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THE ECONOMIC AND ETHICAL DIMENSIONS OF HEALTH POLICY

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We are beginning a new century. In medical technology, we are going to witness rapid and unprecedented changes. We can also look forward to continued breakthroughs in biomedical science that are going to be unlike anything we have previously imagined. Hopefully, we will also make serious and beneficial changes in the financing and delivery of medical care, and improve the quality of medical care for an ever larger number of patients. Altogether, these positive developments can have a profound impact on our society, dramatically improving the quality and character of American life well into this new century and beyond.

There is every reason to be optimistic. It is not only what is possible for us, but also how we can and should achieve it. These issues are far beyond mere budgetary questions or how best to allocate scarce public or private resources. The central issue of this symposium is how to fashion a coherent health care policy that will achieve the highest good for ourselves and our children, a quality of human life consistent with the practice of virtue and adherence to our most cherished principles, particularly personal freedom and dignity.

We are thus back to the basics. These are the most important issues in life - what it means to be a human being, and what is proper to the good life. We are also back to the basic ethical questions, including the securing of good ends through good means. A good person cannot achieve good ends any other way. In a very practical way, sound health care policy will have to distinguish right from wrong, good from bad, the just from the unjust. Ineluctably, these ethical questions are the crucial questions in health care policy.

How and in what way do we resolve these questions within the framework of our healthcare delivery system? In my view, the correct answers to these questions can best be achieved through the exercise of personal and economic freedom, secured through limited governmental

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action and a market economy.[1] Economic freedom and personal freedom are inseparable. Health care, after all, is an area where personal decision-making has a profound effect on the course of our life and how well we live out our days. In the broader political sense, the public policy framework we fashion for ourselves, in which that personal decision making is to take place, will have an equally profound impact on the overall quality of life of the members of our society.

Consider the policy framework in which all of us, individuals and families, must make our decisions today.

I. AMERICA'S EXISTING HEALTH CARE POLICY FRAMEWORK

In public policy, my colleagues at the Heritage Foundation are fond of pointing out that the first rule of public policy is that the obvious is always overlooked. When one surveys the course of public discussion on Capitol Hill and in so many other areas - whether domestic or foreign policy - one feels that this rule ought to be enshrined somewhere as an infallible truth. In any case, the existing framework in health care policy is a given for many Americans, and its obvious assumptions are often overlooked and its roots are neither popularly understood nor widely appreciated.

A. Tax-Driven Policy

What is routinely overlooked in American health care policy is that the health insurance markets are, to a large extent, a powerful reflection of American federal and state tax policies. Since the 1940s, the United States has developed a unique system of healthcare financing and delivery. We have created, largely through the powerful instrument of the Internal Revenue Code, an employer-based healthcare system. The way it works is very simple, tax relief, unlimited tax relief is provided when you purchase health insurance. But you get that tax relief on one and only one condition, that you get your health insurance policy through your employer.

This World War II era tax policy has profound consequences for the health insurance market and personal decision-making in the health care

1. For a more detailed discussion of this point, *see* Robert Emmet Moffit, *Personal Freedom and Responsibility: The Ethical Foundations of a Market-Based Health Care Reform*, 19 J. MED. & PHIL. 5, 471-481 (Oct. 1994); *see also*, STUART M.BUTLER, PRIVATE SECTOR INCENTIVES AND ETHICAL HEALTH CARE, *Ethical Dimensions of Health Care Policy*, 202-222 (Marion Danis et al. eds, Oxford U. Press, 2002).

system.[2] It means, for example, that your employer owns the health care policy, you don't. It means that the terms and conditions of that health insurance policy are set by the employer in negotiating with another third party, the insurance company. You can only accept or reject the terms and conditions of that policy negotiated between those two parties, and those two parties reach agreements external to any relationship you may have with your personal physician. For all practical purposes, as an individual, you cannot change them. Ultimately, the employer has the last word. If you do not like that last word, you can refrain from participating in the employer's health care plan or quit your job and find an employer whose health care benefit arrangements are more to your liking.

Because the contract relationship is between the employer and the insurer - defining the benefits, the terms and conditions of the delivery of health care services, and the reimbursement of physicians - the point of decision-making in the system is neatly confined. Because that decision-making process is neatly confined- the relationship between the employer and the insurance company- it is also very easy for government officials to control. It is not surprising, therefore, that the health insurance market in the United States is one of the most heavily regulated sectors of the American economy. Nonetheless, the consequence of this growth in state, and recently federal regulation, is that individuals and families have progressively less control over their health care decisions, including health care decisions that might have a profound ethical dimension.

The public tax support for this current arrangement is enormous. Recall that federal tax relief is unlimited; there is no end to the generosity of the health care plan that can get tax free status. If, in today's dollars, you count both the federal tax break and the state tax breaks, tax relief for health insurance in the United States through the employer-based system exceeds $141 billion dollars. It's huge. It is the 800-pound gorilla in the American health care system.

Curiously, this arrangement was not fashioned to create a progressive health care policy. It was, instead, a compensation solution to a compensation problem created by federal price controls in the 1940s, and was thus fashioned under the exigencies of war and international emergency. This federal government decision to give unlimited tax relief for the purchase of health insurance through the employer was a way to

2. In the limited context of this discussion, my use of the term " system" refers to the dominant employer- based private health insurance arrangements that cover most working Americans and their families under the age of 65. Beyond that, the American "system" is not all that systemic.

accommodate the demands of business and labor, whose wage negotiations were constrained by wartime price regulation. One can look at *The Congressional Record* of that period and search in vain to find any member of Congress or anyone in the Roosevelt Administration articulating a highly developed theory that the very best way to promote broad health care coverage and restructure the health insurance industry was to favor exclusive tax relief for health plans purchased only at the place of work.

B. Endless Health Care Debates

Today, Americans are once again engaged in yet another round of intense debates over the shape and direction of the health care system. I was particularly intrigued by Dr. Neubauer's presentation on the seeming inevitability of serial health care reform debates in Germany. They have clearly become a perennial feature of our public life, both here, in Germany and in Europe generally. (Obviously, Britain's establishment of national health insurance in 1948 has not ended the British debate, it has only intensified it on a different level.) Just as the sun rises in the morning and sets in the evening, one can depend on a cycle of legislative initiatives to reform some dysfunctional feature of the health care system. These initiatives will be enacted and within the next couple of years, we are going to have another big debate on health care reform in an attempt to try and fix some of the knotty problems created by the last series of reforms.

Why do we go through these health policy cycles? In the United States, one obvious reason is that few of these legislative initiatives actually solve the problems they are intended to solve, certainly not without creating new problems that, in some cases, can turn out to be even worse than those originally targeted for solution. In the meantime, individuals and families suffer.

Virtually all of the major economic and financial problems of the American health care system, including the problems of rising cost and declining access, and now, serious misgivings about health care quality in the managed care system, stem from the fundamental distortions in the American health insurance market. Perverse incentives plague the system. Plus, given the inequity of the tax treatment of health insurance, which appears to benefit high-income persons with large benefit plans at the expense of low-income persons without employer based health insurance; there is a profound unfairness in the current system. (Without the tax-free income in the form of health care benefits, America's uninsured, most of who are in working families without employer based coverage, pay relatively higher taxes.) Instead of addressing these fundamental

distortions in the market, we have Members of Congress arguing for patchwork compromises that often aggravate these problems or promote an even greater government management of the system. This, in turn, often adds to the inefficiency or inequity of current arrangements. To borrow a phrase from the great English writer G.K. Chesterton, that is why so much of what passes as healthcare reform in the halls of Congress and the state legislatures is an extravagant exercise in the "fine art of missing the point."

C. The Practical Problems

Meanwhile, the problems for individuals and families deepen. Beyond the routine problems of cost and access that energize much of the health care reform discussion, there are other problems, related directly to the loss of personal control over health care decisions. Let me touch briefly on four related problems.

First, in the United States for most people with health insurance coverage, they do not, and practically speaking, cannot own their own health insurance policies. This means that they enjoy no portability of benefits in the healthcare system. If you lose your job or change your job you do not lose your life insurance, auto insurance, or homeowners' insurance, you only lose your health insurance. You do not own the policy. The policy does not belong to you. It belongs to the company you work for; and you and the company both get unlimited tax breaks for health insurance as long as you get it through your place of work.

Second, in the United States we institutionalize discrimination in the tax treatment of health insurance. The Internal Revenue Code discriminates against you if you try to purchase alternative health insurance policies on the individual market. If your employer offers you no insurance, your only practical option is to purchase individual policies on the health insurance market. The price of insurance on the individual market varies greatly, often reflecting the political and regulatory environment that prevails in the different states of the union. In some states, individual insurance is affordable; in others, it is very expensive. But, once again, regardless of the state in which you buy individual health insurance, you have to do it with *after tax* dollars, which can make it even more prohibitively expensive. Individuals and families are often priced out of coverage.

We are so used to thinking in terms of the conditions of the existing system that we cannot imagine what it would be like if things were done differently. Use your imagination. Go home tonight, sit down and before you go to bed write out a number of insurance products or services you can think of – life insurance, auto insurance, homeowners' insurance – and

imagine what those markets might be like if we applied the same tax policy to those goods and services that we apply to health insurance. Imagine for one moment what the American housing market might look like if you could only get your home mortgage if your employer selected your real estate company or defined the terms and conditions of your housing arrangements.

Third, in the United States individuals and families who need the most help do not receive it. Of course, you give tax breaks to people who pay taxes. That is understood. But, if the argument is that health-care insurance or health care coverage is some kind of a social good and something we ought to promote, it is odd that the greatest government assistance, in the form of tax free benefits, goes to those who need the least help. We have no system of refundable tax credits or premium subsidies for low-income persons who would like to buy into the private insurance market. Indeed, there is a persistent prejudice in Congress that such persons should not get such assistance to buy private health insurance, but should instead be enrolled in Medicaid, a financially troubled welfare program with a well earned reputation for poor quality care.

Finally, in the United States, in spite of its global reputation as the international champion of free markets and consumer choice, there is no normal free market for health insurance. While the American system is still largely private, it is barely so. About forty-seven cents out of every dollar spent in the American health care system is spent by the government. Normal markets, as commonly understood by economists and political scientists, are not operating in the health care sector of the economy.

To be precise: there is no normal collision of the forces of supply and demand on the most basic level- the level of individual choice. Most health insurance companies do not have to care what individuals think; they *do* have to care about what the companies who purchase coverage for individuals think. The "Golden Rule", in one incisive, if cynical, formulation, is that those who have the gold make the rules. In the American system, for the most part, the customer for health insurance and the consumer of health insurance are two entirely different personalities. The customer is powerful; the consumer is not. For the efficient functioning of a market this has profound impact on the way we control costs, and on the way we pay doctors and hospitals. We do not do either as well as we should. The reason: in health care we do not enjoy the fruits of the normal economic efficiencies- the consumer-driven efficiencies- that drive other sectors of the American economy.

D. Ethical Problems

As noted, America is at the forefront of a major biomedical revolution. The ethical issues surrounding this revolution are not, and practically cannot, be confined to elite scientists or philosopher kings of the biomedical research community. They are quickly arriving at the center of a broader public debate, even though the public is often awed and confused by the gravity of these issues. Public officials cannot escape them. The President of the United States has already made a major decision concerning the use of federal funds for embryonic stem cell research, and has convened a special presidential commission to address the difficult problems of biomedical ethics. Likewise, the United States Senate has initiated a major debate over the future of human cloning. The momentous public debate has begun in earnest.

In their personal lives, ordinary Americans will not be insulated from the outcome of these public policy debates. Within the next few years, the very first products of applied research from breakthroughs in the human genome mapping project may come to fruition, and, depending on the outcome of deliberations in Congress and the Administration, the applied research from whatever cloning or stem cell investigations are legally permitted may also start to find their way into medical treatments and procedures.

Whatever the outcome of either scientific investigation or the publicly determined legality of these investigations, the fact remains that today the freedom of conscience of Americans enrolled in public and private health insurance programs is not currently protected. This is evident considering the practices of both private insurance and government agencies on matters related to abortion, sterilization, contraception or other such procedures. These are the most common and controversial items. But there will be others, where persons have profound moral or ethical objections. Many Americans do not even realize that they are often paying premiums for medical treatments or procedures that violate their stated personal religious, ethical or moral convictions.

Ethical questions in health care policy are invariably subordinated to either fashionable corporate or political interests. Just this week, a member of the New York State legislature introduced a measure to establish a new health care mandate on health insurance in New York State. The mandate would require any health plan offering maternity services to also offer elective abortion services. Now whether such a bill would ultimately succeed or not is a matter of conjecture. What is not a matter of conjecture is that the personal ethical, moral or religious objections to medical procedures, including the practical ability to exercise

one's conscience in this most sensitive area of personal life, is routinely subordinated to political fashion. One cannot exercise freedom of conscience unless one also has the personal freedom to act on one's conscience. But for doctors and patients alike, freedom of conscience is being undermined. For example: doctors and nurses and hospitals officials are under increasing pressure to perform or participate in abortion or refer for abortion, regardless of their conscientious objection to participating in an act which they consider immoral. In some cases hospital personnel, such as nurses, have even been fired for opposing abortion. The Accreditation Council for Graduate Medical Education proposed that ob/gyn residency programs provide abortion and training in abortion procedures, stimulating Congressional enactment of 1996 legislation to protect the freedom conscience and prevent discrimination against health care providers from being forced to perform or participate in abortions.

Legislative bodies, mostly at the state level, are enacting mandates to cover contraception in health insurance plans, and, in some cases, even for plans sponsored by religious or religiously-affiliated institutions. In California, for example, Catholic Charities is locked in litigation over California's statutory imposition of mandatory prescription contraceptive coverage. In Congress, Senator Olympia Snowe and Rep. Jim Greenwood of Pennsylvania have introduced legislation (H.R. 1111 and S. 104) that would impose a federal contraceptive mandate, including prescription contraceptive drugs and devices, on health plans.

Consider also these questions. Do patients not have the right to select doctors who uphold the traditional Hippocratic oath? Do patients not have the right to choose doctors who see themselves as servants of the patient, who swear to protect their confidentiality and who refuse to sanction certain practices like physician assisted-suicide or abortion? There are those who argue that matters such as elective abortion or physician- assisted suicide are, and should be, purely matters of personal choice, and not matters of either law and government regulation. Americans will continue to hotly debate that proposition. In the meantime, however, if we really believe that these are purely matters of personal choice, then when it comes to insurance coverage for such procedures, we should at least impose that value on ourselves.

Ethical and moral questions will continue to be subordinated to political fashion until and unless Americans open up the health insurance markets, de-politicize health care decisions and return them to individuals and families. If we continue to maintain the current structural arrangements in health care policy, including the structure of government regulatory control over the benefit decisions and where individuals and families are

effectively denied the opportunity to make concrete choices over health plans and benefits, we can continue to expect the worst outcome of current policy; a violation of our right of conscience.

II. A NEW DIRECTION FOR FUTURE POLICY

Who makes the key decisions in the health care system? Who makes the key decisions about what kind of care you get, how you get it and under what circumstances you get it? Who controls the flow of the money in the system? Ask yourselves these questions anytime you ponder healthcare policy or healthcare reform, especially in the context of medical or biomedical ethics. Today employers, managed care networks and government officials make these decisions. The role of the person and the exercise of personal choice, is in reality quite small. Most Americans are on the receiving end of health care decisions made by someone else.

So what should health care reform advocates do? They should reframe the terms and thus change the dynamics of the national health care debate. They should also aggressively promote a positive program of expanding both personal freedom and the personal opportunities to practice virtue. Individuals and families should be able to operate within an economic framework where they are free to choose what is good, and they should be free to choose life. The current structure of third party payment inhibits that freedom.

The good news is that there is a growing, bipartisan consensus among professional economists and health care policy analysts, that we ought to change the tax treatment of health insurance for the purpose not only of creating a more efficient market, but also to expand health care coverage and empower individuals and families to make the key decisions which affect their health care.[3] The key policy change would be to give Americans individual tax credits to offset the cost of their health insurance or their purchase of health care services. This would enable them to pick and choose the plans they want, at the prices they wish to pay. The individual, therefore, would be the key decision makers in the system.

Practically speaking, this means that individuals and families would make the key decisions about the kinds of health plans they get, the kind of benefits they get and the kind of treatments they get. This would introduce unprecedented economic efficiency into the system through the rigorous discipline of a genuinely competitive and consumer driven

3. *See* GRACE MARIE ARNETT, EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM (University of Michigan Press, 1999).

market. But, as I have indicated, this is not simply a matter of economic efficiency. There is no question that such a system would be dramatically more efficient than the system we have today. But the most important thing is that the reform of the tax treatment would restore your personal freedom in the system, including your most important freedom, the right to exercise your moral conscience in the challenging era of biomedical science and technology that is upon us.