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Confronting the Ethics Behind Health Care Reform

by Mark H. Waymack

When then-candidate Clinton proclaimed the reform of America's health care delivery system as one of his central campaign commitments, the chorus of the public seemed aligned behind him. And even during the first year of his presidency, as the White House worked diligently to formulate its proposal for health care reform, almost no one opposed reforming the system. Nearly everyone saw great flaws in the system that ought to be corrected. But as the outlines of the reform plan developed, the unanimity turned into dissension, partly over the practicalities of the proposed program. But deeper, more serious disagreements go largely unspoken. We rarely acknowledge, much less discuss, the conflicting moral reasons that drive the desire for health care reform. Furthermore, I shall argue that unless and until we address those tensions, no health care reform plan will satisfy our moral demands.

Two chief moral demands drive the desire for reform of our health care delivery systems. First, many Americans believe that health care is in some sense a moral right. Second, we fear that the high cost of health care drains resources away from other morally important social goods. Tensions inevitably arise when we try to satisfy both of these moral demands. After discussing these moral demands, I offer suggestions to help resolve the inherent conflict between them and improve the opportunity for constructive health care reform.

Health care as a right

The most prominent moral principle driving the desire for health care reform is certainly a belief in an individual's moral right to health care.

The news repeatedly points out that some 37 million Americans lack health care insurance. (That number may actually be misleading. What it really means is that over the course of a year, 37 million Americans lack health insurance a*t some time.* At any moment in time, around 17 million go without any insurance. And over the entire year, only about 9 million have no insurance.) And lest the middle class rest too easy, the administration emphasizes that anyone can lose coverage all too easily just when most needed.

Notice, however, that these sorts of reasons have no special moral weight unless we assume something peculiar about health care. Millions of Americans can't afford fancy automobiles, fancy homes, yachts, or expensive restaurant meals. Yet society doesn't becry this as morally unacceptable. Nor does the public mandate, on moral grounds, that government provide these families with the means to obtain such goods and services. So health care must be morally different.

Many people believe that health care is a kind of basic human need, basic in a way that a high-priced automobile (or even a low-priced one) is not.

Experts give many different moral reasons to support the view that health care is a basic moral right. Daniels, for example, argues that without adequate health care ill persons lose their basic liberties and basic equality. Loewy, on the other hand, argues that because suffering is bad we all have a moral obligation to come to the aid of those suffering in our community (see "For more information").

It is this strong sense of egalitarianism in our time of basic need, when serious illness and/or chronic disability threatens, that drives the Clintons' emphatic, unswerving commitment to universal coverage. *No person should lack access to health care simply because of an inability to pay for it.*

I must note at least one disturbing feature of this moral right to health care. In health care, no less than in many other areas of life, Americans have no firm consensus on what constitutes appropriate or adequate health care. Indeed, it is for this

reason that the bioethics revolution of the last three decades has placed such importance upon patients making health care choices for themselves, guided by or in consultation with their families and physicians.

I mention this point because it forces another question upon us: A moral right to health care is a right to what? Do patients or their families have a right to choose care that their physicians or insurers feel is futile? Examples might include the maintenance of irreversibly comatose patients on life-support, the use of autologous bone marrow transplants for women suffering from uterine cancer, the maintenance of anencephalic infants on life-support, or aggressive and unlikely-to-succeed interventions for infertile women. Each of these medical interventions is quite expensive and (in the minds of many) very likely of no benefit. But if individuals have a right to health care, and if individuals are respected as decision makers on their own behalf, then does society, through government, have the moral obligation to pay for such services? And what does "universal access" mean for our rural population, who may live hundreds of miles from the nearest physician, and even farther from anything that counts as a "medical center?" The costs of making highly skilled practitioners and sophisticated medical technology readily available to a widely dispersed rural population would be staggeringly high.

Clearly an open-ended right to health care could prove disastrously expensive, especially when we consider the expansive and expensive potpourri of medical technology available now and in the coming years. The stark reality of the size of this bill drives us to our next concern.

Economics and morals

The high cost of health care also drives the desire for health care reform. Health care now accounts for about 14 percent of our gross national product. Whether it is the employee, the employer, the taxpayer, or deficit financing shifting the cost to future taxpayers, someone must pick up the health care tab. And as the costs of health care and health care insurance have risen to dramatic and ever-increasing levels, every single one of the aforementioned billpayers has expressed a desire to pay less, or at least to prevent or contain any new increases.

It is foolish to imagine that resources garnered from streamlining the health care system would adequately cover all the increasing demands for medical services while still offering reduced costs to the consumer. Yes, we would all like more health care, but only if it does not cost more. We are very reluctant to consider spending more on health care, even if it means saving a few lives.

What kind of health care should we buy for those who cannot pay?

Businesses pay the bulk of private health insurance as an employee benefit. The demand for health care services, along with the technological explosion in the types of medical procedures available, caused double-digit inflation in health care expenditures through much of the 1980s. Employees showed very little desire to pay the cost increases directly; but businesses often paid those benefits to remain competitive as employers. Businesses then paid employees less in take-home pay. Thus, during the decade of the 1980s, middle class income in real terms remained relatively constant, but health care benefits increased dramatically. When we factor in health care benefits, middle class income rose approximately 20 percent. Eventually, businesses turned to new means to contain medical premium costs, often to "managed care."

The managed care approach reduces utilization of hospital and high-cost technology services. And the growing share of the market belonging to managed care undoubtedly helped hold health care cost increases to around 5 percent for 1993, rather than the double-digit increases familiar to us from the 1980s. It is no accident, then, that business owners have themselves been in the forefront of those promoting health care reform—the shift from high cost fee-for-service health insurance to more tightly controlled managed care systems. It is also no accident that business views skeptically any sort of health care reform that does not effectively control costs.

Is this cost-oriented reform unethical? That is, is morally guided reform necessarily committed to the expansion of health care services even if it means greatly increased expenditures? I believe the answer must be no. We may at first be inclined to regard this as an issue of morality versus economics. Such

common rhetoric as "a human life is beyond price" can lead us to imagine that morality strives to defend human rights and welfare against our morally crass interests as business owners or consumers. But this confusion arises from an overly narrow conception of human welfare.

Humans also need education, decent housing, a decent diet, and a safe environment. Indeed, it could well be argued that these sorts of goods can be even more important to human happiness, flourishing, and the relief of suffering than sophisticated and expensive medical care. If society has a moral obligation to ensure adequate health care for its people, it also has a moral obligation to address these other important human needs. Health care is but one of many morally important social goods. Then insofar as devoting more resources to health care reduces our willingness or capacity to ameliorate these other human conditions, it would be immoral to increase social expenditures on health care.

Thus, cost containment should not be understood as necessarily immoral. On the contrary, given the poor condition of much of our social infrastructure—from bridges to education—it could well be immoral not to spend less on health care.

Moral tension

It is distressingly easy to see how these two moral values lead in opposing directions. Viewing health care as an individual moral right, a right that society is obligated to fulfill, would seem to push us over the brink into a bottomless pit of health care expenditures. For many people, that last week, that last day, that small but only chance, will be desirable. And without any community consensus on what counts as appropriate or inappropriate medicine, we have no moral grounds from which to deny coverage to someone for the procedure she sees as promising. Respect for the rights of the individual compels us to say, yes. On the other hand, concern for costs, with a moral foundation behind its claim, urges us to say most emphatically, no.

The challenge will be to craft a health care system that acknowledges care for the suffering individual, but which is not an open-ended, unconstrainable medical claim upon society.

The Clinton proposal has tried to cover both demands at once, and in so doing it opened itself to vacillation and moral criticism from both sides. When individual rights are at question, it focuses upon the language of individual security, choice, and quality of care. When the question focuses on what this will cost, the White House appeals to the language of managed care and cost containment.

Most experts in the field, however, when speaking candidly, acknowledge that promoting higher quality, greater access, and individual choice will increase costs, and that the pledge to reduce costs under these conditions is but wishful thinking.

Thus, any program that satisfies the moral demands of health care as an individual right (i.e., universal access to whatever is needed) will fail to meet the moral demands of cost containment. And any program that successfully contains costs, thereby reserving resources for other morally vital social goods, will inevitably fail to meet the moral demands of health as an individual right. Finally, any program that tries to split the difference, so to speak, will wind up truly satisfying neither moral demand.

Toward a moral resolution: understanding health care as a social good

If we regard health care as a good with a special moral status, a status that demands social support, then we must develop a consensus on (a) what constitutes the goods of medicine and (b) how they rank relative to other important social goods. In other words, if we regard health as a social good that society must make available, then we ought to determine what kind and how much health care society needs. And we must acknowledge that the answer to that question likely differs from the answer to the question that asks how much and what kind of health care is best from an individual's point of view.

My concern is that the strong rhetoric of individual rights has blinded us to the erosion in our society of any notion of the common good. As long as individuals think of themselves as strictly isolated or competitive individuals, then it makes perfect sense for each one to attempt to gain as much health care (and other goods and services) as one can extract from other individuals, either by shrewd business/labor negotiations or by influencing governmental policy, even if doing so reduces the welfare of other persons.

At least as a social good, the point of health care cannot be to extend life indefinitely at any cost. Rather, as a social good, the goals of health care are threefold: (1) to return the individual to the productive ranks of society, when doing so is compatible with meeting other social needs (such as education, welfare, etc.); (2) to invest in the well-being

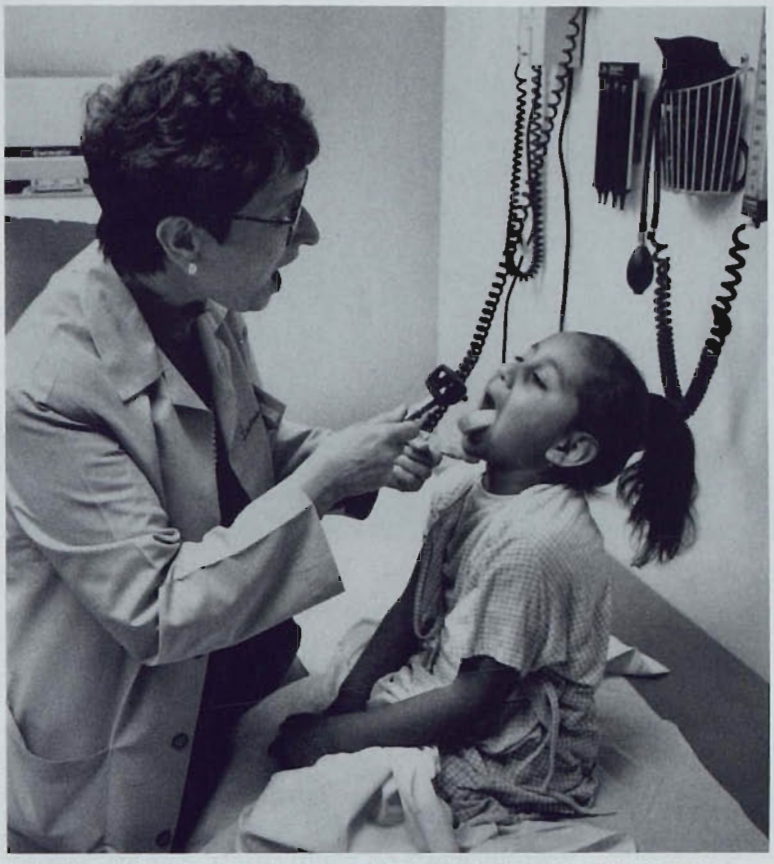
of our future generations, since society as a community extends beyond ourselves; and (3) to care, insofar as feasible, for the individual, even if we cannot afford to cure him.

The first goal is obviously important, since without a productive people we lose the economic base to sustain a health care system, much less other social endeavors. The second goal reminds us that society, as a community, extends beyond ourselves. Not only does our community include our neighbors, in some important sense it extends beyond us into the future. Hence, a truly flourishing society invests wisely in its future, even if it means some sacrifice in the present. That means that some individuals, when they fall ill, will not be able to obtain the health care services that they desire. Procedures that are very expensive and that are not likely to provide much benefit, as judged by a socially accepted measure, should not be part of a governmentally funded program. The third goal recognizes that while it is the social good that we should pursue, we must also acknowledge that individuals suffer from illness. The challenge will be to craft a health care system that acknowledges care for the suffering individual, but which is not an open-ended, unconstrainable medical claim upon society. Access to hospice, for example, may be guaranteed, but access to a liver transplant would not be guaranteed.

Confronting reality

Any morally sensitive health care reform must confront the reality that we cannot guarantee universal access to whatever is individually desired and still meet other morally important social needs. Some politicians will be loath to admit this limit to our social resources, but it is, I submit, the truth. We must then ask of any reform proposal at least the following questions:

- Does it speak first and foremost to the good of society, not simply the right of the individual?
- Given limited resources, does the health program recognize those limits? Is the benefits package designed according to some socially agreed-upon standards of medical practice which considered the huge cost to support permanently comatose patients and extend our lives indefinitely when other morally important social needs for our own and future generations go unmet?



Photos courtesy Children's Memorial Medical Center

Children lack health insurance far more frequently than any other age group.

- Does it provide economically affordable ways to ameliorate the suffering of those who cannot afford care, even when not offering unaffordable medical interventions?

Such questions may not lend themselves well to "sound bite" answers. But they are the true moral dimension of health care reform. ■

■ For more information

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