ISSUE BRIEF

The Ethics of Health Care Reform

by Merrill Matthews, Ph.D.

What does it mean for a health care system to be considered "ethical"? Some claim the most ethical is a government-run system that guarantees universal coverage. Others think the system must control costs, or eliminate profits, or ration care to those most in need. But a consumer driven health care system is the one that best meets the criteria Americans want from an ethical health care system.

Winston Churchill once famously commented, "Democracy is the worst form of government except all those others that have been tried from time to time.

Something similar to Churchill's quote might be said of health care systems: That a consumer driven health care system is the worst form, except for all the others that have been tried.

There appears to be a widespread assumption, held both by liberals and many in the media, that a government-run health care system that provides universal coverage is the most ethical. Yet every health care system struggles with issues of access, cost containment, quality and patients' rights—*every system*. And every one struggles with some of those issues more than others.

So what does it mean for a health care system to be considered ethical? What principles should—"should" being a "normative," or ethical, term—guide that system? And which of the available models comes closest to meeting the criteria?

What Are the Alternative Models?

Health care is paid for in a number of ways:

Paying out of pocket for all costs: Paying out of pocket was the standard way to pay for health care services before health insurance—both private and government-run plans—emerged as the primary payer. In the U.S., health insurance had limited availability prior to World War II, but greatly escalated shortly afterward. However, there have been some recent innovations in the out-of-pocket model, namely allowing people to deposit a limited amount of money tax free into a special account that can only be used for health care expenditures. The country of Singapore, for example, incorporated a variation of the out-of-pocket model by introducing "Medisave Accounts" in 1984, personal tax-free accounts used solely for paying health care expenses. When Singaporeans needed care, they paid for it out of their accounts. Indeed, it wasn't until the early 1990s that Singapore allowed its citizens to combine their Medisave Account with a very high-deductible health insurance policy for catastrophic costs.

An insurance model: Over the past 50 years, health insurance has become the primary way Americans pay for health care. In the first half of that period, health insurance was simply an indemnity service. A patient could go to virtually any hospital, doctor or pharmacy, and the insurer would reimburse for a portion of those costs, after a deductible, with few or no questions asked. As any economist will tell you, such cost insulation leads to higher consumption—and therefore upward pressure on health insurance costs. That pressure drove employers to look for ways to control the cost increases. By the mid-1980s, traditional health insurance was evolving into a managed care model, where patients paid a co-pay more often than a true deductible. Managed care also introduced access restrictions as a way to control costs. But managed care didn't change the underlying economic incentives for patients insulated from the cost of care. In fact, managed care only increased the tension because, over time, patients' out-of-pocket costs have steadily declined.

A government-imposed, public-private model: The rising cost of health insurance—which is a function of higher health care spending—exacerbates the problem of the uninsured. That, in turn, leads to politicians proposing a range of "solutions" to reduce the number of uninsured. But those solutions often rely on government restrictions and regulations to make health insurance fit the politicians' notion of the way a health insurance market should work. That approach was the driving force behind the 1993 Clinton health care reform plan that never passed, and the new Massachusetts reform plan that was implemented in 2006. The idea underlying this public-private model is a system where private sector coverage still plays a role—how important a role depends on who is proposing the plan and the restrictions imposed—but the government has a very heavy hand in developing coverage packages and overseeing, regulating and even financing the system, so much so that it can be hard to tell where the private sector stops and the government begins. This approach appears to be growing in popularity, especially among the Obama administration and the Democratic leadership in Congress, but it is also emerging at the state level, as politicians look for ways to reform health care in their respective states.

All of these systems have their pluses and minuses, and they have their defenders and detractors. The question we want to ask is which one is the most ethical?

A consumer driven model: A consumer driven model tries to find a way to put the patient in charge of most or all of his health care decisions. It usually includes at least two components: health insurance for large expenses, while routine and preventive care is financed out of personal funds, including a tax-favored Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (ideally, without the use-it-or-lose-it provision). The idea is to give patients more control over their money for many of the routine health care decisions, while ensuring they are protected from large, catastrophic claims.

A pure single-payer model: The public pays higher taxes and the government funds most health care expenses. Under the "pure" system, like that of Canada (at least before a recent Canadian Supreme Court decision may have undermined this model), patients are prohibited from opting out and going to the private sector or paying out of pocket for services that are covered by the government plan. The private sector may still exist, but only to offer non-covered services, such as cosmetic surgery. The rationale behind this approach—which has been praised by a U.S. physicians' group pushing for a single-payer system—is that it forces everyone, including the wealthy and powerful, to be in the same system. Doing that, proponents contend, will force the politicians to adequately fund the system—since they will also be in it. [It is interesting to note how many proponents of the pure single-payer system recognize that the incentives created by it are such that people must be compelled by law to remain in the system. If the system were so good, why must people be forced to stay in it?]

A single-payer model with an opt-out provision: Under this approach, used in Great Britain and most single-payer countries, the large majority of people are likely to be in the public system. But there is a private sector, often both for insurance and for health care providers, that people can choose if they want to opt out of the government-run system, although their tax dollars continue to finance the public system. Thus, this model functions somewhat like the public school system where everyone's taxes fund the public system, but those with the desire and the resources can opt out, which arguably allows the system to spend more money on patients remaining in the public system.

All of these systems have their pluses and minuses, and they have their defenders and detractors. The question we want to ask is which one is the most ethical? Answering that question means we first have to ask with what criteria, and what approach, we should use to judge whether a health care system is ethical.

Making Ethical Decisions: Principals vs. Consequences

When confronted with an ethical dilemma, people usually look for a process that helps them make a decision. Historically, philosophers have identified two basic approaches (with several sub-levels): those who look for one or more principles (or rules) to guide them in what they should do, and those who focus on the consequences or results of their actions.

In ethical theory, the first approach is usually referred to as the "deontological approach," after the Greek word "*deontos*," meaning "ought" or "right." The second approach is generally referred to as the "teleological approach," after the Greek word "*teleos*," meaning "result" or "end." To provide you with an example of each, let's turn to the Greek philosopher Socrates for the former and the American theologian Joseph Fletcher for the latter.

After Socrates had been convicted (unjustly, by most accounts) by a jury in 399 BC for allegedly corrupting the Athenian youth and denying the gods, he was thrown into jail to await his execution. Socrates' student Crito came to see him in jail to persuade his teacher to escape. Socrates refused and defended his decision by highlighting the importance of standing by one's principles over any consequences that might befall him. Says Socrates in the *Crito*:

> For I am and always have been one of those natures who must be guided by reason, whatever the reason may be which upon reflection appears to me to be the best; and now that this chance has befallen me [i.e., convicted and waiting to be executed], I cannot repudiate my own words: the principles which I have hitherto honored and revered I still honor, and unless we can find other and better principles, I am certain not to agree with you; no, not even if the power of the multitude could inflict many more imprisonments, confiscations, deaths, frightening us like children with hobgoblin terrors.

Notice that Socrates has found at least one principle (maybe more) that he believes should guide his actions, regardless of the consequences—in this case death. That's the deontological approach.

Now consider theologian Joseph Fletcher's teleological argument in another famous book, *Situation Ethics: The New Morality* (1966):

> Let an anecdote set the tone. A friend of mine arrived in St. Louis just as a presidential campaign was ending, and the cab driver, not being above the battle, volunteered his testimony. "I and my father and grandfather before me, and their fathers have all been straight-ticket Republicans." "Ah," said my friend, who is himself a Republican, "I take it that means you will vote for Senator So-and-So" [i.e., Barry Goldwater]. "No," said the driver, "there are times when a man has to push his principles aside and do the right thing." That St. Louis cabbie is this book's hero.

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Yes, principles are important for Fletcher, but the consequences of our actions sometimes demand, he argues, that we set our principles aside so that we "do the right thing." In other words, there are no principles that cannot be ignored if the situation demands it. Hence, the term "situation ethics," which is sometimes said with a condescending sneer by the defenders of a principles-based approach to ethics.

Now let's apply these two approaches to a couple of contemporary health care examples. Some years ago California was considering legislation that required a doctor to ascertain whether a patient was a U.S. citizen before providing treatment. I heard doctors complain that, if passed, they would have to break the law. They had a moral and professional obligation (principle or duty) to treat a patient, irrespective of the patient's residency status. Those doctors were affirming that they were bound by a principle that took precedent over the law, even if taking those actions meant the doctor might face a penalty.

In another example, several years ago on a radio talk show I debated Dr. Stephanie Woolhandler, a Harvard physician and one of the most vocal proponents of a government-run health care system (indeed, she wants the pure single-payer system with no opt out). During the discussion, I commented on the long waiting lines in Canada. Canadians have a single-payer system and frequently face significant lines to see a physician or receive care—waiting times that often harm patients and undermine the quality of care.

Dr. Woolhandler conceded that there are waiting lines in Canada, but argued that they weren't that long, and even if they were it was a small price to pay for guaranteeing universal health insurance coverage. As a physician, she would normally be opposed to patients having to wait for needed care. But she thought that principle could be set aside if it meant the result was universal coverage.

When a third party—government, insurer or employer—controls most of the health care funds, that entity eventually becomes the decision maker, not the patient.

There has been a long philosophical debate over which approach to confronting ethical dilemmas, principles or consequences, is better and how one determines which should guide us. Trained philosophers often try to be consistent by choosing and defending one approach over the other. But the fact is that most people incorporate *both* approaches when making an ethical assessment; they look for principles to guide their actions, but evaluate the expected consequences. In other words, they want to be "principled" people, but they also want to ensure their actions produce good consequences for as many as possible.

We aren't going to be able to solve the long-running debate over whether the deontological or teleological approach is better suited to guide us in making ethical decisions. But that isn't a problem because I will argue that a consumer driven approach comes closest to meeting the leading ethical principle guiding medicine today, while at the same time addressing the issues that most concern a consequentialist.

Principles for an Ethical Health Care System

There are lots of generally accepted principles in health care, but there has been a growing consensus behind one in particular: that patients should be the ones who make the important decisions about their health and bodies. This principle can be seen in the growing support for informed consent, for full and honest disclosure about a patient's prognosis, and for the right of a conscious and competent patient to refuse care, even if it means death. Call it the "patient-as-decision-maker" principle. And it implies that patients, rather than a third-party payer, should be the key decision maker with respect to basic medical care.

This recognition is quite a change from the doctor-directed health care system that prevailed for decades, where doctors were the primary decision makers, in part because they had the greatest access to information, and they were perceived to know what would be best for the patient.

But change was needed, and handing that decision-making power back to the patient has become one of the most fundamental ethical principles in health care. Virtually all of the major health care reform proposals explicitly embrace this principle by making statements to the effect that patients should make their own decisions about their doctors and treatments.

If we can agree on the primacy of the patient, then an ethical health care system must promote the patient-as-decision-maker model. That goal *could be* achieved in several of the health care systems listed above. But as a practical matter, it isn't; and that's primarily because financial and other constraints enter the picture. When a third party—government, insurer or employer—controls most of the health care funds, that entity eventually becomes the decision maker, not the patient.

Americans, both patients and health care providers, have a lot of experience with third-party payers directly inserting themselves into the health care decision-making process. Those insertions have declined over the past few years, both in frequency and intensity, in part because some HMOs have backed off of some of their more aggressive cost-control tactics. And it should be said that the vast majority of claims are paid quickly and efficiently, without any interference. But as long as a third party pays most of the bills, it will want to have some say in what it's paying for.

Ironically, while single-payer advocates, such as filmmaker Michael Moore, have been some of the most vocal critics of private sector health insurance restrictions, government-run systems are no

better—just subtler, sometimes, in how they go about it. Instead of saying to a particular patient, "Our company health plan will not reimburse you for that procedure," the single-payer systems will just cut the budget from the top down for products and/or providers, making them difficult or impossible to get. There is not a lot of difference between a private sector third party saying, "You cannot have a CT scan" (or a certain drug or an operation), for example, and the government underfunding hospitals so that they cannot have enough CT scanners to treat patients in a timely fashion. The result is the same: the patient doesn't get a needed CT scan. One approach is just a little more blatant than the other, and therefore easier for politicians—and filmmakers—to demagogue.

An ethical health care system doesn't just promise people they will get the care they need, it empowers people so they can get that care.

The point is that whenever a third party is required to pay the vast majority of medical claims, there will eventually be some type of top-down rationing; the only question is who is doing the rationing?

The Need to Achieve Certain Goals

So we have a principle that should guide us in determining the most ethical health care system—the patient as decision maker. But what about the consequences? Anything we want to call an ethical health care system must also be a workable health care system that satisfies needs (i.e., is concerned with consequences). And so we have to balance our patient-as-decision-maker principle with at least three important concerns.

- Ensuring that virtually everyone has access to health care, which is made easier when someone has health coverage;
- Providing access to quality—and when applicable, innovative—care; and
- Keeping costs reasonable.

These are the consequentialist-based issues that drive the second approach for making ethical decisions. What good is it to say that patients are free to choose which type of health insurance policy they want when state laws have made health insurance so expensive very few can afford it? What good is it to say patients can choose whichever physician they want, if physicians don't participate because reimbursement rates are too low? What good is it to say patients have access to quality care when waiting lines are so long patients can't see a physician in a timely manner?

Lots of health care reform advocates ignore these problems. They are so focused on getting the government to "guarantee" that everyone has coverage that they are willing to accept waiting lines, inefficiency, price controls or rationing just so they can claim that the system is universal and equitable. But as Canadian Supreme Court Chief Justice Beverly McLachlin noted with regard to waiting lines, "Access to a waiting line is not access to health care."

An ethical health care system doesn't just *promise* people they will get the care they need, it empowers people so they can get that care.

Comparing the Various Models

I submit that when we consider the various health care systems discussed above, the consumer driven model, which is still a relatively small part of the U.S. system, is the only one that best meets and balances the criteria for an ethical health care system. It adheres to the principle of patient choice while ensuring the more practical concerns of affordability, sustainability and quality. The other models just can't compare.

The Single-Payer System. Because the government pays most of the medical bills in a single-payer system, proponents claim that leaves the patient free to be the decision maker. And in theory it does; in practice, not so much.

People know the old saying about the "Golden Rule," i.e., he who has the gold makes the rules. The motto recognizes the truth that vendors must cater to the one paying the bills. The more the third party pays, the more the vendor has to cater to the third party, not the patient. And while no one finds this practice odd in other segments of the economy—indeed, consumers demand that vendors respect their wishes or they will go elsewhere—some people want to ignore the issue or even deny it goes on in health care. In a single-payer system the government pays the bills. Eventually, no matter how hard people try to keep it from happening, the government will make many if not most of the health care decisions—which negates the fundamental principle of the patient-as-decision-maker.

Traditional Insurance. Of course, something similar can be said of traditional health insurance after it transitioned from an indemnity model to an HMO model. Although both traditional insurance, as well as the single-payer model, usually begin with a significant amount of patient autonomy, that freedom diminishes over time. When a third party is obligated to pay for the vast majority of care—currently, patient out-of-pocket spending is about 12 percent of total health care spending, down from about 40 percent in 1970—patients and even providers will look for ways to insulate the patient even more from the cost of care. When that happens, it's almost an economic law that total spending will increase. Those increasing financial pressures will eventually force the system, even one that wants to grant as much patient freedom as possible, to step in and deprive the patient of that decision-making control. Hence, the rise of HMOs, prescription drug formularies and pre-certification, among other types of access restrictions.

Why should that be the case? Because no system has the financial resources, whether those resources come from the government or the private sector, to provide all the care that cost-insulated patients and their physicians can spend if there are no restraints. Thus, both a single-payer system and the traditional insurance model will eventually see costs rise so fast that they have to clamp down on utilization, which means taking decision-making control away from the patients.

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The point is that traditional insurance, to the extent that it insulates the patient from almost all costs, will eventually adopt access restrictions and even price controls just like government-run plans. And that development undermines our principle of patient choice.

The Out-of-Pocket Model. Of course, a system where most or all of the costs are paid out of pocket greatly reduces or eliminates the top-down control problem. Patients, in consultation with their physicians, make decisions and pay for their care. But such a system also leaves people vulnerable when they face very high health care costs. For example, the Singapore health care system was, for many years, built around Medisave accounts (similar to the Health Savings Accounts plans in the U.S.), only without the insurance component.

Patients were given a range of choices related to their care, depending on how much they wanted to spend, and almost all health care was paid for out of the tax-free Medisave accounts. Since the account money belonged to the individual, spending it was similar to out-of-pocket spending, but the money wasn't coming out of the family's operating budget.

Defenders of the Singapore system argue that Singaporeans had access to affordable, quality care at much lower costs than the U.S. And patients made their own decisions; there was no top-down third party telling them what they could and couldn't have. However, patients were still vulnerable to very high costs because for years there was no catastrophic insurance coverage—a necessary ingredient in order to have access to expensive medical procedures. Singapore changed its model in the 1990s so that people could get access to catastrophic coverage, making it similar to the consumer driven model which often includes a high deductible policy.

Thus the out-of-pocket model permits the greatest patient freedom in one sense—no third-party payer is telling the patient what he can and can't have. But it is still limited because patients incurring costs that exceed their ability to pay face another type of access issue—they can't have what they can't pay for.

The Public/Private System. Today, trying to create some type of public/private insurance partnership is all the rage, with state after state looking at the Massachusetts reform plan, with its "Connector" and requirement that everyone have health insurance or face a penalty. But putting that much control in the hands of the government and selected insurers simply means we will see the same problems that plague single-payer and traditional insurance systems: someone besides the patient will be controlling the money and the decisions. That's certainly what's happening in Massachusetts right now, and it was a key ingredient in President Bill Clinton's health care reform efforts. The problem is that it is very hard to have a marriage of unequals. In

most such public/private partnerships, the "public" partner exerts a much heavier hand than the private partner. And soon, it is really just a public plan.

The Consumer Driven Model. The consumer driven model seeks to put the patient in control of most health care decisions—at least the smaller and routine health care expenditures—and facilitates that goal by putting more of their health care dollars in patients' hands. They still rely on insurance for major expenditures, but insurance under this approach serves as an indemnity tool rather than a cost-containment tool.

The Ethics of the Consumer Driven Model

The consumer driven model is the only one that incorporates both our fundamental principle—patient control—and yet balances the consequence-oriented need for access to coverage and quality care that is financially sustainable over the long term.

In the consumer driven model, patients pay for most of their routine care out of pocket or from a special tax-preferred account, such as an HSA. But insurance is still there to protect them in case of catastrophic expenses. Because it's high-deductible insurance, it's less expensive, leaving money available to deposit into the HSA. (Note: in most employer-provided HSA policies, the employer will pay for the insurance policy and provide some or all of the funds for the HSA).

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Because consumer driven policies cost less and give people more control over their health care dollars, one would expect lots of uninsured people and lower-income workers to be choosing them, and that is exactly what we are seeing among those purchasing HSAs in the individual market. According to various surveys:

- More than a third of purchasers had incomes under $50,000;
- Around a third were previously uninsured.

In addition, more than a third of firms starting to offer HSAs did not previously offer any insurance. The cost of consumer driven plans also tends to grow more slowly than traditional insurance, meaning that over time, HSAs will become more affordable, and so we should see demand grow even more.

Adding the Safety Net

Of course, one of the reasons for claiming a single-payer system is the most ethical is that low-income people and those with medical conditions can get coverage (which, as I have already pointed out, is not the same as "getting care"). No one is excluded.

However, the consumer driven approach has a response: by providing funding support for low-income people, perhaps by using tax breaks or some type of voucher system, they too can buy high deductible coverage and fund their HSA. Nearly all health policy experts now recognize that the current employer-provided health insurance system has a problem: employer-provided coverage and the self-employed get a significant tax break that workers who buy their own coverage don't get. There have been several proposals intended to level that playing field, which is an important part of fundamentally reforming the health care system. But even if Congress fails to do that, it can still provide low-income workers with a tax credit that can only be used toward the purchase of health insurance.

But note, the HSA money that comes from the employer or as part of a government-subsidized plan has to go to the individual, and the person decides how to spend it—that component maintains patient control. There is, incidentally, nothing unusual about this approach. The food stamp program works the same way. Money goes to the individual, who then shops and buys what and where he or she wants. That preserves consumer choice within the safety net.

The same thing can be done for the uninsurables (i.e., the uninsured who have a pre-existing medical condition). That's where state-based high risk pools come in. Some 35 states have created these high risk pools; some work very well, others not so well. But properly structured, they are an excellent way to provide insurance coverage for the uninsurable.

Conclusion

There is only one system that promotes patient choice, and yet still maintains the elements of a well-functioning health care system that ensures access to quality care while keeping costs under control: the consumer driven model.

We agree it is far from perfect, but we also think Winston Churchill would agree that it is better than all of the other systems.

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IPI Issue Brief is published by the Institute for Policy Innovation (IPI), a non-profit public policy organization.

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