The Ethical Implications of the Attempts to Reduce Health Care Costs

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Introduction

- Health Care Costs in the U.S. are high, and others are spiralling out of control
  - (17% of GDP in 2007 -- highest among all industrialized countries – and will reach 26% by 2030).
- Costs are too big, must be contained
- We will show that disparities exist:
  - in the way H.C. is provided in the U.S.
  - or, in health outcomes in various health services
  - or in terms of age, gender, socio-economic positions, race and ethnicity, and education.
- Suggestions have been made for reducing such high costs.
Introduction

- We will show three different ways for cost reduction:
  - Demand-side
  - Supply side
  - Combining those two in what is called a managed-competition approach
- We will show: these proposals further aggravate the existing inequities of H.C., e.g: demand-side is bad for low income people.
- We show: there are ethical implications for those cost-containment strategies, depending upon which ethical theories we emphasize
Introduction

- These theories include:
  - Kantian
- We explore the implication of these theories
Disparities in Health Care in the U.S.

- There are gaps in the quality of health care and access to health care for racial/ethical minorities
- Improvements in health care are not shared equally
- Not new - this was mentioned by Swedish Nobel Prize winning economist Myrdal in 1944 (in his study of race in the U.S.)
- And in 1985, in a task force study: Less H.C. benefits to Blacks, Hispanics, Native Americans, Pacific Islanders
- 2003 Study by Harvard’s Byrd and Clayton
Demand–Side Approach

• Both demand and supply-sides assume the existence of a market for health care in which price is the means of allocation, and consumers are assumed to be sovereign.

• Demand Side: to change the behavior of consumers
Demand–Side Approach

Methods for containing H.C. cost on the demand side:

- Cost sharing—having consumers of H.C. pay for insurance premiums through coinsurance, co-payments, and for deductibles when receiving H.C.
  - These reduce the number of episodes of care, rather than cost per episode.
- Providing consumers of H.C. better information—about kinds of services which are appropriate, or about price and quality of different types of insurance.
Supply–Side Approach

- Several Supply-side containments.
- This is the main tool to make providers (hospitals /physicians) alter their behavior.
- In Medicaid-pay physicians low fees-thus they provide less H.C. to Medicaid beneficiaries
- Guidelines to public programs – so that physicians only provide medically appropriate services.
- Use diagnosis –related groups (DRGs) and capitation to provide incentives for physicians/hospitals – to not “over-provide”, i.e., paying a fixed amount for care regardless of how many services are actually performed.
- Limiting the number of hospitals, doctors, or equipment in the system.
Managed Competition Approach

• This approach combines both demand and supply-sides.
  • This is where health plans compete for enrollees
• Payers (employers, or government) provide a fixed amount of money to the enrollees to buy insurance.
  • They also provide information on alternative plan costs and measures of quality and enrollee satisfaction. Those are the part of managed completion aimed at the demand side.
• If enrollees choose a more expensive plan, they have to pay additional premiums out of pocket
  • These are the part of managed completion aimed at the demand side.
• On the supply side they have to lower costs- to be competitive
• Managed competition was part of the “failed Health Security Act” proposed by Clinton administration
  -Parts of it have been accepted by some private payers
Disparities on the Demand-Side of Cost Containment

• First: The case of patient cost sharing.
• There are five types:
  • A. Through coinsurance, deductibles and copayments at the time of service usage
    • more common in the U.S.
  • supported by RAND Health Insurance Study 1974-1982, which showed consumer demand for H.C. is sensitive to out-of-pocket costs, i.e. people who have to pay more at point-of-service are less likely to seek H.C.
  • Implication for racial/ethnic minorities? – Being poorer, they face de facto discrimination
Disparities on the Demand-Side of Cost Containment

• B. Racial/ethnic minorities, being poorer in health, have great need for H.C.
  • In 2000: While for whites, 8% are in poor or fair health, for minorities: African-Americans 16%, Hispanics 13%
  • E.g., Hypertension 50% higher for African-American than for Whites
  • Minorities have twice as many untreated dental problems
Disparities on the Demand-Side of Cost Containment

- C. In many cases, cost sharing works as a deterrent for seeking medical services
  - Disparities between whites and minorities also exist for Medicare patients
  - African-Americans are three times more likely to have amputation of lower limbs.
  - Being poorer, they are less likely to purchase supplementary insurance than whites.
  - Minorities have twice as many untreated dental problems
Disparities on the Demand-Side of Cost Containment

• D. Minorities are more hurt by cost sharing because they have more to gain from preventive care due to worse health and lower use of H.C.
  • Preventive care & dentistry are very price sensitive: higher costs make minorities seek less, although they need more.
• E. The premium paid by individuals and families for health insurance
  • This too affects the use of medical service, thus leading to disparities
Disparities on the Demand-Side of Cost Containment

• There are two different ways that premiums paid affect the use of medical care.
  • As premium rise, individuals become less likely to buy insurance offered by employers
  • Choice of health plan is responsive to premiums
• Because racial/ethnic minorities have lower incomes, their enrollment in insurance (thus H.C.) is also lower. -e.g., in 1999, 75% of whites had job-based insurance
  • For African-Americans, it was 58% and for Hispanics it was 47%
The Case of Consumer Information

• Demand-side cost containment can also use information = more education, more information about H.C.
• The impact: Differences in benefits, costs, H.C. quality, and degree of satisfaction
• Information is needed to make good plan choices
• Federal Govt. and the private sector do research to find ways to provide better information
• These attempts are less effective for minorities
  - those with less education
  - those whose primary language is not English
  - poor whites too may be at a disadvantage
In 1999:
- Whites: 26% held four-year college degree
- African–Americans: 16% held four-year college degrees
- Hispanics: 11% held four-year college degrees
- Rates were even lower among those whose primary language is not English
The Case of Supply-Side

• Four supply-side approaches to containing H.C. Costs:
  1. Low physician fees
  2. Capitation and DRGs
  3. Utilization review/practice
  4. Supply, technology and expenditure control
Low Physician Fees

- States pay physicians poorly for Medicaid patients = price discrimination
  - Physicians treat more lucrative patients first, Medicaid patients later
- Another implication: providing no medical service for Medicaid patients for whom treatment cost exceeds what states pay
  - Especially when Medicaid patients seek treatment from better-trained physicians, the more specialized, and those with better reputations.
  - These factors would aggravate the already existing disparities of H.C. faced by minorities.
Low Physician Fees

- For whites: only 6% receive Medicaid
- African-Americans 19%
- Hispanics 14%
- Also, African-Americans are 30% more likely to use an emergency room of whites
  - because they have less access to physician offices
Capitations and DRGs

- These two are related
- For DRGs: Hospitals are paid an amount for an in-patient stay.
- For Capitation, a fixed amount per patient per year is given to the physician, rather than the hospital.
- Here too the amount is unrelated to subsequent usage of resources used on the patient.
- One might assume that DRGs do not affect doctors’ decisions, since the money goes to the hospital
  - But hospitals make sure physicians are aware of costs
  - Or even withdraw privileges to practice in the hospital
- On the surface, these two methods do not lead to disparities
- There are however some who suggest they are harmful to minorities
  - e.g: Physicians my see more patients, spending less time on each, or make less hospital referrals
Capitations and DRGs

• These methods may hurt minorities in three ways:
  • 1. Overt discrimination by a doctor favoring his/her own race/ethnicity
  • 2. Physicians may stereotype minorities, in terms of their intelligence, education, self-control rationality
    • Thus they usually see them as risky in terms of noncompliance,
    • Stereotyping may lead to less care, or spending more time with whites
Capitations and DRGs

3. A third related reason: Minorities may receive less care due to what is called statistical discrimination.

If physicians think they know less about the patient or symptoms, they become less certain of a particular type of treatments.

Thus, they favor patients they think they know more about (less ambiguous).

That is much worse for patients whose primary language is not English.

The above demonstrate that financial incentives that encourage physicians to reduce resource usage under managed care differently harm racial/ethnic minorities.
Ethics/Justice Theories and Health Disparities

• How do we apply ethics/justice theories to healthcare disparities?
  • Depends on what ethical/justice theory we employ
  • Responses by a libertarian like Nozick differ from those of a Utilitarian, a Kantian, an Egalitarian, or a follower of John Rawls.
Libertarians

• Libertarians do not believe government should engage directly in eliminating health care disparities
• Under a libertarian conception, health care is not a right
• H.C. should be private
• They emphasize fairness of procedure - not public provision
Robert Nozick (a Libertarian)

- According to Robert Nozick:
  - There are three principles of justice
    - 1. justice in acquisition
    - 2. justice in transfer
    - 3. justice in rectification
  - These suggest no just distribution can exist outside the market.
    - thus: Welfare not a right
    - And, no right to claim H.C.
• Emphasizing procedural justice, libertarians only oppose disparities stemming from discrimination
  • But not those stemming from market forces, or ability to pay, or demand/supply
Egalitarian Theories

• Emphasize that individuals should receive certain goods/services like H.C.
  • But no prominent egalitarian theory advocates equal sharing among all
  • Some Egalitarians advocate only a minimum amount
• Rawlsians, who are a type of egalitarians, accept inequalities if they help the least advantaged
  • Norman Daniels is a Rawlsian
  • He said: “Social institutions affecting health care distribution should be arranged.”
    • i.e. fair equality of opportunity;
    • these institutions should allow a normal range of H.C. to be received.
The above relate to two issues in terms of the right to H.C.

- A right to equal access
- A right to a decent minimum

“Access” to H.C. could mean that individuals are not legitimately prevented from obtaining H.C.

- Which does not mean others ought to provide it.
  - This is a libertarian view.
Egalitarians

• For egalitarians access to H.C. means a right to obtain it
  • i.e., Each person- regardless of age, race, ethnicity, etc. should have access to every treatment possible/ available
• Egalitarians like Rawls or Kant would agree with a decent minimum to H.C. (adequate)
• To them, what is important is lack of discrimination and disparity in provisions. Thus, they support universal access
• The decent minimum H.C. may entail a two-tiered system
  • An enforced social coverage for basic and catastrophic health needs and
  • A voluntary private coverage for other desired health needs.
• The first tier would be determined on the basis of need
  • It would be universal (for all)
The First Tier

• The first tier, lacking discrimination, would cover health promotion, prevention, primary care, acute care
  • It is a safety net, universal and egalitarian.
The Second Tier

• The second tier consists of unequal additional amounts purchased by those who can afford it.

• Together, a mixture of private and public provision.
  • Is acceptable to egalitarians, utilitarians (since it maximizes social utility)
  • And libertarians, since it is private
• Of course, the private component would also lead to disparities – since it is only based on ability to pay.