Access, Cost, And Financing: Achieving An Ethical Health Reform

There must be a balance between a commitment to what's ethically important and pragmatic flexibility about the means of reaching those goals.

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ABSTRACT: Three key ethical issues should inform the broader debate about health reform: (1) Why pursue universal coverage? (2) Why is cost containment an ethical issue? (3) What is fairness in financing? After examining these issues, we conclude that the core ethical values underlying each of these goals— including expanding opportunity, sharing burdens equally, and respect for persons—limit the means that can be pursued in health reform. Although national health reform will not accomplish all of the objectives of social justice, true comprehensive reform—even under conditions of political compromise—represents an important step forward. [Health Aff (Millwood). 2009;28(5):w909-16 (published online 2009 Aug 18; 10.1377/hlthaff.28.5.w909]

We are not a nation that accepts nearly 46 million uninsured men, women, and children. We are not a nation that lets hardworking families go without the coverage they deserve; or turns its back on those in need. We are a nation that cares for its citizens. We are a people who look out for one another. That is what makes this the United States of America.

--President Barack Obama, speaking to the AMA, 15 June 2009

On a few occasions, President Barack Obama has spoken forcefully and eloquently about the values that motivate national health reform. For the most part, however, the national discussion about U.S. health reform has focused on technocratic policy issues, such as payment reform or insurance exchanges. Despite intense political jockeying, there is little debate about the values and goals that should guide this political choice. We should not be surprised at this focus, for the devil is in the political and policy details. Nevertheless, there is an important gap to be filled in the policy discussion. In their important book on international health reform, Marc Roberts and colleagues urge clarity about the values underlying the goals of reform so that the means selected will achieve those goals. Those values must be articulated and defended to provide a coherent basis for both the goals and the means of national health reform.

In this paper we examine three key ethical issues that should inform the broader debate about reform: Why pursue universal coverage? Why is cost containment an ethical issue? And what is fairness in financing? Each issue is
connected to one of the major goals of health reform. Our discussion is hardly exhaustive, but the issues are central.

**Why Pursue Universal Coverage?**

Providing universal coverage through a public or mixed public and private health insurance scheme is a way of assuring equitable or fair, if not truly equal, access to a reasonable array of health services. Even in a universal coverage system, however, geographical inequalities in available services and language or cultural barriers to care may create inequalities in access. The goal of equitable access requires that care be delivered according to need and not be determined by factors such as ability to pay.

Ethical reasoning supports the goal of equitable access by means of universal coverage. Many Americans believe in equality of opportunity for all, both for citizens and for the millions of noncitizen immigrants who pay taxes and contribute to the social security of all. Ill health that shortens lives or impairs functioning has a major impact on the range of opportunities people have. The social obligation to protect opportunity thus implies that we have obligations to keep people functioning normally. Because preventive and curative health services improve population health, equitable access to them is important to protecting opportunities and distributing those opportunities fairly. Turning our backs on people with health needs--failing to provide universal coverage--contributes to inequality in opportunity.

Justice, many believe, requires respecting all people equally. Specifically, showing equal respect requires providing dignified, patient-centered care for everyone--something our current system fails to do, since, as the Institute of Medicine has shown, many people get "too little, too late." Universal coverage respects people equally: it treats health care as more than optional and shows that meeting the basic health needs of all is a matter of social justice.

Even with universal coverage, we will not eliminate all inequalities in health, because these result from forms of social injustice that are broader than the lack of health insurance. Inequalities in education, wealth, power, and social status all contribute to health inequalities, which persist even in countries, like the United Kingdom, Canada, and Norway, that provide universal coverage and achieve high basic levels of education and protection against poverty. Broader measures of social justice are needed to distribute health more equally, but because not all illness can be prevented, universal coverage remains crucial to protecting opportunities and to demonstrating equal respect.

There is no one fair or just way to assure equitable access to care. Health systems with various forms of financing, mixes of public and private institutions, and types of regulation achieve universal coverage for a reasonable array of health services. The tri-committee House bill unveiled in June 2009 (HR 3200) promises to achieve near-universality (95 percent coverage) through individual and employer mandates and a public plan. Other means might work as well. What is essential ethically is that political give and take about means must not compromise the goal of equitable access. Because the perfect--covering all--must not drive out the good, covering more people is better than covering fewer. Still, all departures from universal coverage, including delays in implementation, fall short of what justice ultimately requires.

**Why Is Cost Containment An Ethical Issue?**

High costs and failure to achieve value for money in our health system are not merely economic failings. They are also ethical problems. If we have a health system that delivers health services at very high cost per unit of benefit delivered--and the U.S. system has the highest unit costs in the world--then we can meet fewer health needs than a more efficient system would. Spending more on health but getting less also reduces resources available for other things that social justice says are important--such as education, income support, and job creation. Although important, health is not the only important social good. Health must compete with other important goods for resources and without adding unsustainably to the national debt.

Cost containment is thus about setting priorities in a way that promotes value for money in health and is fair to all parties in need. Although some may think that efficiency is an end in itself, our claim is that value for money is an ethical issue for instrumental reasons: without it we cannot meet as many needs as we otherwise could; without appropriate ways of setting priorities, we cannot meet needs fairly. Since fairness requires efficiency in meeting health needs, appropriate forms of priority setting and cost containment must be central goals of health reform.

U.S. politicians of both parties have historically avoided the cost containment implications of health reform. They
have pretended that we can provide all of the health services that are effective, regardless of cost. It still remains
taboo to raise the specter of "rationing" care or to imply that some people will be denied care that is effective.
Unfortunately, the current partisan climate makes it difficult to give an honest accounting of the projected costs and
savings of health reform.

For his part, President Obama has provided mixed signals on cost containment. He has vowed to veto legislation that
increases the deficit and has spoken approvingly of regulating cost growth in the Medicare program. But he has
also been unwilling to admit that these cost savings cannot come from simply shifting to low-cost, equally effective
treatments—a scenario that appears too optimistic. The public deserves to know what kinds of treatments might be
restricted under the proposed reforms.

A proposal that shows the most promise, but that has not yet been fully developed, is to develop an objective,
independent entity to recommend treatments for Medicare and other public programs. Creating an enforcement
mechanism would be a powerful cost containment tool, since the Medicare Payment Advisory Commission
(MedPAC) has not been given the authority to contain costs.

Useful examples can be taken from several countries that have developed independent organizations to recommend
coverage based on the value of care. The National Institute for Health and Clinical Excellence (NICE) in England and
Wales recommends some limits to coverage in the National Health Service (NHS); the Germans have developed the
Institute for Quality and Efficiency in Health Care (IQWiG); other countries—Australia, New Zealand, Norway,
Sweden, the Netherlands—are experimenting with processes that set some limits (even if they obscure where some
hard choices lie). These systems go beyond safety and efficacy evidence to consider both cost-effectiveness and
broader measures of the opportunity costs of disseminating one service rather than another. Yet none of these
countries has our urgent cost containment problem, for all of them spend 8-11 percent of their gross domestic
product (GDP) on health care, whereas we spend more than 17 percent (and perhaps more as our GDP shrinks in
the recession).

Beyond the "easy savings" that might be realized through greater efficiencies, electronic medical records, and pay-
for-performance, we will need to grapple with the fundamental imbalances in bargaining power in the market for
health care. All other systems try to achieve a better balance between the buying power of the purchasers of health
services—monopsony powers—and the monopoly powers of the sellers of such services. Savings for consumers
could be realized through better price control of drugs and other services, but these efforts have often been stymied
(for example, Medicare is prohibited from negotiating drug prices).

Cost containment decisions are difficult and morally contentious. It is important to make them in a way that increases
their legitimacy. That means, minimally, deliberating about priorities in a way that is fully transparent, considers all
evidence and ethical arguments, ideally involves relevant stakeholders, and provides opportunity for revising
decisions in light of new considerations. Only with such an approach can we hope to establish legitimacy and
improve the fairness of priority-setting decisions. Discussing how to contain costs and get more value for money
requires more than technical debates—it requires consideration of these fundamental ethical issues.

What Is Fair Financing?

Fairness in financing is a critical element of health reform. If health care were simply a commodity, we could rely on
markets to distribute fairly; then our only concern of fairness might focus on income distribution. But equitable access
to health care is a direct concern of justice, as our arguments concerning protecting opportunities and treating people
with equal respect imply. Further, equitably distributing health care requires heavily regulated markets. Consequently,
fair financing involves two specific goals: protecting people against the unanticipated costs of catastrophic health
events, and redistributing resources from the better-off to the worse-off groups in society (from richer to poorer and
from well to sick). Although the first goal is generally accepted, the second may require further justification.

As we see it, schemes of cooperation among citizens are fair only if the benefits and burdens of cooperation are
shared fairly. Specifically, this entitles all citizens to some adequate share of the social resources and access to
basic liberties and opportunities, such as education and employment. How important redistribution is in health
financing depends on what else society has done by way of redistributing other goods from those better off to those
worse off in opportunity. If, say, Norway, has done a lot to distribute its wealth in ways that promote the opportunities
of citizens, especially those with the worst opportunities, then arguably its better-off citizens might be expected to contribute less to finance the health of its less-well-off citizens. In contrast, the United States has thinned its social safety net and altered its tax system to redistribute less to those who are worse off. Arguably, therefore, it should place more emphasis on health care financing that progressively distributes from the better-off to the worse-off. Unfortunately, the opposite is the case. The problem is even worse in a major recession.

A health care financing scheme most strongly transfers resources from those who are better off to those who are worse off if the former pay at higher rates than the latter. The proposal in the House to add a tax surcharge to high-income earners to raise revenues for coverage expansions meets this redistributive test (although it hardly corrects for the regressive tax cuts of the past administration). As President Obama said in defense of the proposal: "To me, that meets my principle that it's not being shouldered by families who are already having a tough time." A system that covers medical costs with a flat rate on all income, as in a Social Security tax with no ceiling, is the next most progressive scheme, but that is off the table in the U.S. reform debate.

Finally, a health system is fairer if it pools all risks and redistributes from the well to the sick. That happens with community-rated insurance schemes and with regulation that curtails risk-rating for health plan premiums. This stance rejects the relevance of "actuarial fairness" in health insurance. Actuarial fairness means that insurance premiums reflect risks. But moral fairness requires that we accept the social obligation to finance health care according to ability to pay and reject payment according to risk or need. Fairer financing also requires eliminating medical underwriting aimed at finding prior conditions; the individual mandate eliminates the justification for excluding them.

Because financing proposals are likely to cobble together a range of mechanisms, the public must be informed of the degree to which the combination of sources improves or worsens fairness in financing.

Choosing Means With Values In Mind

The mainstream policy proposals on the table vary in how successfully they promise to accomplish the three goals of universal coverage, cost containment, and fair financing. Currently, plans under discussion do not aim at completely closing the insurance gap, and they fall short of what justice ultimately requires in the way of universal coverage. Since subsidies alone will not guarantee the goal of universal coverage, a mixed public-private system also requires an individual mandate to purchase insurance. The mandate serves multiple purposes: it eliminates any free-riding, it undercuts adverse selection, and it improves population health. As for "lack of choice," we note that in systems based on a payroll tax or general income tax, choice is also replaced by the general obligation to pay taxes--no free-riding here, either. Massachusetts' recent experience demonstrates the effectiveness and political feasibility of an individual mandate as part of a broader set of reform measures. The issues surrounding an employer mandate are more complex, focusing on where the burden for assuring universal coverage lies.

No single proposal to limit costs has won widespread approval, even among the Democrats. The centrist "Blue Dog" Democrat coalition and many Republicans have argued that plans to expand coverage should be scaled back in order to reduce the deficit. But many members of this same coalition have resisted efforts to reduce payments for wasteful spending and to increase government bargaining power. The nonpartisan Congressional Budget Office (CBO) has emphasized that "achieving substantial and lasting savings...would require fundamental changes in the organization and delivery of healthcare." Rationing high-cost medicine and changing the incentives within the system are not going to be easy changes for some consumers and will be resisted by interest groups that will lose profits. Nevertheless, these objectives should be pursued in order to realize the ethical imperatives to conserve resources and expand access to care.

Achieving the third goal, increased fairness in financing, may be accomplished through several measures currently under discussion. A modified community rating system of insurance premiums, in conjunction with an individual mandate, would help ensure that market reform is effective. Adding a surcharge to the taxes of high-income earners to pay for insurance expansions, like capping the current tax exemption for employer-sponsored health insurance, would improve the progressivity of health care financing.

An ethically sound plan does not demand the inclusion of one specific collection of features. However, as the political process plays out, compromises will be inevitable, and not all ethical goals will be fully realized. Political constraints
may render more radical or comprehensive reform infeasible. Yet incremental reforms should not be ruled out simply because they fall short of complete fulfillment of ethical principles (particularly if incremental steps facilitate, rather than limit, progressive realization of full benefits over time). A commitment to ethics in health reform does not preclude all forms of compromise. Rather, ethical analysis helps illuminate the distinction between the goals that are morally critical from the means that fall in the domain of political compromise. Achieving ethical health reform will require a balance between steadfast commitment to what is ethically important and pragmatic flexibility about the means of reaching those goals. It also requires ongoing monitoring and evaluation of the reforms that are implemented, for changes to delivery systems are "social experiments" carrying both risks and benefits that we should track.

The door of opportunity for health reform is now open; enacting comprehensive reform is a critical, but not a final, step toward a more caring, healthy, and equitable society.

NOTES


16. Oberlander J. Through the looking glass: the politics of the Medicare Prescription Drug, Improvement, and


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