

# Ethics and Health Care Reform

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On September 22, 1993, President Clinton delivered an address to the nation that set the stage for the upcoming health care reform debate that will quite likely receive priority in the 1994 session of Congress. He eloquently laid out six values that the Administration views as essential components of an acceptable reform package: creating security, controlling costs, enhancing quality, expanding access to care, reducing bureaucracy, and reducing fraud and abuse. The Task Force on Health Care Reform, organized under the leadership of Hillary Rodham Clinton in January, appointed 550 persons to 35 different working groups, each focusing on one specific feature of reform. One of the authors (H.B.) served on the working group that addressed the ethical foundations of the new health plan.

*Why Ethics?* It is noteworthy that the Clinton Task Force considered ethics important enough to create a special working group on the topic, and even more so that the group was assigned the task of writing what was considered a preamble to the plan as a whole. The message appears to be that the Clinton Administration thought it important to present their health reform proposals as part of a *moral* debate about what is fair and just for all Americans and what Americans, as part of a compassionate society, ought to provide for each other. That is, the new administration sought at the outset to ensure that the debate did not appear to be solely one of politics, economics, or organizational theory. Explicitly listing personal ethical values is a bold move because opponents can readily claim that their counterproposals fulfill some of those values better, but it encourages the debate to rise to a level above interest-group "politics as usual."

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*Which Values?* The ethics working group eventually concurred on a list of 14 discrete moral values that, they argued, should form the basis for any health plan worthy of adoption in the United States (Table). These values were selected because they appeared to be ethically weighty and they seemed to include the values actually held within the American culture when we take the trouble to reflect upon our deeper beliefs.

The working group realized that conflicts among these values are inevitable. The most commonly cited example is that it is impossible to cut costs while simultaneously maximizing consumer choice. Even when conflicts arise and appear difficult to resolve, it is still helpful to recall exactly which values are conflicting and to reassure ourselves that the conflicts are real and not based on simple misunderstandings of the data or on narrow self-interest.

The 239-page Administration plan issued the week before Clinton's September 22, 1993, address to Congress included the list of the 14 ethical values stated in the table. Moreover, it was easy to see that the "six points" President Clinton mentioned in his address to the nation, which form the actual preamble to the printed document, are more or less a distillation of the list of 14 ethical values. Therefore, the Administration appears to have remained constant in its efforts to ensure that the ethical foundations paved the way to a discussion of health care reform.

*What Was Not Said?* One fascinating point of contention arose between the leaders of the Task Force and some of the "ethicists" in the working group. To a philosopher or policy analyst, any national approach to health care must involve deciding who gets access to certain scarce or expensive resources and who does not. The usual word to describe that ethical or policy problem is "rationing," but the Task Force did not want the plan to use the "R-word," fearing its obvious effect as a red flag among those in the political arena for whom "rationing" could only mean something like standing in line to buy gas with government stamps in World War II. The Task Force leadership won the argument, even though some working group members warned that they had

Table. Ethical Foundations for the New Health Care Plan of the Clinton Administration

I.	General Fundamental moral importance of health care
II.	Caring for All Universal access Comprehensive benefits Equal benefits Fair burdens Generational solidarity
III.	Making the System Work Wise allocation Effective treatment Quality care Efficient management
IV.	Choice and Responsibility Individual choice Personal responsibility Professional integrity Fair procedures

better be ready to go toe to toe over the "R-word" with critics of the plan.

*Who Won?* It is widely said today that the Clinton plan may be altered considerably as it works its way through Congress and that what emerges may be quite different from the proposed plan; but as former Surgeon General Koop pointed out, in merely bringing that plan before a joint session of Congress, Clinton has done more for health care reform than any of his predecessors. It is difficult to remember today the state of the debate over health care reform a mere 2 years ago, when there appeared to be no possibility that health care reform would even be on the list of issues in the next presidential election, or during the 1992 presidential campaign, when proposals to stick a few Band-aids on various parts of the health care system were put forth as serious "reform plans." The Republican response to Clinton shows that he basically won the right to define the health care debate on his own terms in two crucial ways. First, any viable plan must provide universal access for all Americans; and second, plans that will be serious contenders will provide a fairly comprehensive overhaul of the US health care system, regardless of whether they rely on government spending and regulations, the private marketplace, or a combination of these. It could be argued that leading off with the moral foundations of the plan may have helped Clinton achieve this victory.

*What's Next?* Some members of the ethics working group were proved right when several critics of the plan immediately resorted to the "R-word" in their attacks. Indeed, the "R-word" may play a role in the 1993-94 debate somewhat similar to that of the "S-word" in 1945-46, when Truman's national health insurance

founded on the American Medical Association's charges of "socialized medicine," a term that amazingly has been absent from the current discussion.

Will the "R-word" ultimately derail the Clinton plan? The plan's proponents are in a bind: they can promise increased benefits for all and then try to figure out how to pay for all that without raising taxes, or they can admit that we cannot afford all the benefits everyone would want and then be accused of "rationing." If the general public understood "rationing" the way the ethicists do, there would be no problem. We could simply get into a discussion of which sorts of rationing are fair and which are unfair, and try to ensure that all the rationing that occurs, in order to hold down costs, is of the former variety. The problem lies in the terms of the debate, which are still unfamiliar to even rather well-educated Americans. As recently as in 1992, the nation was not yet having deep and intense debates over health care policy. In that environment, "rationing" could have the effect of shutting off further discussion by fear-mongering rather than clarifying choices in any useful way.

*What Does It Mean for Physicians?* While few family physicians would approve of every feature of the Clinton plan, we must note that it goes much further than any single document in memory toward acknowledging the absolute importance of the type of care we provide and encouraging the training of future family physicians. In particular, family physicians should agree with most of Clinton's six points. "Security" is something we want for all of our patients. "Cost control" clearly favors primary care, which has been proven in numerous studies to produce equally good outcomes at lower costs when compared with specialty care. It is reassuring to see that the Clinton plan recognizes that "quality" includes primary care and preventive services. "Access" clearly signals the need to train additional primary care providers. "Reducing bureaucracy" makes all of our lives easier. Finally, it is important to continually remind the public about the income gap between primary care and subspecialist physicians, so they can understand that the "fraud and abuse" problem, which translates in public opinion to the "greed" problem, does not lie principally at our doorstep.

However, political conflict over the "R-word" holds potential dangers for generalist physicians in the new plan. In the best-case scenario, the entire nation would follow the example of the state of Oregon, where the populace became quite well educated about health policy options over many years and where the legislature eventually took explicit responsibility for how health care should be rationed. The worst-case scenario would be for politicians to continue avoiding the "R-word" at all costs and instead to create a system in which the primary care physician becomes the rationing agent at the bedside and

no architect of the plan could be held accountable for tough decisions that are eventually made. This, arguably, is exactly what happened with diagnosis-related groups, and we have yet to see any evidence that Congress will not follow the same path. To this end, a proposal made within the ethics working group that local health plans be required to form ethics committees to advise on the definition of the benefits package (where many of the critical rationing decisions are likely to occur) did not make it into the Clinton report to the nation. It is hoped that it may resurface at a later time.

In debating and ultimately influencing our elected representatives' vote on the Clinton plan or its successors,

family physicians and our organizations may want to borrow a page from Clinton's book. Can we help our patients and our communities to articulate the moral values, and the priorities among those values, which ought to guide the American health care system of the future? Can we state our own opinions about various measures, not in terms of "the bottom line," but rather in terms of a moral vision of accessible, affordable, and high-quality medical care? Can we surpass the role of reactor to forced changes, a position occupied far too often by organized medicine recently, and assume the role of leadership to which we should rightfully aspire?