The Ethical Implications of the Attempts to Reduce Health Care Costs

Hengameh Hosseini, Ph.D.

Seton Hall University

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:
  - Libertarian of Robert Nozick (1974)
  - Kantian
  - More egalitarian theories-based on Rawls (1971) – as done by Norman Denials (1985)
- 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

The Case of Consumer Information

- 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 rage 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.