

# Medical Humanities Report

This Issue: The Candidates and Health Care

Fall, 1992

## Weariness and Hope: Reflections on the Candidates' Health Proposals

By Judith Andre, Ph.D.

Americans pay less in taxes than citizens of any other industrialized democracy -- much less. Hardly anyone seems to know that, however. Both facts -- that our taxes are low and that we believe they are high -- are relevant to the politics of health care.

To begin with, any plan which provides health insurance to the 35 million who don't now have it will cost money. The money could come from other government programs: but the only likely source, the "peace dividend," seems to have dried up. Another possibility is that spreading existing government health programs -- Medicaid and Medicare -- thinner. People covered by them would receive less, but more people would be covered. (Oregon is trying to do just that.) If, however, what is wanted is the provision to the 35 million uninsured of what the rest of us now have, without anyone having less than she now does -- then taxes will have to increase. The arithmetic is pretty simple.

Neither candidate mentions the arithmetic, although both must know it. Neither mentions the enormous subsidy which the middle class now receives from the government -- our untaxed medical benefits. Simply taxing those benefits as if they were income would raise about \$70 billion each year, and manifestly move us toward justice as well. As things now stand, those without insurance through the workplace must pay for their own coverage with

after-tax dollars -- of which they probably have fewer to begin with.

So my thoughts about the candidates' proposals begin in anger, at the injustice of the present system, but even more at the ignorance which so abounds. But my bewilderment almost matches my anger: who is to blame? Politicians, for their hypocrisy and the need to win which fuels it? The media, who focus the rays of taxpayers' resistance until it ignites? Who zealously scrutinize candidates' promises and records about taxation, but perhaps once a year compare American taxes with those in other countries? Or should I blame the public, as economist Uwe E. Reinhardt does: "Both [Clinton and Bush] spare voters the troublesome thought that someone must pay for the promised new benefits. Today's electorate expects no more from its politicians, and it deserves no more."<sup>1</sup> But how did the electorate get that way? I prefer to blame politicians and journalists, both of whom have professional obligations, both of whom fail.

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Under my anger, however, is something happier -- hope, at least, and relief. At last the more serious problems in our system are common knowledge; finally it has become conventional wisdom that something must be done. And conventional wisdom focuses on two crucial points: that preventive medicine is important, and that everyone must be covered. Finally, too, the US has noticed that Canada has an interesting and comprehensive national health insurance

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program. Granted, Bush disdains and misrepresents it, and Clinton distances himself from it. Nevertheless, if memory serves, even five years ago the only country mentioned in popular discussions was Great Britain's, mentioned only to be roundly condemned. Furthermore, a wide-ranging scholarly discussion now exists, to which political staff members and specialized journalists pay close attention. Public officials take part in the conversation, charitable foundations encourage it, and exciting proposals are being made.

For all this progress, who deserves credit? Have things simply gotten so bad that we "can't help seeing" the problem? My guess would be no. Although health care professionals and the growing number of uninsured can't avoid the problem, most of us could, for a while yet. In fact, one of the more intriguing figures around shows most Americans satisfied with the care they receive as individuals, but distressed about the system as a whole -- and therefore wanting change. This contrasts starkly to polls in the mid 1980s showing that people who believed they would profit from Reaganomics, although others would suffer, voted in what they took to be simply their own interests.

What we notice and what we care about are complex issues, not reducible to self-interest, media manipulation, or any other simple answer. In the case of national health policy, however, I would credit the media with raising the issue over and over, until almost all of us know something about the problems.

Which is to say that journalists are neither devils and idiots, nor saints and heroes, but, like the rest of us, people who see some things and not others. This touches one of my major research concerns: How do professionals learn to see themselves and the world with moral clarity?

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But my topic here is supposed to be the candidates' health policy proposals. I can only say that neither speaks for me, or to me. As I understand it, Bush's proposal would leave

millions of people uninsured, since the vouchers he suggests would not meet the full cost of health insurance. Clinton's proposal is unclear. What would speak to me? A policy which unequivocally gave coverage to everyone. I am willing, even eager, to pay higher taxes to bring that about. I know that "rationing" is inevitable, is with us now, under disguise. There is no possible system in which everything we know how to do will be done for everyone; that would take the entire gross national product. What now determines who gets what care is some combination of chance and money. If you need a liver transplant and your insurance won't cover it, it helps to be a photogenic child, around whom a fund-raising campaign could be mounted. If a bone marrow transplant is your best chance at life, it will help if some researcher is eager to know whether it works.

So the word "rationing" does not disturb me. I would welcome criteria that were clear, public, applicable to all, and more or less democratically arrived at.

Nor do invocations of freedom and choice enchant me. There are many different kinds and degrees of freedom: public libraries, which are socialist institutions, increase the freedom of readers more than they limit the freedom of tax payers. Public health care might do something similar. What is needed is a discussion of a detailed particular ratio between public and private. What kind of choice matters, and why?

Which means, I think, that the following article by economist Andrew Hogan is essential reading. To it I now direct your attention.

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Uwe E. Reinhardt, "Commentary: Politics and the Health Care System," *The New England Journal of Medicine*, Sept. 10, 1992 (vol 327), p.811.

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# The Political Economy of Justice and Efficiency in the U. S. Health System: Do Bush, Clinton or Perot Offer Any Remedies?

*By Andrew J. Hogan, Ph.D.*

Thirty years ago health care costs were growing at least as fast as they are today, but most health policy experts and common citizens thought that the health system was improving, delivering more and better services to more people.

Twenty-six years ago, government initiated a reform which was at least as sweeping as anything proposed by the current presidential candidates: universal health care for the elderly and the permanently disabled (Medicare), broad coverage for the poor (Medicaid). These reforms were considered both affordable and fair.

Today, there are many policy analysts (I among them) who think that Medicare and Medicaid are on the verge of bankrupting the federal government and many state governments. These programs are already significantly underfunded, and like Audrey, the plant in the Little Shop of Horrors, they increasingly demand "feed me". Like Audrey, these programs began small but grew much more quickly than their host taxpayers' economic blood supply. In the meantime, the number of persons not covered by either of these public programs or private health insurance has grown substantially, after having shrunk to less than 10% of the population in the mid-1970s.

Almost everyone - consumers, government, business, labor and providers - recognizes that the current rate of growth in personal health expenditures is unsustainable in the long run, given recent growth trends in *per capita* income. However, none of these parties has yet begun to seriously act as though our current health care system is unsustainable. The reason for this lack of action is obvious: health care reform in an era of declining median family income is a loser, in the political sphere, in business-labor relations,

for consumer advocates, among health care providers. Americans seem unable to accept, and hence to manage, a declining standard of living, at least in so far as health care is concerned.

One broad strategy about our health care financing crisis is to adopt policies which will accelerate the underlying rate of economic growth. Specifically, this strategy says that the basic design of the U.S. health system - private employment based insurance for workers and their families supplemented by public insurance for non-workers (retirees, the permanently disabled, the unemployed and unemployable poor) - will be reformed incrementally to produce greater efficiency and equity. The fundamental affordability problem will be addressed, not by rigorous health care cost containment, but by general economic growth. In other words, the percent of gross domestic product devoted to health care will fall due to a combination of modest constraints on health expenditure growth and an acceleration of income growth. Those who have followed the policy debate on the federal budget deficit will recognize the basic features of the "pay-our-way-out-of-the-deficit approach" (Perot) versus the "grow-our-way-out-of-the-deficit" (Bush and Clinton). The real debate between Bush and Clinton focuses on the role of the public sector and public investment in stimulating economic growth.

Although Mr. Perot's position on health care is incomplete and underdeveloped, a logical extension of his deficit policies would be to reduce the consumption of health care to a level that is more commensurate with society's ability to finance it. A logical goal in the Perotista frame-

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work would be to reduce health care spending to roughly 10% of GDP. The practical implications of such a goal would be the elimination of up to 1/3 of all hospital beds (20% of hospitals), reduction in the number of medical schools to about 100 from the current 121, and some strict limitations of the spread of new technology, accompanied by a very significant increase in certain public health activities designed to reduce the incidence of preventable disease. Even without his other self-inflicted political wounds, Mr. Perot is un-electable on such a platform, not withstanding the excellent economic case which could be made for it.

The Bush and Clinton plans, although still somewhat sketchy, both rely on a "growing-our-way-out-of-the-health-care-crisis" approach, in that neither offers a realistic plan to constrain healthcare costs to rates of growth which the U.S. has enjoyed (or suffered under) over the last four presidential administrations, i.e. real per capita income growth of less than 2%. If real annual income growth could be pushed up to 3% - 4%, then either the Bush or the Clinton plan will succeed. If real income continues to grow at about 2% annually, then neither plan can succeed in the long run. Growth rates between 2% and 3% will postpone the need for more drastic reform, but we are likely to see a continuation of the gradual financial deterioration of the health system.

Both the Clinton and Bush plans borrow heavily from the ideas of the Jackson Hole Group, which has evolved Alain Enthoven's original "Health Plan" into a comprehensive approach to managed competition. However, both plans avoid the feature of limiting the tax exemption on employee health benefits; this is a crucial step in making health care consumers cost conscious. Neither plan provides many details for financing the expansion of coverage to the uninsured. Both make unsubstantiated assumptions about control-

ling the growth in health care costs through either market forces (Bush) or regulation (Clinton)

The Bush campaign has identified the really interesting question for the Clinton plan, but not their own: what happens when the plan fails.

	BUSH	CLINTON	PEROT
Cost Containment	More efficient market competition	National budget constrained to rise no faster than inflation	Reduce benefits, reduce tax exemptions
Expanded Access	Refundable tax credit for poor Tax deduction for near poor	Mandated benefits for workers public coverage for all others	?
Quality / Appropriateness Assurance	Medical malpractice reform, reducing defensive medicine	National health standards board, identifying clinically effective treatments to be covered by insurance	?
Reduction in Administrative Waste	Electronic billing and medical records in standardized formats	Administrative streamlining	Administrative streamlining
Financing	Reduce Medicare / Medicaid budgets to pay for tax incentives	Cost containment	Raise taxes, reduce tax exemptions

The reason that this is the interesting question is that all of the health plans of all of the major industrialized nations are failing the affordability test is that health expenditures have been growing at roughly twice the rate of income almost everywhere over the last 30 years. What distinguishes the U.S from these other countries is the lack of grace (some might say the loss of grace) by which our failure is being realized. Here, I think, we can see some real distinctions between Clinton and Bush.

The failure of the Clinton plan will move us from our present system into an expanded Medicaid for everyone. Under the Clinton plan low income workers and low wage workers will be moved into an expanded Medicaid along with nonworkers; this new program is called a public sponsor. If the overall health plan fails, the public sponsor will be underfunded, but unlike our current system it will not be possible to

reduce public sponsor enrollment. As a practical matter, you cannot raise taxes much on families with stagnant incomes, leaving underpayment of services as the only option. Underpayments will, of course, generate cost-shifting, raising private insurance premiums, which at the margin will drive lower wage employers out of the private system into the public system (adverse selection). Those left in the private system will find the burden of cost shifting resting on fewer shoulders, driving even more into the public sponsor. In the end, almost everyone will be in the public sponsor, and we will have a Canadian single payer through the back door, with a small, elitist private system as a political escape valve. (The U.S. health system is Canada's escape valve.)

The Bush plan, if it fails, will keep the health system on its current path of deterioration, although that deterioration might be briefly postponed. Since no new public money will be put into the system, the current system's affordability problems will simply be shifted around by offering the currently uninsured tax credits financed by the greater underfunding of Medicaid and Medicare. One would predict a shifting of greater responsibilities for Medicaid onto the states, who will, in turn, reduce the Medicaid roles by shifting Medicaid recipients onto the federal tax credit/rebate programs. What level of government will win out in such maneuvering remains to be seen.

The insurance market reforms proposal in the Bush plan will reduce some of the most blatant exclusionary practices of the small group insurance market, but at the cost of raising the average premium, driving some medium size employers into self-insurance and some small employers out of the market altogether. The global effect on access to care is likely to be minimal.

The Bush plan will fail the same way the current plan is failing: as costs go up, the number of uninsured and underinsured goes up, decreasing

political support for the current system and raising interest in health system reform. Most middle class Americans have come to see themselves as one pink slip away from being uninsured, and they don't like what they see happening to the uninsured. In some future recession, the fear of becoming uninsured will outweigh the reluctance to pay for a universal system.

All this highlights the paradox of the U.S. health system. Middle and upper income workers are provided with substantial tax subsidies, resulting in their becoming over-insured and cost unconscious. Low income families are largely unsubsidized, unless they are on Medicaid, which is underfunded. Since poor health and low income are associated, we confront the paradox that those who most need health insurance coverage receive little or no help in acquiring it, while those least in need of assistance are induced to over-consume, driving up the prices of health services for those who must pay out-of-pocket. The result is conspicuous overconsumption of the least efficacious health services by the middle and upper income employees and retirees, while the low income working class family under-consumes those basic services which contribute most to the public health. Thus the paradox of U.S. health care: unsustainably high cost and politically debilitating poor public health outcomes.

Many Americans hope that we can return to the high economic growth rates which characterized the two decades following World War II. The British offer us a sober example that regaining economic leadership is not easy. If we do follow the British example of relatively slow economic growth, we will also likely follow them in managing our health system - sharply focused public health interventions with deteriorating amenities and service quality in the acute care sector - something very much like my version of the Perot plan.

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Before asking your physician for a prescription for anti-depressives, consider that Britain spends 40% what we do on health care both in absolute expenditures and as a percent of GDP, while providing universal coverage and achieving both lower infant mortality and greater life expectancy at birth. Notwithstanding the long waiting lists for some elective procedures, the British are more satisfied with their system than we are with ours. No Briton is denied access to basic life saving medical services for financial reasons. This basic

security is provided at a cost which is reasonable given the standards of living in British society. We may think that the British system is beneath our dignity, but it is fair and affordable and politically stable - all characteristics lacking in the U.S. health system. None of the presidential candidates has laid out a health reform plan with sufficient detail to assure the voter that we too may be moving toward a fair and affordable and politically stable health system.

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## Literature in Review

**Changing to National Health Care: Ethical and Policy Issues**, edited by Robert Huefner and Margaret Battin (University of Utah Press, 1992).

*By Leonard Fleck, Ph.D.*

This is a very rich collection of essays on a complex topic that will be at the center of health care ethics for the remainder of the decade and beyond. Two things, in particular, give a unique character to this collection. First, all the essayists have gotten beyond the "right to health care debate." That is, many philosophers in the decade of the 70s and early 80s seemed to think that the moral issue regarding health policy was whether or not everyone had a right to health care. If we could justify an affirmative answer to this question, then this was the end of the moral debate and we could leave to bureaucrats the mundane task of figuring out implementation details. But these essays make clear that there are an enormous number of other moral issues that must be addressed, not just in getting from here to there, but in being there at some point in the future. This, in fact, is the other distinctive feature of the collection. Even if we all agree that some form of national health insurance is morally superior to our current haphazard and fragmented and patently unfair approaches to health financing, there will be daunting moral problems associated with any plausible form of national health care we adopt. The essay by Battin is especially germane to this point.

In her essay entitled "Dying in 559 Beds: Efficiency, 'Best Buys,' and the Ethics of Standardization," Battin concedes that to create a more equitable health care system we must accept some level of standardization for our health care practices and this will mean sacrificing marginal quality improvements in the interest of lower costs. However, Battin argues that while for most medical problems this standardization may be justified on the grounds of fairness, dying is another matter. She writes: "Cheap, rapid dying may be a personal goal for some patients but ought not be imposed as an institutional or societal one." What Battin wants to endorse as a kind of a moral right is "a death of one's own," since such diversity may be the best protection against both manipulation and abuse in this matter.

Among the other large issues addressed by essays in this volume is the "transition problem." Leslie Francis speaks to the issue of morally legitimate expectations in this regard. Recently, a number of large corporations have indicated political support for adopting a Canadian style single-payer health insurance system since this would remove from their back very large potential health costs associated with their retirees, who have been promised very generous health benefits. These retirees then have legiti-

mate expectations that these promises will be kept. If we adopt some system of national health insurance, however, almost certainly this national health plan will not be as generous as what these retirees expect. This is not a trivial transition problem. It requires careful moral reflection. A number of companies have recently simply abandoned these commitments to retired workers on the grounds that these are health benefits, freely given, and just as freely taken away. If this were to become something of a pattern across industries, would this diminish the burden of moral justification for government in a transition to national health insurance?

Other essays in this volume look at the history

and politics in this country of earlier efforts to put in place some system of national health care, consider what we might learn from other countries that have systems of national health care, and consider what we might learn from a system of national health care we already have in place, the Veteran's Administration system. The main impression that a philosopher will come away with from these readings is that the moral issues raised by national health insurance are much more complex than might initially be thought, and much more sensitive to political and economic and organizational and technological and cultural details to which moral philosophers are sometimes insufficiently attentive.

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## Notes and Announcements

On Nov. 8, Professor Leonard Fleck will be in New Orleans at the annual conference sponsored by the American Association of Medical Colleges. He will be doing a workshop on the "Just Caring" project because it is considered one of the more innovative ways of integrating moral and public policy issues into the medical school curriculum. What is being referred to here is the course, "The Social Context of Clinical Decision-Making," which is a year-long course for the second year medical students.

On Nov. 21, in Memphis, TN Professor Fleck will be one of three panelists in a philosophy seminar discussing democratic approaches to health care reform, of which the "Just Caring" project is a pre-eminent model. This seminar is more academic in that the discussion will center around the theoretical foundations (political/philosophical/ moral) of the "Just Caring" project.

Professor Judith Andre's article, "Blocked Exchanges: A Taxonomy," was published in the October 1992 issue of Ethics. The September issue of the Journal of the American Medical Association has published her letter regarding the article "Models of Physician-Patient Rela-

tionship." Professor Andre presented her paper "When Physician and Pregnant Patients Disagree" for the College of Human Medicine last June and again at Ingham Medical Center October 8.

### Fellowships

The University of Illinois at Chicago has asked us to announce that they are making available a limited number of short-term fellowships in Medical Humanities. During the 1992-92 academic year (including Summer 1993), the Medical Humanities Program of the Department of Medical Education, University of Illinois College of Medicine at Chicago will offer two short-term fellowships for individuals already possessing a doctoral degree in a health science or liberal arts field. This program enables scholars to deepen their background and/or further their research in the medical humanities. Fellowship stipends are \$3000; candidates will be considered beginning January 15, 1993. Further information, please contact Norman Gevitz, Ph.D., Medical Humanities Program, Department of Medical Education, M/C 591, UIC College of Medicine, 808 S. Wood Street, Chicago, IL 60612; or phone program assistant Andrew Deppe at (312) 996-5606.

# Coming Events

The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.

Wednesday, Nov. 4, C-214 E. Fee Hall, 12:00-1:00  
HIV and a Dental Student with Vence Bonham Jr., J.D.,  
Associate General Counsel

A third year dental student at Washington U. of St. Louis was dismissed because of the risk that he could transmit HIV to patients while performing invasive procedures required by the curriculum of the dental school. The student sued, charging handicap discrimination. Federal District Court upheld the university's decision. Mr. Bonham will present the facts of the case and discuss its implications. Center faculty will join him in discussing the ethical issues involved.

Nov. 4-5, King-Chavez-Parks Scholar returns to M.S.U. Howard University Professor Marian Secundy will be visiting the Center. For further details on Professor Secundy's schedule, please contact Jan Holmes at 355-7550.

Thursday, Dec. 3, C-214 E. Fee Hall, 12:00-1:00  
Pitfalls and Pratsfalls of Hospital Ethics Committees with  
Tom Tomlinson, Ph.D., Center for Ethics and Humanities  
in the Life Sciences

Under pressure from the Patient Self-Determination Act and new JCAHO accreditation requirements, many hospitals are scrambling to write or revise their policies on limitation of treatment, advance directives, informed consent, and other ethical matters. There are many kinds of traps and blunders to be avoided in such policies. Dr. Tomlinson will discuss these, with examples and suggestions for improvements.

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