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## ETHICAL ISSUES IN HEALTH CARE REFORM

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The subject of health care reform is much in our minds these days. On the one hand, it is difficult to find anyone who admits to being opposed to health care reform. On the other hand, I think we may all easily foresee it is going to be extremely difficult to come up with a health care reform program that will satisfy everyone. So, if almost everyone agrees it needs fixing, why is it so difficult for people to agree on what we should do to “fix” the health care system?

I want to show that there are at least three different angles—three different perspectives—on health care and the “ethic” of health care. Each of these three perspectives has its own peculiar “ethic” and these ethics are all too often conflicting. Furthermore, not only do we find different people with different ethics approaching this issue from these different perspectives, usually each of us feels pulled by more than one perspective. Thus, for any health care reform program to *really* prove ethically satisfying and successful, it must somehow bridge or go beyond these disparate perspectives.

Let me begin by outlining the different ethics of each of the three perspectives.

### **Health Care as a Positive Moral Right**

As a nation, we have come to regard health care as something of a moral right. That is, individuals have a right to health care, and if a person has insufficient economic resources to pay for such care, we as a society have an obligation to see that poverty is not an obstacle to receiving health care.

Behind this view is the assumption that health care is somehow morally different than other goods and services in our society. We feel no moral obligation to purchase a Cadillac Seville for each and every citizen. We even feel no moral obligation to purchase a used car for someone so he or she may drive it to and from work. Neither do we feel we must purchase a big screen television for each household that cannot afford one out of its own economic resources. But health care, somehow, is importantly, morally different.

There are various kinds of arguments used to support this position. One might argue, for example, that if one’s health is compromised, then one is unable to participate in our society. One does not

have the same access to the goods and services, jobs and rewards, as healthy people. Thus, our commitment to moral egalitarianism, to equal opportunity, requires that we, as a society, ensure that each and every citizen has access to health care. Indeed, equal opportunity would appear to dictate not only that everyone have access to health care, but qualitatively equal health care.

This moral commitment to the moral equality of individuals is already present in our national system of organ distribution for transplantation. No one can use his or her wealth in this country to purchase an organ, thus excluding people of more meager resources from the chance for an organ transplant to save or improve their lives. Rather, each and every one stands in a line—take a number and wait. The only thing that is supposed to advance you faster in line is a severe crisis in your medical status such that if you do not receive that organ soon you will die.

A different kind of moral argument for this position might be one derived from a view of human life as “sacred,” as being beyond price in its worth. Since life is sacred in a way that automobiles are not, we have a moral obligation to ensure that fiscal stinginess on our part does not result in the unnecessary loss of human life.

I said earlier that we, “as a nation,” hold to this view. Evidence for this claim can easily be found in the language behind the Medicare and Medicaid acts of almost thirty years ago. The Medicare act explicitly states that every older American should have access to the “best” medical care available without regard to his or her ability to pay. A similar spirit is behind the Medicaid program—that we, as a nation, have a moral obligation to ensure that extreme poverty not be a barrier to access to quality health care.

This moral view, that each individual has a positive moral right to the highest quality health care, is an important assumption behind the Clinton health care reform proposals. Notice three key reasons the Clinton team offers for the necessity for reform:

1. First, there are currently some 37 million persons in America without any health insurance. Furthermore, a like number of Americans are grossly under-insured.
2. Second, even securely middle-class Americans are in great danger of losing their health care insurance. Since insurance companies are in business to make money, they are inclined to avoid subscribers who will make heavy use of medical services. Hence, health insurers are apt to find ways to limit benefits to currently enrolled members, and are extremely apt to deny enrollment to applicants with existing medical conditions. Since the cost of medical care can be so ghastly high these days, without decent health insurance the average middle class family can quickly become impoverished by a single major illness. Indeed,

the Clinton committee argues many Americans are scared away from starting small businesses because they cannot afford the high premiums insurance companies may demand. As the Clinton health care reform committee argues, middle class Americans are afraid to switch jobs because of the prospect of losing their health insurance; and they are scared that through catastrophic illness they may lose meaningful coverage even if they do not lose their jobs.

3. The Clinton committee is eager to assure Americans it will not ration care. It holds we should be increasing access to care, not restricting access. Hence, the Clinton reform proposal is explicitly anti-rationing. It is not a reform program designed to withhold or ration services.

What ties each of these three points together is the notion that Americans should not be vulnerable to loss of access to health care. Rather, access to health care should be guaranteed morally. Clearly, such reasons for health care reform only make sense if one is committed to the position that each individual has a positive moral right to health care.

Not surprisingly, the American Medical Association (AMA) is in favor of health care reform. Physicians, at least at times in their professional history—and the late twentieth century has been one of those times—have held that they have a moral obligation to promote the medical welfare of their patients as individuals. Clearly, if a patient cannot obtain medical services because of an inability to pay, then that patient's medical interests are not being best served. Hence, the AMA has come down squarely on the side of universal access. (Of course, one may be cynical and point out that physicians are liable to have more income-producing business if there is governmentally paid universal access, but I leave that point for a few minutes).

Clearly, if we believe health is a *positive moral right* of each and every individual, then the existing health care system (insofar as it can even be called a "system") is a moral travesty. Each and every day millions of Americans are denied access to basic, primary health care because they cannot afford it. Many of them get sicker and sicker until what had been a simply correctable, treatable problem becomes a life threatening nightmare.

The way health care is now delivered (or not delivered) to individuals shows little or no respect for a positive moral right to health care. To meet this moral demand in a minimal sense will require a health program providing universal coverage. And in a stronger sense of egalitarianism and the value of human life, a suitable health care reform proposal should provide not only for access to minimal health care, but rather for the highest quality health care available.

## Health Care and the Ethic of Business

Health care has never been a completely charitable endeavor. Through the ages, physicians have typically felt some professional moral obligation to provide *some* care to the indigent, but (at the professional level) it has usually been at the margins. After all, physicians, like most of us, have themselves and their families to financially support.

With regard to hospitals, the story is a bit more complex. For much of the history of medicine, the economically advantaged received their health care in the home. Physicians made house visits and, when necessary, nurses or other care givers were available, either from family or from hiring. Hospitals, for the most part, were charitable institutions designed to provide a place of care for those so destitute as to not have care available in the home. But as medical science and technology developed, the hospital became an integral locus of health care delivery, whether for rich or for poor. Then, the post World War II period saw a mushrooming of employer-paid health insurance programs, such as Blue Cross/Blue Shield. This meant hospitals would receive adequate reimbursement for the hospitalization of a far greater portion of the American population than ever before. Finally, the institution of Medicare and Medicaid, nearly thirty years ago now, meant hospitals were being compensated for care that previously had been charitable. Not surprisingly, our notion of hospitals as charitable, philanthropic institutions has changed to hospitals as business institutions.

Naturally, the health care industry responded to market forces. The demand for physician specialists, trained in the ever broadening ranges of medical technology, forced up specialist incomes and encouraged more medical students to eschew general practice in favor of specialties. Hospitals that had on hand the latest in medical equipment attracted these specialist physicians and their patients (and their revenue!). Hence, hospitals rose to the challenge—they expanded and modernized their facilities and installed the newest, glitziest technology as it rolled off the production line.

In at least some areas, the health care industry as a business has been enormously successful. America is, without doubt, the leader of the world in terms of medical expertise and innovation. We surely have more MRIs, CT Scans, laparoscopic equipment, etc. per capita than any other country. The attractiveness of our hospitals, as well as the opportunity for high income, has made America the beneficiary of a world-wide physician brain drain. Some of the most talented medical minds and hands from numerous countries—Britain, Canada, India—have brought their considerable talents to benefit the people of America—well, at least to those who can afford their services.

As with most any economic commodity, there will be some who can afford the best and others who cannot. Health care has proven to be no exception. A very few people can afford a Lexus automobile, fewer still a Jaguar or Rolls Royce. A few more have access to a Cadillac. Many Americans, on the other hand, can manage the price of a Ford Taurus, a Toyota Corolla, etc. Nearing the bottom, a few can only manage a Hyundai. And woe be unto those who purchased a Yugo, that import from a country that no longer really exists. And finally, there are many Americans who cannot afford any automobile. Very few Americans would look upon this and cry moral turpitude. The health care industry, analogously, is only behaving according to the same marketplace laws of behavior as automobile manufacturers.

Lest one rush to condemn such practices in the health care industry, please remember it is we who have insisted the industry behave in this fashion. We flock to the specialists when we feel the need. We prefer the hospitals with the best hotel services and the best technology. We prefer to take our business to the physician with whom we are comfortable. The health care industry is only doing what we ask of it: operate according to the *ethic of business*.

From this perspective, physicians, hospitals, insurers, even drug companies are not moral villains. They are simply acting according to the ethic of business.

Still, even from this perspective, there is a need for health care reform. We feel as though the industry has gotten away from us, it has slipped out of our control and now the spiraling costs of health care—around 14 percent of our GNP—economically threaten us. We find it more and more difficult to compete in the international marketplace because our health care costs, borne largely by employers, are far, far greater than those of any of our competitors. And if the real buying power of middle class income has been stagnant for the last decade, it is at least partly because of the double digit rise in health care premiums employers have been faced with most years. Vastly higher employer-paid premiums must mean less money available for real wage increases. So that we have some sense of what we are talking about, let me note that we currently spend around \$3,500 per person annually on health care. Individuals pay for only about 20 percent of that figure out of pocket, the rest being picked up by employers and government. Think what kind of pay increase that could mean for a typical, middle income family of four! The Clinton reform proposals argue that costs must be contained—and they are surely right.

How did we get into this pickle, where we seem to be spending far more on health care than any of us would appear to want? The straightforward answer points to how most Americans are insulated from medical expenses. Since the advent of widespread health in-

urance (the second half of this century) Americans have paid less and less of their health care expenses out of pocket. The bulk comes from employer-paid premiums and government programs such as Medicare and Medicaid. So, although it is partly my money in a very distant sense when I receive medical care, the reimbursement mechanism is so removed from me as an individual that I do not directly feel the expense. Hence, whereas when it is most definitely *my budget* that feels the pain when I buy an automobile for myself, it is not my personal wealth that feels the pain when I receive expensive medical care. So, while I might settle for a Ford Taurus (or in my own case, a *well used* Volvo), when it comes to my and my family's health care, I have no real incentive to economize. Hence, I demand the best of whatever medical care has to offer.

No wonder our expenditures on health care are so high!

In one sense, health care reform is already underway. In response to these economic forces and constraints, employers have turned to cost-effective, managed care programs to limit the growth in what they must spend for health care as a benefit to employees. And the Clinton reform proposal clearly embraces this notion of *management* of health care expenses.

### **Health and the Social Ethic**

Finally, we also regard health as a social good. It is not in our nation's own best interest to have a populace wracked and consumed by disease. From even the most cynical view, sick people do little to contribute to economic production and income taxes. A healthy workforce can produce more than a sick workforce. From a more generous point of view, few of us would disagree with the statement that suffering is bad and health is good. But when regarded as a *social good*, the question is not simply how much health care is in the best interests of *the individual* (that was our first moral perspective). Rather, the question becomes how much health care is in the best interests of *society*, given our limited resources and the welter of other good and services that are of value. For example, how much should we spend on health as opposed to education? As opposed to public housing? As opposed to law enforcement? As opposed to our physical infrastructure—roads, utilities, etc.?

Consider the case, for example, of the Lakeberg Siamese twins, Angela and Amy. The twins were born at Loyola University Medical Center, joined at the abdomen. They shared several major organs, including the liver and a malformed six-chambered heart. Medical opinion was that Amy had no chance of long-term survival; Angela, if separated from Amy, had a 1 percent chance of survival. The Loyola physicians recommended against doing the surgical separation, urging instead that the twins be allowed to die. (I should mention that the Loyola physicians recommended against surgery not

primarily on the cost consideration, but rather because they believed it would constitute pointless suffering for *both* of the twins). The Lakeberg parents, rejecting the advice of Loyola physicians, opted to go to Children's Hospital in Philadelphia where pediatric surgeons were willing to perform the surgery, even though they agreed the chances for long-term survival were 1 percent.

Now I have no idea what the costs will be at Children's in Philadelphia. But I can suggest that the costs at Loyola were in the neighborhood of \$1 million. As a society, are we willing to pay for that procedure one hundred times with the likelihood of saving one life in the long term? That would be, according to a crude calculus and *ignoring* the huge costs at Children's in Philadelphia, a willingness to spend one hundred million dollars to save one life. I doubt many of us would consider that a prudent investment.

Oregon has taken the lead here. In a bold experiment, the state ranked several hundred medical interventions according to their importance and cost-effectiveness. Each year, the legislature is to decide how much money it can allocate to the Medicaid program. It then runs down the ranking of medical interventions and (using epidemiological statistics) draws the line where it estimates the state will spend that much money if it pays for all the interventions above that line. Not surprisingly, immunizations are near the top, as are appendectomies, antibiotics for bacterial infections, etc. Near the bottom are such items as liver transplants and intensive care unit care for AIDS patients at the end stages of the disease.

I am sure you are all able to see how these three different moral perspectives on health care offer a recipe for conflict.

A health care reform program that satisfies our rhetoric of health care as a moral right of the individual would presumably cover the Lakeberg twins. It would pay for liver and pancreas transplants. But such a program would devastate the economy and draw much needed funds away from other social goods such as schools, housing, roads, defense and job opportunities.

A program that treated health as *simply* an economic good and/or service would do nothing to extend coverage to the uninsured. And in the cold calculations of the marketplace, the suffering of economically marginal people will not be heard.

A program that regards health care *simply* as a social good would inevitably reduce patient choice (something the Clinton committee seeks to preserve), not only in terms of physicians, but also in terms of what services they may receive, e.g., health as a social good would most certainly not fund the Lakebergs, nor would it fund most of the intensive care unit care delivered in our nation's hospitals.

So any health reform program that adheres to just *one* of these ethics is doomed to moral failure according to the other two.



By the same token, it is hard to see that any reform program could satisfy all three at once. The Clinton program would seem to emphasize universal access, while trying to also accommodate economic concerns by means of insurers *competing* for the business of the “health alliances.” The committee imagines that administrative costs and fraud can somehow be made to vanish and then whatever is needed will miraculously be paid for. A more jaded view would suggest that if we want to pay less for our health care *and also extend coverage to the currently uninsured*, then ultimately we must buy less health care per capita. In the words that our economists are wont to use, “There’s no free lunch.”

Is there any way out of this unfortunate position? Or must we be cynics and conclude that any reform proposal is doomed to failure?

I am convinced the only way for us to really make progress toward an effective, and morally needed, health care reform is to openly acknowledge the moral legitimacy of each of these three perspectives at one level; but then we must go beyond that. It will be necessary for us to engage in a meaningful discussion of how to balance these disparate moral commitments. To do that we must go beyond these three perspectives, we must get above them to a higher level of moral value that can arbitrate between them. That is, we must work out a notion of what we want health care to do for us, as individuals and as a community. We must have a higher sense of what the good life is for us as individuals, and what would constitute flourishing for our social community. Only then will we be able to see how medical care fits into that larger picture, of which it must inextricably be a part.

I only hope that we may have the ability and the courage to undertake such an enterprise—our very future, moral and economic, is certainly at stake.