Guest Editorial

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Starving for Health Care: Ethical Issues Surrounding the Uninsured Population

For decades, one of the allures of stable employment in the United States has been access to employer-sponsored health insurance. By the same token, one of the fears accompanying the threat of unemployment has been the loss of such insurance. When employer-sponsored health insurance is the norm, it is mainly the jobless and the self-employed who are left to "go it alone" in the open market. Today, however, economic downturns and skyrocketing health care costs have encouraged companies that historically have offered health insurance to their employees to drop or severely curtail these health benefits. As a result, many people with full-time jobs now find themselves joining the ranks of the uninsured.

In 2001, 41.2 million people (14.6% of the total U.S. population) had no form of health insurance and, despite Medicaid, 30% of the poor did not have any coverage.[1] By 2007, approximately 47 million people in the United States—38 million of them employed—were uninsured.[2] In that same year, approximately 57 million Americans had difficulty paying their medical expenses.[2]

In addition to providing medical care and disability benefits to veterans with illness and injuries related to their military service, the VA has for many years also served as a "safety net" for veterans with low incomes who cannot afford private health care. The VA determines priority for access to its health care services by classifying veterans into eight groups. According to this system, veterans who don't have service-connected conditions (or who have been classified as 0% disabled and, thus, do not receive disability compensation) but have incomes below a specific threshold are included in priority group 5.[3] Despite these efforts to provide for low income veterans, as well as the recent decision to expand health care eligibility to some veterans in priority group 8 whose income exceeds the threshold by 10% or less, many veterans are not being caught by this safety net. In 2004, an estimated 1.77 million (7%) of the total 23.88 million U.S. veterans were neither insured nor receiving VA medical care.[4]

HEALTH DISPARITIES AMONG THE UNINSURED

But just what does it mean to be uninsured in the United States? In a nation where people are living longer, new and innovative technologies continue to improve lives—for those who can afford them. When lack of insurance impedes access to these innovative diagnostic, therapeutic, and preventive modalities, the result is that the uninsured live sicker and die younger than their insured counterparts.

Approximately 18,000 people each year die from a preventable disease because they lack health insurance.[5] Uninsured individuals are more likely to have diseases diagnosed in the later stages, which can contribute to premature death. People without insurance also may not receive the routine preventive care that could help them avoid illness or halt the progression of acute conditions to chronic ones. Additionally, they are nearly 50% more likely than those with insurance to die of traumatic injuries.[6] A statewide study of trauma patients conducted in Massachusetts indicated that uninsured patients were less likely to receive operations or rehabilitative therapy and more likely to die in the hospital.[6]

Beyond the negative effects on the individual, inadequate medical care of the uninsured also has public health implications. When infectious diseases go undiagnosed, untreated, or insufficiently treated, for instance, affected patients serve as reservoirs of infection for the larger population, which can lead to disease outbreaks that reach epidemic or even pandemic proportions.

THE RIGHT TO HEALTH CARE

One of the greatest conundrums in American constitutionalism is the question of whether the government has an ethical obligation to satisfy basic necessities, such as health care, for its citizens.[7] President Franklin Delano Roosevelt argued that every American was entitled to "the right to adequate medical care and the opportunity to achieve and enjoy good health."[8] At the international level, the right to health was articulated initially in the Constitution of the World Health Organization in 1946.[9] Today, most developed countries have

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codified the government's obligation with respect to health care into law.[10] In 2005, Yamin pointed out that the United States was "the only industrialized country in the world that does not provide a plan for universal health care coverage and some kind of legal recognition of a right to care" for all its citizens.[10]

Several core American values support this notion that health care is a basic right that should be protected by law. The first, and perhaps most fundamental, is the concept of equal opportunity. In a 2007 publication laying out an ethical framework for guiding health care reform, Levine and colleagues suggested, "Equality of opportunity is compromised whenever identifiable subpopulations of society are disproportionately affected by limited access to care."[11] The American ideal that all men are created equal is contradicted when the disparities in access to health care services result in poorer health for certain populations, while forcing the inequitable subsidization for these services by the insured and private paying citizens.[11,12]

Disparities in health care arising from the insurance gap also violate the cherished values of compassion and respect for human dignity. These values are central to the health care profession. The American Nurses Association's Code of Ethics, in its first provision, declares, "The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems."[13]

ETHICAL IMPLICATIONS FOR HEALTH CARE PROVIDERS

According to the American Medical Association's Code of Medical Ethics, "a physician shall support access to medical care for all people."[14] This principle becomes an ethical dilemma, however, in our currently divided system in which those without insurance are not provided the same access to health care as those with insurance.

Health care providers are continually obligated to balance the increasing need for cost containment and appropriate allocation of medical resources with their professional ethical obligation to "regard responsibility to the patient as paramount" when making clinical decisions.[11] This delicate juggling act can lead to a multitude of unethical and illegal health care practices.

The practice known as patient dumping, for example, frequently hinders access to health care services for the uninsured.[15] Patient dumping occurs when a medically unstable patient is intentionally denied access to emergency medical care, improperly transferred, or discharged inappropriately for nonmedical reasons, such as lack of health insurance or financial resources.[16] Blalock and Wolfe found that 427 hospitals in 46 states had violated the 1986 Emergency Medical Treatment and Labor Act (EMTALA) and 12.9% of these hospitals had previous violations.[17] Since 2002, 137 patient dumping citations have been reported by the HHS Office of Inspector General.[18]

FIXING A FLAWED SYSTEM

At the heart of the human rights movement is the right to the highest attainable standard of health. Yet the current structure of the U.S. health care system includes a fundamental paradox: the "existence of dramatic therapeutic gains alongside large discrepancies in access to quality health care."[19] The United States spends 14% of its gross domestic product on health care, and yet over 40 million Americans remain uninsured.[19] The nation needs to move toward an equitable system that allows all citizens to have the same access to health care.[20]

While implementing some sort of "universal health care coverage" seems the most straightforward solution to this problem, the concept is controversial for a number of reasons.

The current phenomenon of limited health care financing by private insurers can challenge a society's values in when it comes to resource allocation decisions. Any effort to reform health care has the potential to affect cost, quality, and availability of health care for all of those who rely on provision of services, including the medically insured and uninsured. As such, it would be beneficial for health care providers, patient advocate groups, health care organizations, and government agencies to collaborate at the policy level to explore alternatives to resource allocation based on "medical need, efficacy, cost-effectiveness, and proper distribution of benefits and burdens in society."[21]

For example, the important question for the proposed public option in the health care reform bill being debated before Congress is whether it can use Medicare's payment rates. Medicare uses its massive size to negotiate deep discounts for medical services while private insurers pay much higher rates. If the public option could use Medicare's rates, it would provide savings for the government and consumers. Its low premiums and generous benefits would attract many consumers, giving the public option and Medicare even more bargaining power. If the public option can't use Medicare's rates, however, it is unlikely to save very much money or be a dominant player in the marketplace. Nevertheless, without a public option, we are trusting private insurers to fix the system they created and are spending a far too healthy budget to keep it in place.

While the current presidential administration has placed health care among its top priorities, it will take time to implement a plan. In the meantime, the uninsured continue to face the life threatening consequences of limited access to care. When the U.S. government views health care as a human right, it will have made a considerable step toward serving society. ●

Author disclosures

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