et al., 119.

<sup>21</sup> Brock and Daniels, “Ethical Foundations of the Clinton Administration’s Proposed Health Care System”.

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<sup>22</sup> U.S. Census data, accessible at [www.census.gov](http://www.census.gov)

<sup>23</sup> Goodman, et al., 219. Per U.S. Census data in 2000, sixteen percent of the uninsured had incomes over \$70,000/year.

<sup>24</sup> Medishare is a large group of Christians around the U.S. who formally share medical expenses. They studiously avoid calling themselves an insurance plan, so as to avoid insurance regulations and mandates. They keep payments low by only enrolling healthy, normal weight, non-smoking, non-drinking, regular-church attending Christian families. They have high deductibles, no coverage for substance abuse treatment and no coverage for ethically objectionable services. Also, they negotiate members' bills on the basis that their members are "uninsured" (which this writer feels is ethically questionable). The Mennonite and Amish communities pay medical bills in full and in cash, covering all major medical expenses of their brethren. Their costs are limited due to lifestyle and community norms.

<sup>25</sup> Lyndon Johnson, 1965, on the occasion of signing Medicare into law stated, "Not one of these, our citizens, should ever be abandoned to the indignity of charity." Many authors who advocate single-payer also feel that charity care is denigrating to the recipients.

<sup>26</sup> Brock and Daniels.

<sup>27</sup> Vicki D. Marsee, "Ethical Perspectives of Reimbursement Under Economic Pressures".

<sup>28</sup> Daniels.

<sup>29</sup> Brock and Daniels.

<sup>30</sup> Daniels.

<sup>31</sup> The communitarian view of distributive justice, sometimes denoted as a "social gospel", is most historically associated with the Catholic Church. The most active contemporaneous evangelical group advocating for social policy based on this philosophy is Sojourners (see sojo.net).

<sup>32</sup> Leonard Weber, "The Patient as Citizen", 12.

<sup>33</sup> Ibid, 13.

<sup>34</sup> Marsee, 371.

<sup>35</sup> Skocpol and Keenan, "Cross Pressures: the Contemporary Politics of Health Reform", 26-27.

<sup>36</sup> Goodman, et al., 10.

<sup>37</sup> Aaron and Schwartz, 102.

<sup>38</sup> Ibid., 119, regarding how British physicians rationalized their part in limiting treatment by gradually redefining standards of care, and telling selective patients that "nothing can be done" instead of telling them that the option was there, but would be politically difficult to access.

<sup>39</sup> This writer has talked extensively with physicians from Romania who worked before the Revolution in 1989. Care for patients was officially "free" but with rationed resources, an oversupply of patients, and extremely low wages for physicians, it was the cultural norm for the patient to pay the physicians with "gifts". Christian physicians were conflicted, desperately needing the money to support their families. Some compromised by accepting payments from those who were better off than they were, but not from those who were poorer.

<sup>40</sup> Goodman, et al., 9-10.

<sup>41</sup> Ibid., 34. See also Aaron and Schwartz, 87.

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<sup>42</sup> Aaron and Schwartz, 23.

<sup>43</sup> Some authors refer to this phenomenon as “job lock”.

<sup>44</sup> Newhouse, 351. The RAND experiment contains some intriguing but limited data on the cost effectiveness of targeted benefits.

<sup>45</sup> For example, persons with PKU are generally uninsurable because they require a very expensive phenylalanine-free formula to meet their dietary protein needs. As long as they have this formula and adhere to their diet, they are otherwise healthy (without the formula, they develop mental retardation and seizures). If they had a disability-specific benefit for their formula, they should be privately insurable under a community rating. There would be no incentive for fraudulent claims—the diagnosis is made by state screening programs, and the foul-tasting formula is not good for anything else.

<sup>46</sup> Aaron and Schwartz, 133.

<sup>47</sup> *Ibid.*, 10.

<sup>48</sup> There is a much lower percentage of specialists in those countries with national healthcare in comparison to the US-- even what we would consider primary care specialists such as pediatricians, obstetrician-gynecologists, and internists.

<sup>49</sup> Brock and Daniels.

<sup>50</sup> Brock and Daniels.

<sup>51</sup> See Aaron and Schwartz, 116, for discussion of “visibility of illness” and “advocacy” in relation to rationing.

<sup>52</sup> Andy Humm, Gay City News 03/29/2007 “ACT UP Roars Again at 20” accessed 9/5/07 at <http://gaycitynews.com>

<sup>53</sup> Estimates are that 80% of fetuses diagnosed prenatally with Down Syndrome are aborted. Statistics for fetuses diagnosed with heart defects and cleft palate are similar.

<sup>54</sup> Thomasma, “The Ethics of Managed Care”, 244.

<sup>55</sup> Stephen Bertram, “State Children’s Health Insurance Program Reauthorization”, 824.

<sup>56</sup> All children’s hospitals treat many patients without reimbursement or with reimbursements below cost, with help from private charitable contributions. Some treat all patients free of charge: St. Jude’s treats children with cancer, and the Shriner Hospitals give care to children with burns, orthopedic injuries, and orthopedic disabilities.

<sup>57</sup> “They” is the leadership of the organization—actually less than 40% of members prefer single-payer insurance, according to a membership survey in spring 2007.

<sup>58</sup> The AAP policy statement “Scope of Health Care Benefits for Children From Birth through Age 21” contains two pages of recommended benefits for children including specialty medical care, specialty and subspecialty surgical care, comprehensive mental and behavioral health services, home services, equipment and supplies, dental care including orthodontia, parent support services, family counseling, physical/ occupational and speech therapy, services for pregnancy and “fetal management options”, substance abuse treatment, vision services/glasses, transportation services, etc. The same document states “If professional standards of care for children do not exist or are outdated or contradictory, decisions about existing interventions must be based on consensus pediatric expert opinion.”

<sup>59</sup> News release from the AAP on the “Pediatrics for the 21<sup>st</sup> Century Symposium Series”, August 2007.

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<sup>60</sup> Matthew Levy, AAP legislative liaison, quoted in “Campaign to urge universal children’s health-care coverage gathers momentum”, in *Contemporary Pediatrics*, 23 (8) 2007, 98.

<sup>61</sup> Priscilla Ring reporting from the 2007 AAP Legislative Conference, AAP newsletter (to members), August 2007, 4.

<sup>62</sup> Adolescent medicine is primarily concerned with psychosocial issues, therefore “standards of care” will be heavily influenced by philosophic beliefs and values. In published guidelines for adolescent medical care, five-sixths of the care recommendations are for screening or counseling, rather than traditional medical services.

<sup>63</sup> See Hillard, “Preserving Confidentiality in Adolescent Gynecology”, a symposium in which adolescent physicians discuss contacting teens at school instead of home, having secret files for portions of a teen’s medical record, making confidential referrals for reproductive services, finessing communications with parents with intent to deceive, and falsifying lab billing statements—and feeling ethical about it.

<sup>64</sup> P. Budetti, “Health insurance for children—a model for incremental health reform,” *New England Journal of Medicine* 1998;338:513. See also Bertram, 824.

<sup>65</sup> The average Medicare beneficiary spends approximately 20% of their income on health-related costs including premiums for Medicare A and B, supplemental policies, medications, and non-covered services such as eyeglasses. Pipes, 39.

<sup>66</sup> Goodman, et al., 107. Here quoting a study from 1993, costs are now presumably higher.

<sup>67</sup> *Ibid.*, see Chapter 15 regarding age discrimination in Britain and New Zealand.

<sup>68</sup> Daniels, “Justice, Health, and Healthcare”.

<sup>69</sup> Fletcher, “How Genetic Discoveries Will Aid Healthcare Reform”, 818.

<sup>70</sup> *Ibid.*, 819.

<sup>71</sup> *Ibid.*, 822.

<sup>72</sup> Fox, “Religious Group Attacks Religion in Healthcare”.

<sup>73</sup> Marshner, “The Health Insurance Exchange: Enabling Freedom of Conscience in Health Care”.