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Access to Care

From the Editor

Clinical Cases

Journal Discussion

Medical Education

Clinical Pearl

Health Law

Policy Forum

Medicine and Society

Op-Ed

Upcoming Issues of *Virtual Mentor*

August: Difficult Conversations in Medicine
September: Ethical Challenges in Organ Donation
October: Ethical Decision Making in the Diagnosis and Management of STDs

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From the Editor
A Long Way to Go

The Death of Bessie Smith by Edward Albee, presents the playwright's version of the last hours of the famous blues singer's life. It is a disturbing play: Smith is a black woman in 1930s America who has been in a terrible car accident and is taken by her boyfriend to the nearest hospital. The drama centers around Smith's boyfriend's pleading with hospital staff to allow the black woman to be admitted to the whites-only hospital. His pleas fall on deaf ears, and Bessie dies en route to a black hospital. When I first saw the play in high school I was dumbfounded—could this have happened in America? Could anything like it happen today?

Barriers to health care come in many forms. Racial disparities in care are still far more prevalent than many of us would care to admit. Infant mortality for African Americans is twice that of Caucasians [1]. Rates of diabetes are higher in minority populations than in Caucasians, with rates for African Americans, Latinos, and Native Americans at 70 percent, 100 percent, and 200 percent higher, respectively [2]. Inequalities in health insurance coverage, poverty, geographic isolation, and language barriers, all affect an individual's access to health care. As cited in several of this month's articles, 45 million Americans are presently without health insurance. How do these people obtain care? What do they forego?

In this installment of *Virtual Mentor* we explore some of the challenges to access. We do not pretend to cover the issue in its entirety; there are simply too many aspects of the problem to touch on them all in a single volume. Rather, we have tried to concentrate on what we see as the general themes, with an emphasis on legislative and political trends that we believe will have the greatest impact in the coming years.
Of those Americans who are covered by health insurance, nearly a third are enrolled in the government-sponsored programs Medicare and Medicaid [3]. Given the importance of these 2 programs, we have devoted considerable space to them. Much of the policy forum discusses how recent and proposed legislative changes to Medicare and Medicaid will affect those covered by these programs.

Our op-ed section looks at some current proposals for health care financing—Health Savings Accounts (HSAs), income-based tax subsidies, and government-administered health care. Which of these will improve coverage for the currently uninsured? Moreover, which are likely to be endorsed by the American people and enacted by the legislature? Medicine and society outlines the state of the medical "safety net"—the community health clinics and public hospitals that provide the majority of care for the uninsured. Another medicine and society contributor gives us insight into barriers to care that refugees and other immigrants face when they enter the US system. An international perspective on access to life-saving HIV medications reminds us that we are members of a global community, and, as such, we have responsibilities that extend beyond our own borders. And finally, in medicine and education, one doctor recounts his experiences teaching medical students at a homeless clinic in Denver, discussing his belief that physicians can learn the importance of providing charity care if they are exposed to it early in their careers.

To return briefly to Bessie Smith: the real details of her death are somewhat obscure, but Edward Albee appears either to have been mistaken or to have invoked poetic license in his rendition. Most historians agree that she was taken by ambulance from the crash scene, and that no ambulance driver would have attempted to take her to a white hospital at that point in American history. She was taken directly to a black hospital and died some hours after being admitted. We no longer have hospitals segregated along racial lines, but a recent *New York Times* article suggests that we now may be segregating along other lines: the article documents an uninsured man who refused to go to the hospital after becoming short of breath because his bill there was already so high that the hospital was garnishing his wife's wages. Later that day, his wife came home from work and found him dead [4]. Although we have undoubtedly come a long way toward improving access to health care in the past 70 years, with Medicaid and Medicare being notable examples, it appears that we still have a long, long way to go.

References

1. Department of Health and Human Services. *Minority Health Disparities at a Glance*. Available at: www.raceandhealth.hhs.gov/glance.htm. Accessed July 12, 2004.
2. Center for Disease Control. *Chronic Disease Overview*. Available at: www.cdc.gov/nccdphp/overview.htm. Accessed June 29, 2005.
3. Almanac of Policy Issues. *Health Insurance Coverage: 2001.* Available at: http://www.policyalmanac.org/health/archive/health_insurance_coverage.shtml. Accessed June 29, 2005.
4. Cohn J. Uncharitable? *New York Times.* December 19, 2004;section 6:51.

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Clinical Case
When Diagnosis Becomes Unaffordable
Commentaries by William Hensel, MD, and Justin List, MAR

The waiting room is packed at the Urgent and Family Care office. Dr Garrison picks up the chart for the next patient, Mrs Williams, who has come in because of cough, fever, and chills.

"Good morning Mrs Williams, I'm Dr Garrison, how can I help you?"
Mrs Williams looks older than the 50 years listed on her chart, and Dr Garrison is struck by how gaunt and pale she appears. Mrs Williams reports that she has had no serious illnesses or surgeries but admits that she has been a 2-packs-per-day smoker for the past 30 years.

After performing a physician exam, Dr Garrison tells Mrs Williams that she would like to order a chest x-ray and a complete blood count because she is concerned about the possibility of pneumonia.

"Pneumonia? Again? I've had that 2 times in the last year." Mrs Williams exclaims.
Dr Garrison flips back through her chart and sees that Mrs Williams was treated for pneumonia in their office 4 months ago. Dr Garrison orders the chest x-ray and the labs and reviews Mrs Williams' previous films. She sees an abnormal area in the right middle lobe. In the previous film it had been read as "anatomic variant, likely related to pectus excavatum," with an infiltrate distally. Today's results show that the distal infiltrate is gone, but the area originally read as "anatomic variant" appears larger and more defined. Mrs Williams' white count is in the high normal range. Given the patient's smoking history, Dr Garrison is concerned about the possibility of a mass. Could this be lung cancer or is it just another pneumonia?

"Mrs Williams, I was just comparing your chest x-ray to the one you had before in our office. I am concerned about an area that just doesn't look right to me. It could be that you have pneumonia again in an area of your lung that is a little abnormal and prone to getting infections. I'm going to treat you with antibiotics, but, given your smoking history, I'm also worried, honestly, about the possibility of a cancer. I'd like to do a CT scan of your chest, so we can get a better idea of what's there."

Mrs Williams is silent for about a minute. "Dr Garrison, I've thought about lung cancer because my cousin just died of that, and he smoked a lot too. But I don't have any health insurance. I just started a new job and I'll be eligible for health insurance in 6 weeks. I started in the middle of the month, and they don't count part of a month when they figure eligibility for benefits. So in 6 weeks, I'll see which plan I can afford to be in. I don’t know what my rate will be when they find out that I smoke. So, can we wait to get the CT scan until after I have insurance? My cousin didn’t have insurance and their family went bankrupt paying for his treatments. Now he’s dead and his wife and kids got nothing. I don’t want to do that to my family. Plus, you said it could just be another bout of pneumonia.”

Commentary 1

by William Hensel, MD

Physicians must balance their ethical obligations to patients with those to society at large. Society trusts the profession of medicine to self-regulate the care it delivers, but it has strict rules for reimbursement of that care, especially when it comes to caring for those who are unable to pay. Physicians work within those reimbursement rules, attempting to meet patients’ needs and preferences whenever possible. But what if society’s rules are unjust? What then is the physician’s obligation? These ethical dilemmas frame the problem confronted by Mrs Williams and Dr Garrison.

Ethically, Dr Garrison cannot simply blame our US health care system, which seems to accept as inevitable 43 million uninsured patients, and leave Mrs Williams to fend for herself [1]. Instead, she must advocate for Mrs Williams and help her navigate through the barriers to her care.

All patients, and especially those who are seriously ill, need health care professionals whom they trust to guide them through our complex system and to assist them with the difficult decisions they face. In this case, Mrs Williams has been seen in the practice before, but not by Dr Garrison. I will resist the temptation here to comment on the decline in continuity of care. Focusing on the situation at hand, Dr Garrison should discuss with Mrs Williams which doctor in the practice she would prefer to see for her subsequent care.

What else should Dr Garrison try to accomplish during this initial visit? The answer is not much. Mrs Williams has just received shocking news: she might have lung cancer. She knows full well the potential horror of the disease—she has witnessed the tragedy of her cousin and his family. When confronted with such devastating news, rational thought typically takes flight and is replaced by confusion and denial. This is not the time to discuss rationally Mrs Williams’ request to wait 6 weeks before further testing.

Dr Garrison’s best strategy is to schedule a follow-up visit in 1 to 3 days with Mrs Williams’ doctor of choice. She should encourage Mrs Williams to bring a trusted friend or family member to that visit. The simple act of deciding which doctor she will see and identifying a support person can help Mrs Williams reestablish some control over her life, control that was lost moments earlier when the possibility of cancer was mentioned. Dr Garrison should then conclude this initial visit as empathically as possible.

The doctor that Mrs Williams chooses must carefully plan the next appointment. A well-structured visit with information regarding her options for determining a definitive diagnosis will help give Mrs Williams the confidence that she will need to deal with her health crisis. It should begin with the doctor's asking what thoughts she has had since the last time she was at the office. If Mrs Williams remains focused on financial concerns and reiterates her request to wait 6 weeks until she has insurance before pursuing any further diagnostic tests, the doctor must gently outline the problems with this approach:

- The insurance delay will probably be longer than 6 weeks. It is unlikely that Mrs Williams will be able to sign up, on day 1 of her eligibility, for a plan that will immediately cover a CT scan of her chest. Realistically, as much as 4 to 8 weeks should be added to her estimated 6-week delay.
- The insurance company will most likely consider this a pre-existing condition. Even though Mrs Williams does not have a definitive diagnosis, she does have symptoms and objective x-ray findings that point to a possible neoplasm. Thus, waiting may not achieve the desired result of having her tests and treatments covered.
- Any delay in the diagnosis and treatment of lung cancer may affect the treatment outcome. Delaying 6 weeks or longer could decrease the chances of a cure if the suspicious area turns out to be cancer.

Given that the risks involved in waiting are great and the benefits uncertain, the doctor should advise Mrs Williams to proceed with the CT of her chest. Psychologically, patients deal better with known problems than with uncertain fears. So, even if the CT scan confirms that Mrs Williams has a lung cancer, the conclusive diagnosis will take her out of limbo and allow her to begin to deal with her cancer. I would recommend that the physician schedule the CT scan before Mrs Williams returns for her follow-up—within 48 hours of the initial visit, if possible—so that she can say to Mrs Williams, “I took the liberty of making you an appointment for tomorrow. It can be cancelled or postponed, but I wanted to give you the option of immediate care.” This paternalistic approach can be justified in times of crisis but must be judiciously balanced with efforts to empower the patient’s own decision making so that she can regain a sense of control.

Anticipating that Mrs Williams might ask, the doctor should know the approximate cost of a chest CT ($850-$900 for scan and radiologist’s interpretation at my institution) and be able to direct her to the hospital’s financial counselor or other community resource to help resolve some of her financial concerns. The doctor could also offer to make this appointment for Mrs Williams.

A timely follow-up appointment should be scheduled to review the CT results and to discuss options with the doctor. At some point, the doctor should address end-of-life issues with the patient. The recent Schiavo case emphasizes the importance of discussing advance directives regardless of the test results. Because it is difficult to prognosticate without an accurate diagnosis, a tissue biopsy is typically necessary before Mrs Williams and her physician can have a serious discussion about the risks and benefits of the various treatment options. Should the tests confirm cancer, and depending on her prognosis and personal values and beliefs, Mrs Williams might choose palliative care over aggressive curative care. Shamefully for this country, her lack of insurance may influence that decision.

The physician will face an unfortunate dilemma if Mrs Williams insists on waiting until she has insurance. The insurance company may contact the practice and ask if there is evidence that this was a pre-existing condition. Physicians must respond truthfully to such direct questions; to do otherwise is unethical and constitutes insurance fraud.

How forthcoming should the doctor be if the insurance company does not ask direct questions? Suppose Mrs Williams asks the doctor for advice on how she might get around the pre-existing condition clause in her insurance coverage? The central point of this commentary is that ethical physicians should advocate for their patients and help them negotiate the health care system. To what lengths individual physicians are willing to take their advocacy depends, in part, on how fair they think our current system is. America stands alone among industrialized nations in its failure to ensure that all its citizens receive basic health care. I believe that it is unjust to limit access to care for 43 million Americans because of their inability to pay. Therefore, I would do all that I could legally and ethically do to help Mrs Williams obtain access to care—access that should be her right.

Reference

1. Institute of Medicine. Insuring America's health: principles and recommendations. *Acad Emerg Med.* 2004;11:418-422.

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Commentary 2

by Justin List, MAR

This case illustrates some of the frustrations experienced by patients and physicians due, in large part, to systemic shortcomings in health care delivery in the US. It also raises questions about the professional obligations and limits of care Dr Garrison owes to her patient, and it vividly portrays how financial concerns may critically impact health outcomes. To be sure, there is medical uncertainty about Mrs Williams' actual illness, but there are tests available to help Dr Garrison rule out or confirm the presence of a malignant mass. A delay in the diagnosis of lung cancer could result in a poorer outcome for Mrs Williams, and, unfortunately, she cites financial not clinical or personal concerns for postponing testing. Determining Mrs Williams' illness expeditiously using the standard diagnostic procedures seems ethically imperative for optimal patient care, but prudential concerns and the wishes of the patient must be seriously considered, despite the potentially tragic outcome of delayed testing.

There are at least 3 potential dilemmas for Dr Garrison. First, her clinical encounter with Mrs Williams is encumbered by nonclinical financial, family, and insurance matters that could impact her patient's health. Thus Dr Garrison finds herself in a situation where prescriptions for standard and advisable medical tests butt up against systemic injustice in the delivery of health care that make getting such tests difficult. As a result, it is likely that Dr Garrison's ethical duties in this encounter will include helping her patient navigate the insurance and payment system. Second, Dr Garrison must establish trust with Mrs Williams early in the clinical encounter, a potentially difficult task, given Mrs Williams' lack of continuous care from a single physician. Third, Dr Garrison must resolve conflicts among respect for patient autonomy, clinical judgment, and the economic and social realities of the health care delivery system. A form of soft paternalism in response to the injustices of the system may seem appropriate, eg, pressing Mrs Williams to get the testing, while at the same time searching for or directing Mrs Williams to financial assistance opportunities. But such actions have an impact on a key principle of medical ethics—respect for patient autonomy.

Examining the dynamics of the patient-physician interaction more closely allows for a greater understanding of the possible relationships between patient autonomy and professional duties. In "Four Models of the Physician-Patient Relationship," Ezekiel and Linda Emanuel compare paternalistic, informative, deliberative, and interpretive models of patient-physician relationships, taking into account in each model the (1) goals of the professional interaction, (2) physician obligations, (3) role of patient values, and (4) notions of patient autonomy [1].

The paternalistic and informative models are undesirable approaches in this case. In the paternalistic model, the physician decides the best course of action almost unilaterally, and patient autonomy is relegated to patient assent. Using the informative model, the physician acts as a technical expert, providing facts and information to the patient but offering little overall guidance. With this approach, physicians' values and assessments of their patients' values are supposed to be absent, and patients have more or less complete autonomy in medical decision making. Both of these are inappropriate models for Mrs Williams because they entail what many consider unacceptable and unequal levels of knowledge, power, and decision making within the patient-physician relationship.

The remaining models—deliberative and interpretive—may better help Dr Garrison share her knowledge and professional opinion with Mrs Williams while simultaneously discerning Mrs Williams' values and honoring her autonomy.

Using the interpretive model, Dr Garrison would limit the expression of her own values and desires as they bear on the clinical decision. Rather, her responsibility is to elucidate her patient's preferences in order to match them with medical actions that accommodate them. Dr Garrison would act like a counselor, trying to understand the underlying reasons for Mrs Williams' unwillingness to undergo a CT scan, but she would ultimately make recommendations based on Mrs Williams' preferences. Dr

Garrison's belief in the injustice of the health care system will likely remain deeply troubling to her if Mrs Williams opts to forgo further testing.

Following the deliberative model, Dr Garrison would act as a teacher or friend, aiming to help Mrs Williams determine the most important health-related values in the clinical situation and then correlating those with the options available to her, all things considered. Most likely, the options would include treating possible pneumonia and pushing Mrs Williams to get a CT scan, despite her financial reasons for not wanting to do so. Of course, Dr Garrison cannot force Mrs Williams to get the scan, but she can make her professional advice explicit and underscore the importance of placing one's health above other factors that can, lamentably, devalue it. Dr Garrison's responsibilities under this model are to advocate for the most clinically relevant medical choices and explain the implications of those and any other alternative treatments.

Dr William Hensel's adjoining discussion of this case reflects the deliberative approach to the encounter between Dr Garrison and Mrs Williams, the one also most favored by Ezekiel and Linda Emanuel. Although this model may best allow Dr Garrison to persuade her patient to go ahead with the CT scan, Mrs Williams will still ultimately have to decide what to do. The cardinal principle of respect for individual patient autonomy in Western medical contexts requires that the physician honor the patient's wishes. According to a biopsychosocial understanding of health care decision making, Mrs Williams may reasonably hold nonmedical values that support a decision to delay or deny further testing. In this situation, Dr Garrison should convey compelling arguments that might assuage Mrs Williams' financial concerns without making her feel guilty about deciding to forgo testing. When financial concerns stand in the way of adequate diagnostic procedures despite the serious health consequences at stake, physicians often feel helpless within the health care system.

As if working to decrease medical uncertainty about Mrs Williams' condition were not enough for Dr Garrison to do in this clinical encounter, her ethical responsibilities also include actively helping Mrs Williams navigate the health care system. From her physician's perspective, Dr Garrison probably hopes that all her patients rank their personal health as a priority. In this particular case, however, the physician has no choice but to honor the autonomous decision of the patient, despite the potentially unfavorable health consequences. Mrs Williams' concern for her family and their finances seems to outweigh her concerns for her own health, even though these considerations should not be at odds with each other. Dr Garrison's awareness of medical uncertainty may help her feel more comfortable with Mrs Williams' decision to delay testing. Before Mrs Williams makes a final decision, though, Dr Garrison's duties as a patient advocate lie in vigorously challenging the forces that, and negotiating with the people who, may be leading Mrs Williams to minimize the importance of her health.

Reference

1. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA*. 1992;267:2221-2226.

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Clinical Case

How Good Is Good Enough?

Commentaries by G. Caleb Alexander, MD, MS, and Robert C. Bowman, MD

Dr Benson is a primary care physician practicing in a town of 5000 people. He often manages patients with complex medical issues and prides himself on his ability to stay current on advances in medical treatment. Each year he exceeds his continuing medical education (CME) requirements, is well respected among his colleagues, and is often consulted by other physicians for difficult cases.

Last week Dr Benson received a troubling phone call from Sandy, the mother of one of his patients. He has known the patient, Carla, since she was a child. She was always what he thought of privately as a “difficult” patient, and during her adolescence he spent a great deal of time helping her through a substance abuse problem and a bout of major depression. Carla is now 24. Sandy called Dr Benson to tell him that Carla’s behavior had grown increasingly erratic over the past several weeks; she lost her apartment and moved back home, has maxed-out her credit cards, and does not seem to be sleeping more than 2 or 3 hours a night. Following the conversation with her mother, Dr Benson asked Carla to come in and visit with him. Dr Benson suspected that Carla was abusing drugs again, but acknowledged that she could have a psychiatric disorder.

After talking with Carla, who insists that she has been “clean” for several years, performing a thorough physical exam, ordering lab work, and asking Carla to consent to a urine drug screen, Dr Benson thinks he is seeing an acute manic episode. Dr Benson gets Carla’s permission to have her mother come in from the waiting room so they can all discuss the diagnosis.

With Sandy present he explains what he believes to be the diagnosis, but says that a definitive diagnosis for such a serious disorder should be made by a psychiatrist.

“Where do we have to go to see a psychiatrist?” Carla’s mother asks.

Dr Benson explains that the nearest one is in the city, 100 miles away.

“We can’t get there.” Sandy cries. “The car broke last week and we don’t have any money to fix it, and nobody’s going to drive Carla 100 miles for a doctor’s appointment. Can’t you just give her something?”

Dr Benson hesitates. He has managed patients with bipolar disorder who were sent to him already stabilized on their medications, but he has never diagnosed and started a patient such as this on a new regimen, and, moreover, he does not track the constantly changing literature in psychiatry and neuropharmacology. He also knows that, even if Carla sees a psychiatrist in the city for a diagnosis, she will not be able to make the long trip on a regular basis for follow-up appointments.

Commentary 1

by G. Caleb Alexander, MD, MS

Deborah Tannen, a sociolinguist, writes about the "Heinz dilemma," a hypothetical scenario used to evaluate developmental stages of moral reasoning [1]. In the scenario, a man's wife is dying, but he can save her life by stealing a drug that he cannot afford to buy from a pharmacy. The question—should he steal the drug?—is posed to 2 children. The 2 address the dilemma in very different ways—1 concludes that it may be okay to steal the drug and offers a rationale based on rules and rights. This child states that the man should steal because, even though stealing is wrong, letting someone die a preventable death is even more wrong, and thus stealing can be justified in this setting. The second child answers by trying to accommodate the man's needs without requiring dishonesty. Maybe the pharmacist could help the man, for example, or maybe the husband could pay the pharmacist back at a later date, and so on.

Intuitive reactions to the dilemma that Dr Benson faces may be close to 1 of these 2 paths of moral resolution. Some may argue that the physician should treat the patient while others may argue that to do so without specific psychiatric consultation or support would be unwise and that there must be other ways around the immediate predicament the physician faces.

Regardless of the path one chooses, the dilemma that Dr Benson faces should be familiar to many physicians. Although it may seem unlikely that patients' access to care can be limited by geographic boundaries, such barriers are ubiquitous and unavoidable, in the United States and elsewhere [2]. In fact, outside of urban areas in developed countries, where other barriers to care are prevalent, difficulty accessing specialists and medical technologies may be the rule, rather than the exception. And in some ways, the predicament faced by Dr Benson is quite similar to other situations physicians routinely face. On the one hand, there is the aspirational ethic to treat all patients with an equally high standard of care. On the other hand, such a goal may at times conflict with physicians' responsibility to be wise stewards of societal resources [3] or with financial constraints placed on patients and physicians [4].

How then should physicians, in general, and Dr Benson, in particular, navigate situations where a patient needs treatment that is not readily available? Answers to several clinical questions can help guide a physician through this process. First, what is the incremental benefit of the optimal treatment over the one that is more readily available? In this case, how likely is it that a psychiatrist's evaluation would yield a different conclusion than Dr Benson's? Second, what steps can be taken to narrow the gap between the likely safety and efficacy of the optimal and that of the second-best treatments? Might a phone consultation, for example, provide a minimally acceptable means for obtaining a psychiatric consultation? Third, how comfortable are Dr Benson and the patient with the anticipated plan of care? Given that Dr Benson is "well-respected among his colleagues," it is likely that he has the clinical acumen to help assess the probable incremental benefit of optimal treatment over the one he can provide. Principles of informed consent, important in any setting, become especially powerful where there are "tough calls," such as whether a marginally more risky management approach is acceptable because of its greater feasibility. Finally, a less clinical question: how much additional effort is required to obtain the first-line therapy? In this case, 10 miles versus 100 miles versus 1000 miles may make a big difference.

Arguing that physicians should never stray from optimal care creates a world of moral idealism divorced from clinical reality—a reality that for many precludes access to state-of-the-art specialists and medical facilities. Just as a t-shirt may be used as a tourniquet, or a stick as a splint, physicians and patients may be required to decide whether or not an available therapy is good enough. This case provides an extreme example. However, in more subtle ways, physicians do so all the time—rationing, by any other name...[5].

References

1. Tannen D. *You Just Don't Understand: Women and Men in Conversation*. New York, New York: Random House, Inc; 1990.
2. McLafferty S, Broe D. Patient outcomes and regional planning of coronary care services: a location-allocation approach. *Soc Sci Med*. 1990;30:297-304.
3. ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation, American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136:243-246.
4. Weiner S. "I can't afford that!": dilemmas in the care of the uninsured and underinsured. *J Gen Intern Med*. 2001;16:412-418.
5. Asch DA, Ubel PA. Rationing by any other name. *N Engl J Med*. 1997;336:1668-1671.

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Commentary 2

by Robert C. Bowman, MD

The broad scope of rural practice allows physicians to encounter patients of all ages and in a wide variety of clinical and financial situations. There is a multidimensional aspect to rural-based care that integrates knowledge of medicine, relationships, finance, and health care systems. A challenging patient such as Carla, the person described in this case, requires the physician to have as much interpersonal skill as medical expertise.

This case is further complicated by a patient who is:
1. Unpredictable,
2. Limited in ability to care for herself,
3. Diagnosed with a complex illness, and
4. Living in a setting with limited mental health resources.

Although Carla's diagnosis falls within a narrow range of possibilities, the most likely of which are drug abuse relapse and bipolar disorder, the treatments vary widely, and the wrong one could worsen her condition. Moreover, many pharmacotherapies have significant side effects and costs that can make adherence difficult. The risks of treating a case like Carla's are considerable, given that the threat of harm she poses to herself and others is moderate as assessed by Dr Benson. Had this been a high-risk case, emergency transport to a psychiatric facility would have been necessary.

The assistance of a third party (the patient's mother, Sandy) is an essential element in this case, but it also complicates matters since Sandy's interests, concerns, and relationship with her daughter must be fully ascertained. Based on her reaction to Carla's latest behavior and the patient's previous history, it is possible that Sandy is experiencing a significant degree of "caregiver burnout."

Given the resources available in their town, Dr Benson might consider taking the following steps.

First, he must secure permission to discuss Carla's case with other health care professionals. Next, he should call the nearest psychiatrist and, at the same time, ask his own staff to pursue transportation options with the local senior center, a church group, or another community resource. While he waits for the psychiatrist to return the call, Dr Benson can investigate his clinical suspicions by reviewing diagnostic criteria, possible treatment options, and other information for patients with bipolar disorder.

Another concern is that Carla is at risk of "falling through the cracks" due to her financial and insurance situation. Her greatest difficulties revolve around affordable care and access to medications. If there is a "sliding scale" fee system at a local clinic or pharmacy, Dr Benson can explore this option on Carla's behalf. As with primary care, the physician and his staff must gain the patient's trust, help her to anticipate side effects of any medications she is prescribed, and work through the challenges that each stage of treatment brings. Again, the clinical advantage lies with an experienced medical group that knows their patients and their community, as well as their medicine.

When the psychiatrist returns Dr Benson's call, the 2 can fully discuss Carla's case, and the psychiatrist can suggest treatment. With Carla's consent, an evaluation with the psychiatrist should be scheduled for a time when she can be transported. In a situation like this, where setting up and keeping regular appointments is difficult, it may be appropriate for Dr Benson to start Carla on a pharmacological regimen based on the advice of the psychiatrist even before her first psychiatric appointment. In addition to the psychotropic drugs, an example of a possible plan of care might include counseling at a local mental health center twice a week with periodic visits to the psychiatrist for overall symptom management. If the psychiatrist is willing to accept Carla's case, some of these follow-ups might require travel 100 miles to the city, and some might take place when the psychiatrist is supervising at the local mental health center. No matter what the doctors agree to, consent must be given either by Carla, if she is deemed competent, or her mother before any decisions are made.

It is possible that an easier care plan might be available for Carla and Dr Benson. Integrated care clinics—the latest trend in rural mental health care—have mental health specialists on-site, either on a part- or full-time basis. Besides effectively merging mental health into overall health, this arrangement helps remove the stigma of going from a small town to an urban mental health facility for care. Two competing primary care offices in Moose Lake, Minnesota, for example, have even employed a psychiatrist to assist with care.

It is not uncommon for rural physicians to provide care outside of their specialties, though it must be acknowledged that patient care might be compromised by the rural physician's lack of specific training. This absence can involve either lack of depth (primary care) or lack of breadth (specialists), hence, a physician's recognizing his or her own limitations is a key aspect of quality care. Fortunately for Carla, behavioral issues are a common part of primary care training, although, as this case illustrates, care for mental illness can quickly exceed the scope of most physicians.

According to rural health researcher Jack Gellar at the University of North Dakota, the "safety net" for mental health patients in rural areas is primary care. With each patient and each passing day, rural primary care physicians extend their abilities to care for more complex patients.

Robert C. Bowman, MD, has directed rural medical education efforts at 2 medical schools and 2 national associations—the National Rural Health Association and the Society of Teachers of Family Medicine—since he began his initial rural practice in Nowata, Oklahoma.

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Clinical Case

Is Greenacres (SNF) the Place to Be?

Commentaries by Hasan Shanawani, MD, MPH, and
Kathleen Nathan Lowe, MSW, ACSW, CMSW

Dr Wayne is on bi-weekly rounds at the Greenacres Retirement Home. He picks up the chart for Mr Hooper, a 75-year old man with dementia and congestive heart failure who was admitted almost 5 months ago. The nursing staff had specifically asked for Mr Hooper to be seen because he has developed a pressure ulcer on his sacrum that has not been responding to standard treatment.

Dr Wayne reviews the information in the chart: Mr Hooper was living at home prior to suffering a heart attack 6 months ago, after which his congestive heart failure became markedly worse. Mr Hooper then went through a few weeks of cardiac rehab with minimal results before being sent to Greenacres, where he has had 2 months of physical therapy, again with marginal results. Dr Wayne looks over his physical therapy notes. Based on a review of the chart it seems that Mr Hooper is getting worse.

Although he is on Aricept and Haldol, Mr Hooper's dementia often makes him combative. Now a pressure ulcer has developed, possibly complicating the care plan.

Two nurses accompany Dr Wayne and help to position Mr Hooper so the ulcer can be examined. It's extensive but doesn't appear to extend to the bone or need much debridement. After examining the wound Dr Wayne begins discussing a treatment plan with the nursing staff. During the discussion Mr Hooper's wife and son enter the room.

"Dr Wayne, we're glad you're here. We wanted to discuss my husband's skin breakdown," Mrs Hooper says.

Dr Wayne explains that the skin breakdown is significant, but he believes it can be handled by the wound care team at Greenacres. It is in a sensitive area, however, and if it seems to be going into the bone or developing a lot of necrosis, he probably will need to be hospitalized.

"Well, Dr Wayne, that's something we wanted to talk to you about too," Mr Hooper's son begins. "Dad has Medicare, but it doesn't cover the nursing home costs now, and we've been paying for his care out of his savings. We're working on getting Mom and him on Medicaid, but right now they don't qualify. We don't think we're going to be able to afford to keep him here much longer if we don't have some kind of help, and mom can't manage him at home."

Dr Wayne agrees that it would be difficult for Mrs Hooper to care for her husband at home.

"What I'm saying, I guess, is could you admit him to the hospital for this now? If he's in the hospital Medicare will pay for it and then will pay for another 90 days in the nursing home for rehab. By that time we should have Mom and Dad's Medicaid application sorted out. Besides, you said you think he's probably going to be hospitalized for this anyway."

Commentary 1

by Hasan Shanawani, MD, MPH

There are several questions regarding Mr Hooper's case: First, where does the physician, as medical expert, believe this patient's treatment should occur, and, second, what are the physician's obligations as a steward of a government insurance program? These 2 questions give rise to a third: How do the latter obligations compete with the physician's role as a medical professional and advocate for *this* patient?

There is a large body of research, peer discussion, and scrutiny that guides our decision making with regard to location of care. Often, the decision about *where* to treat an individual patient is as important as *how* to treat him. We have evidenced-based guidelines and algorithms to help us determine whether a patient with pneumonia should be treated as an outpatient, on a general medical ward, or in an intensive care unit [1]. The American College of Surgeons has built an entire enterprise around the triage, disposition, transfer, and ultimate level of care to be provided to victims of trauma [2]. There is a legal canon devoted to patients with acute psychiatric illness, how to manage them, and when they must be committed to an inpatient psychiatric ward against their will [3]. When the decision we make is questioned in the context of a bad outcome, we may be held medically liable or found negligent based on our decisions if we have departed from the unanimously recognized standard of care.

The training we receive, as well as guidelines, rules and regulations, and legal judgments relevant to our decisions about where to treat patients all have a distinct and important characteristic to them: the decision is driven exclusively by *medical* variables of the patient's health, available resources and expertise, and the anticipated care needs of the patient. Nowhere do "nonmedical" variables of patient financial resources, insurance reimbursement, and patient and family preference play an explicit role in those decisions.

However, there are innumerable instances where we must make treatment decisions about location of care that *are* based on factors other than what we would consider "medical." There are many cases of patients admitted for asthma exacerbations from an emergency ward not because they met clinical guidelines requiring admission, but because a doctor felt the patients in question lacked the knowledge base to manage the disease on his or her own, didn't have family to help out if they got sicker, or didn't have a doctor to follow-up with if they were released. As a medical student, I remember caring for dozens of patients on 6 weeks of intravenous antibiotic therapy for endocarditis. The concern was not that they couldn't care for their indwelling catheters—but rather that they were injection drug abusers, and we were afraid that they would use their newly placed access site for illicit drug injection. Furthermore, we routinely admit patients to provide vital therapies they are unable to purchase as outpatients, despite knowing that they most likely will never have the resources to pay for their inpatient stay.

In the case at hand the inclusion of a third-party payer further complicates this matter and often drives the decision for location of care. At the medical center where I trained in pulmonary medicine, the decision of whether to complete the workup of a pretransplant candidate as an inpatient or outpatient was made almost exclusively on the basis of whether the patient's insurance provider would pay for the procedure at one or another location. We routinely keep patients in the hospital to continue an extended therapy that could be delivered in a nursing facility or with home IV care because the patient's insurance provider will only reimburse the care if it is administered in an acute inpatient ward. Often, provider policy seems to fly in the face of both cost-benefit analysis and best medical practice. For example, despite multiple papers on the cost-effectiveness of treating deep venous thrombosis with low-molecular-weight heparin therapy administered at home [4], there are many insurance providers who will not authorize this on an outpatient treatment basis. From the physician's standpoint, keeping a patient in the hospital when a safe, cheaper, outpatient alternative is available seems medically unnecessary, fiscally wasteful, and most likely against the patient's wishes. While there may be defensible reasons behind the decisions insurance providers make, they clearly aren't based on any medical or financial consideration.

The second question this case raises goes to the role of physicians in the grand scheme of cost-savings efforts. With the cost of medical care in America bursting at the seams, this question is not trivial. But I believe that it is, for the most part, irrelevant when I am sitting across from a patient. Nowhere in our training as professionals are we taught that the best interest of our patient must be sacrificed for the financial needs of an entity we work with, or even for. We often fight with insurance providers to reimburse care we believe a patient needs, either in advance of or after a therapy is provided. It is the physician's job to provide the best care possible, a clinical judgment guided by a number of variables, one of which is what effective therapy will be least costly to the patient we serve. Some ethicists go further, [5] suggesting that any goal other than the best interests of the patient violates the central principles of professionalism. These proponents believe that dealing with questions of fiscal responsibility while caring for a patient constitutes a conflict of interest. It is no different in principle, they say, than being paid by a drug company to promote its product or to enroll patients as subjects in a research protocol. Physicians sometimes have priorities other than the patient, which at the very least need to be clearly explained and *consented to* by patients *before* they enter a patient-doctor relationship with us.

The Veterans Administration (VA) hospital system is a case study in the struggle to restrict care and medical expenditures at several levels [6]. On the one hand the VA system has formulary barriers that restrict physicians' choice of antibiotics, lipid therapies, and antihypertensives. On the other hand, we are rarely, if ever, told in advance that we may not treat a veteran for a condition that is deemed service-connected. To date, if VA doctors choose to admit a veteran for a medical or social condition, regardless of emergent need or even medical appropriateness, there are virtually no obstacles to the admission. There is currently discussion in Congress about limiting access to the VA system [7], and it seems that new fees are imposed on the veterans daily. But, for now, once the patient is in a VA hospital bed, for better or for worse, both the patient and the doctor have wide latitude.

In the case of Mr Hooper, the answer to the question of how bureaucratic obligations compete with the physician's role with an individual patient seems unfortunate, but straightforward. While I might want to discuss at a policy level the appropriateness of where and when Medicare, Medicaid, and other insurers pay for care, the reality here is that without a hospital admission, Mr Hooper will most likely be discharged from the rehabilitation center where he is currently receiving care due to financial constraints. Without a hospital admission, there is a good chance that he will receive *no* professional care for his pressure ulcer if the family is unable to pay for a visiting nurse. Fiscal advocates for Medicare might argue that I have an obligation to their solvency that should direct me not to admit Mr Hooper, and I might, but for the fact that Medicare will pay to treat this condition in one particular venue. My decision is not whether he needs treatment or not, but how to get it, and to some degree the insurers have forced the decision. Moreover, I am unaware of any instance where a physician, after withholding care for insurance reasons, was then protected by the insurer from liability if a patient suffered a bad outcome.

There are many opportunities to debate how nonmedical aspects of a patient's care—financial stewardship and fiscal responsibility—may lead to limited medical care, but opposite a sick patient is a dangerous place to hold that debate. The congressional argument over care of veterans is an example from the distant halls of policymakers. There needs to be a society-wide dialogue about what care we value and wish to pay for in this time of limited means; the bedside is not the place for the discussion.

References

1. LaForce FM. Triaging care for patients with pneumonia. Real progress. *Arch Intern Med*. 1997;157:15-16.
2. Shakiba H, Dinesh S, Anne MK. Advanced trauma life support training for hospital staff. *Cochrane Database Syst Rev.* 2004:CD004173.
3. American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association. *Criteria for Short-Term Treatment of Acute Psychiatric Illness.* Washington, DC: American Psychiatric Association; 1997.
4. van Dongen CJJ, van den Belt AGM, Prins MH, Lensing AWA. Fixed dose

subcutaneous low molecular weight heparins versus adjusted dose unfractionated heparin for venous thromboembolism. *Cochrane Database Syst Rev.* 2004;18:CD001100.
5. Pellegrino ED. Clinical Ethics. Paper presented at: Intensive Bioethics Course, June 8-13 2004. Georgetown University, Washington, DC.
6. Jha AK, Perlin JB, Kizer KW, Dudley RA. Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *N Engl J Med.* 2003;348:2218-2227.
7. Harris M. Veterans' Health Care Agency Prepares for Budget Shortfall and Cut. *The Baltimore Sun.* May 6, 2005: 4G.

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Commentary 2

by Kathleen Nathan Lowe, MSW, ACSW, CMSW

Dr Wayne's plan to allow the wound care team to treat Mr Hooper's skin breakdown at the nursing home is based on his clinical judgment after examining the patient. Despite the family's request for hospitalization, Dr Wayne should not modify the treatment plan unless a change in Mr Hooper's condition warrants it or the only treatment options are home care versus hospital care.

Arranging for a "qualifying hospital stay" (as requested by the Hooper family) so that Mr Hooper can become eligible for Medicare coverage in a skilled nursing facility is unethical if it is done solely for the financial benefit of the family. One of the physician's responsibilities to the health care system is to be an honest gatekeeper, giving access to government insurance programs only when the patient legitimately meets the eligibility criteria.

It is unclear from this case whether the Hooper family has already applied for long-term care Medicaid. If they have, the process usually takes 45 days, during which time the family must document financial eligibility for the program. Most notably, if the applicant has savings or assets, he or she must "spend down" until no more than $2000 in countable assets remains.

If the applicant is already in a skilled nursing facility, then coverage could be retroactive to the day he or she met the "spend-down" requirement. So, in this case, the Hooper family could use their existing funds to pay current long-term care expenses while aiming for that $2000 asset limit. If they truly have no more money to pay long-term care expenses, then they should qualify for Medicaid.

The long-term care Medicaid program exists to aid people who do not have sufficient funds to pay for a skilled nursing facility. Although there is still some stigma attached to younger Americans receiving "welfare," our government has allowed for legal long-term care planning as a way for the elderly to protect savings while still becoming eligible for long-term Medicaid benefits. Medicaid is both a state and federal government program, but eligibility rules differ depending on the state in which one resides. Generally, in addition to the asset criteria, the monthly income of the applicant must be less than the monthly cost of care in the facility at the Medicaid rate. This obviously presents a problem for a married couple when 1 spouse requires care in a long-term care facility.

In the past, some couples facing this financial predicament divorced in order to meet the financial needs of both the ill and well partners. The law now allows that, in qualifying for Medicaid, the couple's assets can be divided to protect a portion for the at-home or "community spouse," while still meeting Medicaid requirements for the ill spouse. According to the North Carolina Division of Medical Assistance:

- The community spouse may keep half of the couple's assets (up to a maximum of $95 100).
- The couple's home is not counted in determining assets.
- The institutionalized spouse's income may be apportioned to the community spouse.
- The personal possessions of the community spouse are excluded from countable assets.
- One car is excluded from countable assets.

So, once Mr and Mrs Hooper have applied for Medicaid, their assets would be divided, and Mr Hooper would have to spend down his portion. Each state has allowable ways to spend down assets in preparation for Medicaid eligibility. A pre-paid burial plan, for example, might be an acceptable way to achieve the $2000 asset limit. Another facet of Medicaid law pertains to the transfer of assets. Giving away assets (eg, to a child or grandchild) for the sole purpose of qualifying for Medicaid is not allowed. Generally, the state will look back 3 years from the time of the Medicaid application to ensure that no such transfers have occurred. The penalty for such actions is ineligibility for Medicaid for a given period of time which is determined by how much money was transferred [1].

Whether this legal practice of long-term care planning is ethical or not becomes Dr Wayne's professional dilemma when the Hoopers ask him to collude with them in manipulating the system. If Dr Wayne hospitalizes Mr Hooper, the "qualifying hospital stay" will then open access to Medicare coverage for up to 100 days of nursing home care when Mr Hooper returns there [2]. This allows the family time to qualify for the Medicaid program and preserves the money they are currently spending from their savings. Although Dr Wayne might sympathize with their financial plight, I believe it is simply unethical to exploit the Medicare program in this way.

The social work profession, like the medical profession, is rooted in core values that undergird its ethical principles and standards. These entail responsibilities not just to patients but also to colleagues, our practice settings, and the broader society [3].

As stewards of the resources that our government has set aside for the Medicare and Medicaid programs, we must be honest gatekeepers in providing access to these funds. Sometimes it is easier to grant a patient's request for access rather than to confront one's plan to circumvent the rules. This is true about all kinds of requests, eg, for unnecessary medication, superfluous assistive devices, inappropriate referrals, and the wrong level of care designation. Dr Wayne appears to have cultivated a positive patient-doctor relationship, and he is not eager to jeopardize this by denying the family's request.

It is not enough to know the ethical thing to do when dealing with patients—a physician must also have the emotional strength and resilience to confront situations that challenge the integrity of their gatekeeping role. Families who want to preserve assets for inheritance or other personal reasons may be motivated to shift the financial burden of their loved one's care onto the public and misuse funds reserved for those who are truly indigent.

Social workers are available to partner with physicians to assist in managing these issues. Together the health care team must understand the treatment that each patient's situation necessitates, and we must hold firm to the ethical standards of our respective professions in granting access to health care and to the government insurance programs which pay for such care.

References

1. For a summary of rules regarding Long Term Care Medicaid Eligibility, see *Financial Rules for Long Term Care Recipients*. North Carolina Division of Medical Assistance. Available at: http://www.dhhs.state.nc.us/dma/ltcfactsheet.htm. Accessed June 23, 2005.
2. For further information regarding Medicare coverage of long term care, see http://www.medicare.gov/Publications/Pubs/pdf/choosingltc.pdf. Accessed June 21, 2005.
3. National Association of Social Workers. *Code of Ethics*. Available at www.naswdc.org/CODE.htm. Accessed May 20, 2005.

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Journal Discussion

The Emanuel-Fuchs Voucher Plan for Health System Reform

by Christian J. Krautkramer

Emanuel, EJ. Fuchs VR. Health care vouchers—a proposal for universal change. *N Engl J Med*. 2005;352:1255-1260.

> [A single-payer health care system] is no more politically feasible today than it was when President Clinton rejected it as a model for reform. Sure, a compelling case can be made that the Canadian or French system serves those countries' citizens better than the American system does ours. But an equally compelling case can be made that we'd be better off with an extra dollar-per-gallon tax on gasoline. These are, in the end, liberal sugarplum visions. If progressives want to use this moment to achieve universal health care, they will need to put forward a proposal that makes the most of what's good about the current system and reflects America's basic values [1].

These words, written by Ezekiel Emanuel and Victor Fuchs, capture a rare event in American political history: the interest—and the opportunity—for a marriage of two fundamental and often opposed values, namely, social equality and individual free choice, in the interest of achieving substantial health care reform. If ever effective policy was needed, it is now: about 45 million Americans lack any health coverage; the vast majority of them are working but cannot (or will not) purchase health insurance. Those who lack coverage are more likely to live sicker and die younger. The Institute of Medicine estimates that each year 18 000 people without health insurance die prematurely, and the total annual loss in human capital is upwards of $130 billion [2,3]. Emanuel, a physician-philosopher, and Fuchs, an economist, believe that any plan to successfully avert what has become a catastrophe-in-waiting must concurrently maintain the freedom of choice Americans so value while expanding health coverage for everyone [4].

The Health Care Voucher Proposal

Emanuel and Fuchs propose a 10-component voucher plan for universal health coverage, summarized in 4 key concepts [4]:

Sufficiently Comprehensive Benefits

According to their plan for guaranteeing basic, universal health coverage, every American under 65 years of age will receive a voucher for purchase of a sufficiently comprehensive health plan from a private insurer of their own choosing; participation in the voucher system will be mandatory. Insurers who want to compete for vouchers will be required by law to provide a plan with predetermined, minimum "universal benefits," that include inpatient and outpatient hospital care, physician office visits, preventive services, mental health care, and tiered prescription drug benefits. Voucher holders will still be responsible for "modest" deductibles and copayments. Persons in existing publicly provided health insurance (such as Medicaid or SCHIP) will be rolled into the new voucher program. Medicare enrollees (people aged 65 or older) will continue to be covered through existing programs, but those newly eligible for Medicare will enroll into the voucher program, thus phasing out Medicare over time.

Privately Delivered Coverage and Care

All Americans will choose a basic health plan from a private insurer whose plans meet the government standard for universal benefits. A person who desires services not covered by the basic plan will be able to purchase supplemental services and pay for them with after-tax, out-of-pocket dollars. Employers will no longer offer health insurance as part of an employee's compensation.

Publicly Financed

The voucher system would be publicly financed through a dedicated, value-added tax (VAT). The level of the VAT would be legislatively determined, and the amount of money brought in by the tax would govern the level of coverage. Public demand for more services would mean a higher tax; conversely, if the public desired a lower tax, they would have to settle for fewer services.

Federally Administered

In a structure similar to the Federal Reserve System, a Federal Health Board, supported by regional health boards, would manage and oversee the voucher system and be directly accountable to Congress. An independent Institute for Technology and Outcomes Assessment would be established to research and assess cost-effectiveness in the health care system.

Eliminating Financial Barriers to Health Care

The principle advantages of the Emanuel-Fuchs voucher plan over other health-care financing proposals that cede administrative powers to a government—namely single-payer systems—are that it preserves market competition among insurance companies and health plans while eliminating the financial barriers to obtaining health care coverage. Private delivery of health care services would remain; so too would private reimbursement and its provider, the health insurance industry, a sector that contributes hundreds of billions of dollars a year to the US economy and employs hundreds of thousands of workers. The seeming simplicity of single-payer proposals ignores the indirect, macroeconomic consequences of eliminating an entire sector of the United States' economy, including the challenge of finding jobs for displaced workers and means for injecting new money into our economy.

Because participation in the voucher plan is mandatory, health care becomes, in effect, a public good, paid for and provided to all citizens. This eliminates the so-called "free riders" who receive health care without paying for services and pass on the costs to taxpayers. Without free riders, emergency room waits would decline, the need for a health care safety net would eventually disappear, and money would be freed for more equitable distribution among all citizens.

Political Feasibility

Despite maintaining the individual's ability to choose his or her health care coverage, something Americans so value, the voucher plan faces significant obstacles to adoption. Emanuel and Fuchs astutely point out,

> the American political system resists change; it tends to enact major social programs only during times of war, economic depression, or civil unrest. Even without such traumas, there will come a time when the [problems] of the current [health care financing system] will be so intolerable the public will not only accept but demand comprehensive reform [5].

Since most Americans currently receive decent health care without having to wait for it, they will be generally reluctant to accept sweeping reform, especially if it puts their health or pocketbooks at risk. Moreover, if health care stakeholders (eg, managed care groups, insurance companies, and even physicians groups) perceive that reform will reduce their influence or financial gain, they could stymie change by sowing doubts and fears about government-financing of health care among the public. This happened in 1993, when many health care stakeholders claimed that President Clinton's proposed Health Security Act would turn the United States into a single-payer health system. The resulting public pressure contributed heavily to the proposal's collapse [6].

Financing

The authors do not offer a firm idea of what the voucher program would cost, although they project that sharp reductions in current administrative costs would greatly offset new costs generated by increased use of health care services by the previously uninsured.

What makes the proposed VAT an attractive source of funding for health care? VAT is levied on sales of all goods and services at every stage of production, unlike retail sales tax which is collected only at the point of sale from the final customer. Advocates say that a VAT is fair because it distributes tax burden more evenly throughout an economic system; businesses would be unable to pass their full VAT-related increases on to the consumer because they would still have to compete in the marketplace. Emanuel and Fuchs call their financing plan "progressive" because it provides the poor with a good in the form of health care, while the cost is shared by all taxpayers. Critics, however, say a VAT will be "regressive" if it taxes basic, needed goods because the poor spend a far greater percentage of their income on necessities than do middle- and upper-income earners. An effective VAT-financing system will have to distribute cost equitably at all points of production, put controls in place to protect consumers from unjust price increases, and protect basic goods like groceries, electricity, and pharmaceuticals from being unfairly taxed.

Impacts on Cost of Care

The most important criterion when judging the validity of a health care financing reform proposal is its ability to expand coverage for the uninsured. Emanuel and Fuchs believe their plan will achieve this goal. At the same time, they admit that issues of quality and cost of care need to be studied. First, the taxpaying, voting public will only accept a universal health plan if it is both financially sound and provides even better coverage than the current system. It is unclear whether this voucher plan can satisfy these demands. The authors believe that the combination of more efficient delivery with a marked decrease in administrative costs would offset a projected 5 percent increase in services [5], but these claims seem undersupported by the studies they cite [2]. Additionally, any plan that creates a centralized oversight body to make decisions regarding the value of a voucher (ie, the Federal Health Board) should include basic protections to shield policymakers from lobbying practices by insurers intending to pad their profits.

Emanuel and Fuchs argue that much of the $100 billion now spent on administration and sales by private insurers would be saved [5]. However, it seems unlikely that an insurer would reduce such costs. Persons previously eligible under public insurance programs (like Medicare and Medicaid) would now be absorbed by insurers, creating a greater administrative burden. In fact, insurers would be likely to hire new workers to handle increased administration and to serve as sales staff to compete for the newly voucher-eligible—both the previously uninsured and those previously insured under public programs. Thus, administrative and sales costs may actually go up under the voucher system. Nor is it clear that physicians’ administrative duties would decline: instead of justifying a procedure to Medicare or Medicaid administrators, physicians would now deal exclusively with insurers, but with no net savings in time for more patient contact. A single-payer system, of course, does significantly streamline administrative overhead, but at the macroeconomic costs mentioned earlier.

Finally, the cost of providing health care services and the price consumers pay for such services will be stable at best and will possibly increase under a voucher system. Roughly 10 percent of those who use health care services account for 70 percent of usage [7]. If it turns out that the previously uninsured, newly-covered individuals are using a disproportionate share of services (ie, if many new users have chronic health conditions that require long-term care), the Federal Health board will have to raise the value of the voucher, reduce the universal benefits package, or put insurers at risk of losing money. Nothing in the voucher system operates to squelch cost increases, so it leaves patients potentially susceptible to increases in health care costs.

Conclusion

Health care reform has been under discussion for years. Economic, ethical, political, and cultural shifts may be pushing us towards significant reform. The Emanuel-Fuchs voucher system plan weaves ideas of freedom, choice, and social obligation together to remove financial barriers and open access to health care for all Americans. Many of the authors’ claims regarding improving efficiency in the system, reducing administrative overhead, and improving the cost-efficiency of delivery remain undersupported. The authors concede, however, that further study is needed to clear up questions of the plan’s impact on cost, efficiency, and quality of health care before determining whether such a sweeping reform will beneficial to the overall health of the United States.

Questions for Discussion

1. The authors admit that the current political climate makes adoption of universal health care nearly impossible. Could the voucher plan be implemented incrementally? For instance, could a pilot voucher program (eg, a plan covering currently Medicaid- and SCHIP-eligible persons along with the uninsured) produce data that allowed policymakers to make more accurate economic predictions, helping sell the plan on a wider scale to taxpayers? How would such a pilot plan be funded? Beyond the primary benefit of removing financial barriers to health care access, would there be secondary benefits of access to and quality of care (for instance, would giving current Medicaid enrollees a voucher encourage them to seek better care or improve the quality of care they receive because of reduced stigmatization)?

2. Although the voucher plan removes financial barriers to health care access, other obstacles to entering the health care system persist. Examples of such barriers may include one's proximity to health care facilities, the location of medical specialists, the availability of certain medical procedures, and language and cultural barriers. Should the voucher plan include policies to overcome the remaining challenges to accessing care, and, if so, what might those policies look like?

3. The authors speculate that overall use of health care services would rise by about 5 percent; mostly from one third of the previously uninsured persons becoming new users. They argue that increased use by those currently insured with policies less generous than the voucher system's universal benefits package would be balanced by decreased use among those who currently have more generous policies. Do you think this is an accurate prediction? Under what conditions might previously insured persons increase their use of services? Decrease their use of services?

References

1. Emanuel EJ, Fuchs VR. Solved! *Washington Monthly.* June 2005. Available at: http://www.washingtonmonthly.com/features/2005/0506.emanuel.html. Accessed June 29, 2005.
2. Institute of Medicine. *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academy Press; 2004.
3. Institute of Medicine. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academy Press; 2003.
4. Emanuel EJ, Fuchs VR. Health care vouchers—a proposal for universal change. *N Engl J Med*. 2005;352:1255-1260.
5. Emanuel EJ, Fuchs VR. Health care vouchers. 1258
6. Johnson H, Broder, DS. *The System: The American Way of Politics at the Breaking Point.* New York, NY: Little Brown and Co; iv-668.
7. Institute of Medicine. *Insuring America's Health*,123.

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Medical Education

Medical Student-Run Clinics for the Underserved

by Ed Farrell, MD

Medical students who work at the Stout Street Clinic in Denver, Colorado, often come away from their experience surprised at how dramatically they have been affected. One student who recently worked at the clinic for a 6-week rotation, noted afterwards that among her many reasons for coming to Stout Street were to see interesting pathology and learn more academic medicine—both of which she did. Her surprise came when she also learned a lot about life. Students are often changed in unexpected, profound, and lasting ways after experiencing first-hand health care delivery to the poor, underserved, and marginalized.

The Stout Street Clinic (SSC) of the Colorado Coalition for the Homeless (CCH) has been operating in Denver for 20 years. I was drawn to working there in 1994 because it was a clinic that did more than treat homeless clients with GABHS (group A beta-hemolytic streptococcal) pharyngitis with penicillin; the staff actually delved into the deeper dilemmas affecting their clients and tried to solve them. Common problems of clinic visitors include domestic violence, mental health issues, substance use, and lack of access to jobs, housing, and health care. The clinic itself and CCH provide an array of resources that includes medical and mental health services, substance use treatment, community outreach, and housing for homeless clients. In 2004, 8877 individuals were served at SSC, and there were 29 497 client encounters.

For the last 14 years the medical students at the University of Colorado Health Sciences Center have operated a Saturday clinic at SSC as part of an elective medical course. The student-run clinic is open 24 Saturdays per year and is supervised by an on-site, volunteer, attending physician. The clinic provides weekend services for working and nonworking homeless clients.

SSC is run by first- and second-year medical students, with the participation of third- and fourth-year students. Every year approximately 40 students participate in 4 teams of 10. Each team is in charge of the clinic 6 times per year. A 6- to 8-person medical student steering committee oversees recruitment of students for the operation of the clinic. In September, the steering committee, in conjunction with SSC provider staff, holds an orientation evening at the clinic. During the orientation, all new students get acquainted with the training areas, including front desk, SOAP (subjective, objective, assessment, plan) chart notes, laboratory, and treatment room. This whirlwind orientation of mostly "shell-shocked" first-year students gives them a taste of what to expect when they are thrown into the clinic setting a few weeks later.

Fortunately, there are experienced second-year students at the clinic each Saturday, and a comprehensive orientation manual serves as a guide for specifics that may have been covered during orientation but not remembered. Furthermore, one of the clinic health care professionals is on-call for the harder questions. These range from the mundane, such as where to find a cab voucher for a homeless family who needs a ride to a distant motel, to the critical, such as how to arrange a mental health hold for a severely depressed, psychotic client.

Students gain experience in various areas of clinic operations by working at the front desk and in the lab or treatment room and by seeing patients. Patients appreciate the extra attention of multiple physicians-in-training all coming together with the attending physician to deliver personalized care.

Students who work at SSC almost always have a paradigm-shattering experience about who the homeless are and how they got there. The stereotypic image of skid-row alcoholics just doesn't fit the children, the woman fleeing domestic violence, the client with severe depression and limited or no access to mental health care, or the client with a methamphetamine addiction, a shooter's abscess, and no treatment program that will admit him. When a student does meet a person who seems to fit into society's caricature of the homeless and comes to know him or her and how he or she became homeless, the student is changed. Serving in the Saturday clinic teaches many students that even chronically homeless men and women with alcohol dependence are no different—underneath their layers of indescribably hard knocks, too much alcohol, and too little love—than you, me, and the rest of humanity.

Students also come face-to-face with the deleterious impact that our inadequate health care system has on people without health insurance or without access to health care, a perspective they may not gain through traditional medical education. They see, directly, the reality of the recent Institute of Medicine report that at least 18 000 people die per year because of their lack of health care [1]. When medical students learn that more than 700 000 Coloradans lack health care, they understand that this statistic metes out personally negative consequences for people with whom they have met and for whom they have cared. Students also see first-hand the many factors that can cause homelessness and affect health negatively, such as lack of affordable housing, jobs that do not provide a living wage, domestic violence, and other social circumstances.

Many times I have heard from former medical students that their Stout Street Clinic experience inspired them to work with indigent populations full-time, to volunteer regularly in a clinic, or to treat patients regardless of their financial status. The experience frequently does much more than just motivate medical students to deliver charity care—it inspires them to work for justice in the health care system and instills within them the notion that those who are homeless and disenfranchised have as much right to high quality, compassionate, and comprehensive health care as anyone else.

One memory in particular remains fresh for me, even though it is from 8 years ago. I was calling a local emergency room, spinning my usual tale of advocacy for a homeless gentleman without insurance or a payer source. "Lowell" had severe lower extremity stasis dermatitis with a secondary infection, and discharging him to the streets would not allow him to get better. The emergency room doctor interrupted early on and said, "Oh, don't worry—I worked at Stout Street Clinic as a medical student. We'll definitely admit him and I'll make sure the inpatient team is aware of Lowell's circumstances." Clearly, medical students' perspectives and horizons are widened in life-changing and career-changing ways, when they have the benefit of working in a clinic that serves disadvantaged populations.

Reference

1. Institute of Medicine. *Coverage Matters. Insurance and Health Care.* Washington, DC: National Academy Press; 2001.

Ed Farrell, MD, has been lucky enough to serve at the Stout Street Clinic of the Colorado Coalition for the Homeless for 11 years. He regularly works with medical students, resident physicians, and other clinic staff to ensure a successful student-run Saturday clinic during the medical school year.

Virtual Mentor
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Clinical Pearl
Evaluation of the Solitary Pulmonary Nodule
by Julia Feliz Alvarado, MD, and Richard Albert, MD

Introduction
A solitary pulmonary nodule (SPN) is a single, spherical lesion that is less than 3 cm in diameter and completely surrounded by lung parenchyma.

The incidence of a SPN on plain chest radiographs ranges from 0.09 percent to 0.2 percent [1]. With the increase in chest CT scans for a variety of reasons, more SPNs are being found that would have gone undetected on plain chest radiographs. Some SPNs require evaluation or treatment and some can be monitored over time and re-imaged. When should a clinician evaluate and treat a SPN by bronchoscopy, needle biopsy, or surgical excision?

The evaluation of a SPN balances the probability that the lesion is malignant and the need to detect malignancy at the earliest stage against the cost, complications, sensitivity, and specificity of various diagnostic approaches and the desire to avoid invasive strategies in patients with benign disease or comorbidities that predispose them to complications. And, of course, patient preferences weigh in. Given these considerations, this article proposes a general approach to evaluating patients with a SPN.

Predictors of Malignancy
The potential cause of a solitary pulmonary nodule that is of most concern is cancer. For this reason, the initial differential diagnosis is often divided into 2 broad categories: benign and malignant. While numerous studies have attempted to predict the likelihood that a SPN is cancerous, the data have to be interpreted in lieu of the specific patient population studied. Ultimately, predicting malignancy remains an inexact science. The most common method uses a Bayesian approach in which pretest probability is assessed by clinical evaluation and modified by the results of a number of newer diagnostic tests.

Patient factors associated with an increased likelihood of malignancy include older age, a history of smoking, and a history of prior malignancy [2,3].
Radiographic characteristics that have been proposed as useful when making an assessment include:

- *Calcification:* Calcified lesions are less likely to be malignant than non-calcified ones, but *the pattern of calcification is very important.* Patterns most consistently associated with benign disease include central, diffuse, laminar, or popcorn-like calcification. Nodules with stippled or eccentric calcification are possibly neoplastic. Notably, up to 7 percent of lesions that appear calcified on a chest roentgenogram will not demonstrate calcification on chest CT.
- *Border characteristics*: Lesions with smooth borders are more likely to be benign; spiculated lesions are more likely to be malignant.
- *Rate of growth*: Malignant lesions have a doubling time of between 30 and 360 days. Lesions that do not change in size during an interval greater than 2 years are, accordingly, considered to be benign.
- *CT Densitometry*: Quantifying the density of SPNs by CT (ie, determining the Hounsfield unit) is also useful, with densities > 164 H (or greater than the density of a phantom) being considered benign [3,4].

Diagnostic Approaches

Diagnostic options include monitoring with serial radiographs, obtaining a PET scan, performing bronchoscopy or transthoracic needle aspiration, and resecting the lesion by thoracotomy or video-assisted thoracoscopy.

Watchful waiting with serial CT scans is the least invasive approach, but observing a lesion increases the risk that a metastasis might occur if the lesion is malignant, or that an infectious disease will worsen or spread to others. Generally, observation with repeated imaging is reserved for patients who are thought to have a very low risk of malignancy, those with comorbid conditions for whom more invasive approaches would increase the risk of complication or death, and those who choose this approach for personal reasons. Patients who opt for watchful waiting and serial roentgenographic monitoring should have a chest CT every 3 months for the first year and every 6 months for the following year unless the lesion grows. If no change in size occurs over the 2 years then no further follow-up is needed.

Bronchoscopy has a lower rate of complications (eg, pneumothorax, hemorrhage, death) than transthoracic needle aspiration biopsy, but also has a lower yield. The yield is greater when the SPN is in direct proximity to a bronchus, when the nodule is > 2 cm in diameter, and when the chest CT indicates that a bronchus leads to the nodule. Ultrathin bronchoscopy allows the surgeon to direct the bronchoscope as far as the ninth generation bronchus [1].

Transthoracic needle aspiration biopsy is done under CT guidance and has an excellent diagnostic yield with a positive predictive value of 98.6 percent and a negative predictive value of 96.6 percent. The diagnostic yield for lesions smaller than 2 cm is approximately 60 percent (as compared to 10 percent with bronchoscopy). The complication rate, however, is 30 percent (as compared to 5 percent for bronchoscopy) [1].

Thoracotomy done either by video assistance or by direct visualization (open) has a mortality rate of 0.5-5.3 percent [4].

PET scans seem to have a greater ability than CT scans to detect occult metastatic disease, improve accuracy of stage classification, and increase the sensitivity of finding mediastinal lymphadenopathy with metastases. One study suggests that PET scanning is also cost-effective in these specific patient subsets:

1. Patients believed to be at low risk for malignancy by clinical evaluation but who have radiographic findings that are of concern for malignancy.
2. Patients believed to be at high risk for malignancy by clinical evaluation but who have radiographic findings that are consistent with a benign condition.
3. Patients believed to be at high risk for malignancy by clinical evaluation who also have a high predicted surgical morbidity or mortality and who are reluctant to pursue more invasive testing [5].

Management

After presence of a SPN has been confirmed, a number of potential management strategies may be pursued. In all strategies, the first step should be to review all prior chest radiographs. Unless the lesion is visible on films taken more than 2 years earlier, the nodule should be evaluated further (assuming the patient desires such an approach). Although SPNs from a few benign conditions can enlarge over time, an enlarging lesion must be considered malignant. A chest CT enables the size, location, and density of the lesion to be determined with the greatest sensitivity and specificity. Assuming the lesion does not have any markers of malignancy, individual patient considerations should assist with the plan for subsequent evaluation and treatment. In addition, the risk factors associated with both benign and malignant diagnoses will help guide and facilitate discussions with the patient so that he or she can fully participate in the decision making process.

It should be noted that patients with histories of previous tuberculosis exposure and those residing in areas where coccidiodomycosis or histoplasmosis is endemic might benefit from needle aspiration or bronchoscopy (with or without bronchoalveolar lavage) inasmuch they will have an increased pretest probability of having 1 of these infections.

Patients whose SPNs are not thought to have an infectious etiology will also need to be evaluated for potential neoplastic causes using one of the previously described diagnostic approaches. Any approach should weigh the risks and benefits to the patient and consider the patient's individual wishes and needs.

When and to whom do I need to refer a patient with a solitary pulmonary nodule?

A pulmonologist should be consulted if the generalist has questions about the best diagnostic approach or if the primary care physician believes that a diagnostic procedure such as bronchoscopy, transbronchial biopsy, or bronchoalveolar lavage is needed. Pulmonologists may also be able to better advise patients regarding the risks and benefits of various approaches. When percutaneous aspiration biopsies are necessary, they are usually performed by invasive radiologists.

If an SPN is growing, or if a patient prefers to have it removed without additional testing and is a viable candidate for surgery, he or she should be referred to a thoracic surgeon.

References

1. Ost D, Fein A. Evaluation and management of the solitary pulmonary nodule. *Am J Respir Crit Care Med.* 2000;162:782-787.
2. Libby DM, Smith JP, Altorki NK, Pasmantier MW, Yankelevitz D, Henschke CI. Managing the small pulmonary nodule discovered by CT. *Chest.* 2004;125:1522-1529.
3. Neifeld, JP, Michaelis, LL, Doppman, JL. Suspected pulmonary metastases: correlation of chest x-ray, whole lung tomograms, and operative findings. *Cancer.* 1977;39:383.
4. Ost D, Fein A. Management strategies for the solitary pulmonary nodule. *Curr Opin Pulm Med.* 2004;10:272-278.
5. Gould MK, Sanders GD, Barnett PG, et al. Cost-effectiveness of alternative management strategies for patients with solitary pulmonary nodules. *Ann Intern Med.* 2003;138:724-735.

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Virtual Mentor
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Case in Health Law

Chaoulli v Quebec: Testing the Single-payer System

On June 9, 2005, the Supreme Court of Canada struck down a Quebec law that banned the use of private insurance for publicly insured health services covered under that province's universal health care system, Medicare [1]. The goal of the long-standing ban was to prevent those who could afford it from "jumping the line," and paying for faster service with private insurance rather than waiting their turn for Medicare treatment, as those with less money must do. The historic ruling threatens to alter the country's determined resistance to a 2-tiered system of payment for medical services.

The following comments, based on a discussion with Canadian Medical Association president, Albert J. Schumacher, MD, and a written statement from physicians Sylvia R. Cruess, MD, and Richard L. Cruess, MD, provide some background for the landmark Court decision and some thoughts on its implications for the country's universal health care system.

In a joint statement to the press, the Canadian Medical Association (CMA) and the Canadian Orthopaedic Association expressed concurrence with the fundamental position of the Court's decision that Canadians have the right to timely access to health services [2]. Quoting from that statement, CMA president Albert J. Schumacher, MD, said that the Court's decision "represents a stinging indictment of the failure of the governments [federal and provincial] to respond to the mountains of studies and years of research" with any real improvements in the system [2]. Wait times have become so long as to amount to rationing, Schumacher said, adding that patients have died on the wait list.

The Canada Health Act, passed by Parliament in 1984, established universal and mandatory coverage for all citizens and forbade Canadian physicians to accept private funds for medically necessary services. The act listed 5 criteria for the national health care system:

1. Public administration – by a nonprofit public authority appointed by the government of the province;
2. Comprehensiveness – coverage of all services provided by hospitals, medical practitioners, or dentists and, where the law of the province permits, similar or additional services rendered by other health care practitioners;
3. Universality – plan services available to 100 percent of the insured persons of the province;

4. Portability – residency requirement or waiting period of no more than 3 months before residents of a province are eligible for services;
5. Accessibility – provision of services on a uniform basis that does not impede or preclude access through financial or other barriers.

Dr Schumacher said the Supreme Court decision could have the effect of adding "timely access" as a sixth criterion for the Canadian health plan [3].

The CMA and 6 national specialty associations established a Wait Time Alliance to work on timely access to care for Canadian citizens long before the Supreme Court ruling [4]. The goal of the Wait Time Alliance, which released an interim report on April 3, 2005 [5], is to determine evidence-based benchmarks for acceptable wait times in 5 areas of medical need—diagnostic imaging (CT scans, MRIs and nuclear medicine), hip and knee replacement surgery, radiation therapy, cataract surgery, and cardiac care. Procedures in these areas of medical need are classified into 3 levels of priority—emergency, urgent/semi-urgent, and routine—with medically appropriate wait times stipulated for each level of priority. The final report of the Wait Time Alliance is due out by the end of summer.

Despite claims by the media and some politicians that the Court's ruling could signal the collapse of universal health care in Canada, Dr Schumacher doubts that it will open floodgates to a private insurance industry. At most, the decision cracks the door for those instances in which wait time is tantamount to rationing of a needed service. Dr Schumacher predicts that Canada may migrate, as some European countries have done, toward the existence of a small private health care market that represents a single-digit percentage of the much larger government system.

References

1. *Chaoulli v Quebec* (Attorney General), 2005 SCC 35.
2. CMA/COA press conference [press release and conference]. Available at www.cma.ca/index.cfm/ci_id/44609/la_id/1.htm. Accessed June 20, 2005.
3. Personal Communication with *Virtual Mentor* editor: June 23, 2005.
4. The Wait Time Alliance comprises the CMA, the Canadian Association of Radiologists, the Canadian Association of Nuclear Medicine, the Canadian Association of Radiation Oncologists, the Canadian Cardiovascular Society, the Canadian Ophthalmological Society, and the Canadian Orthopaedic Association.
5. Eggertson L. Access to health care: Wait Time Alliance first to set benchmarks. *Can Med Assoc J*. 2005;172:1277.

Albert J. Schumacher, MD, a family physician in Windsor, Ontario, is president of the Canadian Medical Association. Dr Schumacher is strongly committed to student leadership training programs that help develop medicine's professional leaders of tomorrow.

Commentary

Sylvia R. Cruess, MD, and Richard L. Cruess, MD

We have said—and written—that it is unsustainable morally and politically to forbid a private sector in the health care field if the population believes that the public sector will not care for them when they are sick. Every citizen deserves access to care when he or she needs it. Canada balanced its budget 10 years ago by making significant cuts in the health care system (and health education, including medical schools). This transformed a system that had once been performing well—number 1 in Organisation for Economic Cooperation and Development (OECD) ratings—to one with long waits, insufficient facilities, and less-than-modern equipment. We thus began rationing health care more than we had before, albeit in a reasonably equitable fashion, with crisis cases handled quickly and well, but long waits in emergency departments and for elective procedures. The planners and policy makers were reluctant to put more dollars into the acute care system, which was what the public clearly wanted. Until recently, reform efforts were concentrated on primary care and community and preventive care, which are laudable activities but only if the acute care system is able to treat citizens when they are sick. Moreover, in the 1990s the federal and provincial governments, acting together, cut positions in medical school and residency programs based on the assumption that doctors generate expenditures. Similar cuts were made in nursing. This was done on the basis of seriously flawed studies and led to a shortage of physicians, nurses, and other health care workers. The end result was an underfunded and understaffed health care system which did not meet the needs of its citizens who had nowhere else to go for care, since the Canada Health Act and most provincial laws essentially outlawed all private health care insurance and delivery.

The voters rebelled, and health care has become Canada's number 1 political issue. In response to voter pressure Canada is now expanding enrollments in medical and health professional schools, building new schools, adding residency positions, and relaxing immigration rules for foreign-trained doctors. Finally, all levels of government are attempting to refinance the health care system with large infusions of cash, but these measures will take 5-10 years to have a real effect. The Supreme Court decision comes against this backdrop.

It now appears that it is unconstitutional in 1 province (Quebec) to forbid the sale of private insurance to pay for any service that is covered by the publicly funded system. The prohibition has been found to contravene the province's own Charter of Rights, which guarantees the security of the individual. The Court, in a majority decision written by a judge from Quebec, stated that access to health care is necessary to preserve this individual security. Had adequate and timely care from the publicly funded system been available, the Court would presumably have supported the existing law. Health care is a right in Canada, and the Court has certainly supported this principle. It is somewhat ironic that Canada's universal single-payer system was established because health care is believed to be a right—which is not true in the United States—and that the Court is opening the door to an expanded private sector in order to preserve this right.

The future is difficult to predict, but there will certainly be changes. There is strong sentiment in Canada against the establishment of a market-dominated health care system like the one in the US. Equal access to care irrespective of the ability to pay is a principal supported by most Canadians. The Supreme Court judgment is at present restricted to Quebec, but challenges will undoubtedly be filed in other provinces in the near future, raising the ruling's impact to the national level. There will undoubtedly be a vigorous debate on what changes Canadians want. It is probable that we cannot avoid an expanded private sector in which Canadians can purchase health insurance and receive some care in the private sector. However, it will probably be a private sector activity that is restricted in scope and heavily regulated. As an example, there are no private general hospitals in Canada, and governments can certainly determine what happens in the hospital sector that they control. They also must give permits for all health care-related construction. Finally, most provinces are very active in workforce planning and will continue to try to influence how many enter practice and what they do.

None of this would have occurred had the public system been funded adequately and the medical workforce maintained at adequate levels. Canada's Supreme Court has stated that timely access to competent care is a right and that the publicly funded system did not provide it. This will result in some form of a parallel private sector, but the most significant result may well be to force all levels of government to meet their obligations and to improve access to the public system. This is what many of us hope. The most difficult task will be to preserve the values of equity and social justice inherent in the present system as an enhanced role is given to the private sector.

Sylvia R. Cruess, MD, is an endocrinologist, a professor of medicine, and a member of the Centre for Medical Education at McGill University. She previously served as director of the Metabolic Day Centre and as medical director of the Royal Victoria Hospital in Montreal. She was also a member of the Deschamps Commission on Conduct of Research on Humans in Establishments. Since 1995 she has carried out research on professionalism in medicine.

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Virtual Mentor
Ethics Journal of the American Medical Association
July 2005, Volume 7, Number 7

Policy Forum

The Medicare Prescription Drug Law: Implications for Access to Care

by January Angeles, MPP, and Marilyn Moon, PhD

The Medicare Modernization Act (MMA) of 2003 provided the largest benefit expansion in Medicare's history. Since its beginning in 1965, Medicare has never covered prescription drugs. Medicare recipients have had to seek drug coverage from a variety of other sources, including the joint federal/state Medicaid program which serves low-income individuals. But under the MMA, elderly and disabled participants will be able to obtain coverage for outpatient prescription drugs beginning in January 2006 through Medicare Advantage or private stand-alone drug plans. General skepticism about the adequacy of the benefit conferred through the newly enacted "Medicare Part D," however, has raised the question of whether it really improves the elderly's access to prescription drugs.

Medicare Part D, which includes government subsidies for prescription drug coverage and guaranteed ability to enroll, will no doubt be helpful to some. The new law will effectively result in the government's paying 75 percent of the cost of a benefit that will, in turn, cover about half of all drug costs for those who enroll. But since the drug benefit is not fully comprehensive, its overall impact will be mixed. How much it will improve the situation for a given Medicare beneficiary will depend on that individual's income and secondary insurance coverage.

Those who currently have no private supplemental coverage and are spending high amounts on drugs will be better off under the new Medicare plan. Individuals who now purchase prescription drug coverage through private supplemental plans (known as "Medigap") are also likely to benefit. Premiums for the Medigap plans that cover prescription drugs average about $2300 to $2700 per year, of which approximately $700 to $1100 goes towards prescription drug coverage [1]. Medicare Part D offers better coverage than these Medigap plans for half the cost of the Medigap premiums.

People who are eligible for low-income subsidies established through the MMA but whose incomes are too high to be eligible for Medicaid will also have generous coverage that they otherwise could not afford. That is, in many states eligibility for Medicaid protection is limited to people with incomes below 74 percent of the federal poverty level. The low-income subsidies, on the other hand, extend to those with incomes up to 150 percent of the poverty level. Thus, individuals with incomes ranging from about $7000 to $14 000 will have access to a good drug benefit.

But others may not benefit as much from the new law. Those whose incomes and assets place them just above the threshold for the low-income subsidies are unlikely to be able to afford the Part D premiums and copays and may choose to forgo coverage. For example, a person who makes $14 000 per year (approximately 150 percent of the federal poverty level) must spend $670 up front on the annual premium and deductibles before being able to take advantage of Medicare Part D. For many in this income range, these fees would constitute a significant financial burden.

Finally, 2 groups may actually be *dis*advantaged by this new legislation. First, those with generous supplemental retiree coverage may lose their private drug benefits or see them reduced. Employer-sponsored retiree insurance has been declining for a number of years, and there is concern that employers may decide to substitute Medicare Part D for the prescription drug benefits they currently offer, or drop drug coverage altogether. In fact, to minimize occurrence of the latter, the MMA legislation includes subsidies for employers who offer coverage at least as generous as that offered by Medicare. So, some companies may be able to reduce their coverage and still receive subsidies for what they do offer. It will be difficult, however, to sort out whether changes that occur in retiree plans are a result of a longstanding trend or specifically induced by the new legislation.

Those likely to be the most disadvantaged by the new law are those known as dually eligible beneficiaries, the 6.4 million Medicare recipients, who currently receive prescription drug coverage through Medicaid. Because Medicare has never before covered prescription drugs, Medicaid has paid for the medication costs for this population. In 2006, this group will have to switch from Medicaid to Medicare Part D plans in order to continue receiving prescription drug benefits, but may face decreased benefits and higher payments under the new plan.

Medicare Part D offers generous subsidies and coverage for those who are dually eligible, but it establishes copays that are generally higher than what many states currently require members of this group to pay. Specifically, at least 11 states do not currently charge a copay, and 13 states have copayments lower than the established Part D levels. Thus, dually eligible beneficiaries residing in these states who represent 3.9 million people or 63 percent of all full benefit, dually eligible beneficiaries are likely to see increases in their out-of-pocket costs for prescription drugs.

Private drug plans that participate in Medicare Part D have considerable flexibility in deciding which medications to cover and are only required to cover 2 drugs in each "therapeutic class." In contrast, Medicaid currently provides access to a wide and comprehensive list of drugs, and states cannot deny coverage for medications that are deemed medically necessary. Consequently, those with dual eligibility may find themselves unable to obtain needed medications that are not included in their Part D plan's formulary. The only way to acquire medications not included is to shift to a new plan or to file and win an appeal—a complicated process that may be difficult for participants to navigate.

Historically Medicaid programs have been able to supplement coverage gaps in Medicare benefits, but the MMA now specifically prohibits states from using federal matching payments to supplement Part D coverage for full benefit dually eligible beneficiaries [2]. States may supplement Part D benefits using their own funds, although they are not obligated by law to do so. Given the tight fiscal situations that many states are in and the pressures to cut the growth in Medicaid spending, many state officials have signaled that they are unlikely to supplement Part D plans [3]. Adding prescription drugs to the Medicare benefit package has been a controversial issue for a long time. The overall inadequacy of the benefit package is a result of an attempt to keep costs down. Thus, the protections afforded are not as well-designed as they could be, leaving some groups with continued drug affordability problems while creating some new problems that do not exist under the current system. Ultimately, if we want Medicare to be a comprehensive and high quality health insurance, then we have to be willing to finance it adequately.

References

1. Consumers face huge disparities in Medigap rates, according to Weiss Ratings Study [press release]. Palm Beach Gardens: Florida; July 14, 2003. Available at: http://www.weissratings.com/News/Ins_Medigap/20030714medigap.htm. Accessed June 24, 2005.
2. Sec. 103(c) / 1935(d)(1). *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*. Available at: www.cms.hhs.gov/medicarereform/MMAactfulltext.pdf. One exception is that states can use matching funds for certain drugs that Part D plans are not required to cover.
3. Smith V, Gifford K, Kramer S. *Implications of the Medicare Modernization Act for States: Observations from a Focus Group Discussion with Medicaid Directors*. Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50422. Accessed June 24, 2005.

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Virtual Mentor
Ethics Journal of the American Medical Association
July 2005, Volume 7, Number 7

Policy Forum

Utah's Primary Care Network: States Can Do Better

by Judi Hilman, MA

States have taken a variety of approaches to managing rising Medicaid costs, some of which include more restrictions on eligibility and fewer services. Utah's broad, if somewhat paradoxical, solution to controlling Medicaid costs while serving more of the uninsured is the Primary Care Network (PCN). Proponents and critics alike agree that the PCN is not a total solution. Yet, as states look for ways to cover their uninsured while curtailing escalating Medicaid costs, some are exploring options like Utah's PCN.

A single mother of a 15-month old boy, Molly was enrolled in the PCN from June to December 2003. When she applied, Molly thought the $50 enrollment fee was reasonable. She later dropped PCN because the program was not helping her with the medical tests she needed for her gastrointestinal distress.

What is the PCN?

For a $50 annual enrollment fee and stiff cost-sharing requirements (eg, copays for prescription drugs and physician visits), the PCN provides prevention-oriented primary care to uninsured adults who earn less than 150 percent of the federal poverty level in annual income [1]. This benefit package, however, is far below Medicaid standards. Through Section 1115 of the Social Security Act, states can seek a waiver—or exception—to federal Medicaid standards to test a new concept for health care delivery. The waivers permit states to undertake extensive changes in their Medicaid programs if they can demonstrate that their plan advances the Social Security Act's broad objectives. Historically, most Medicaid 1115 waivers have been used to expand comprehensive medical coverage for low-income adults, such as parents with incomes above the regular Medicaid eligibility limits or childless adults, a group that typically falls through the cracks of the Medicaid program.

The PCN, however, is a unique Section 1115 waiver in several respects: it is the first general 1115 waiver that has *not* covered specialty care or inpatient services, focusing instead on prevention-oriented primary care. The PCN was intended to replace the Utah Medical Assistance Program (UMAP), a disappointing state-funded program for chronically ill childless adults with incomes less than 38 percent of the poverty level. The PCN allocates 16 000 slots for low-income parents and 9000 slots for childless adults (who are usually the more medically needy and thus more costly of the traditional waiver target group), covering up to 8 percent of Utah's estimated 300 000 uninsured.

As of March 2005 the PCN had 20 120 enrollees: 60 percent were parents, and 40 percent were childless adults. Of the childless, 81 percent had incomes below the poverty level; among the parents, nearly 60 percent were living under the poverty level. Hispanics were underenrolled, making up only 8 percent of total enrollees but accounting for 29 percent of the state's overall uninsured [2].

What is Covered at Work (CAW)?

When Tommy Thompson, then Health and Human Services Secretary, presented the Bush Administration's new Health Insurance Flexibility and Accountability (HIFA) guidelines for waivers, states were encouraged to build premium assistance programs into their waiver designs, that is, programs to help low-income workers with employer-based insurance plans make their share of the premium payments [3]. Less than 1 year after implementing the PCN, the Utah Department of Health (DOH) submitted an amendment to Secretary Thompson outlining a premium assistance program called "Covered at Work" (CAW) which was swiftly approved.

For each worker-participant, CAW allocates $50 per month—the estimated market value of the PCN benefit package—toward the worker's share of the premium for employer-based coverage, as long as the employer covers at least half of the premium. Utah is able to offer the CAW program to a maximum of 6000 low-income workers.

Advocates were optimistic at first about CAW's promise of leveraging employer contributions to build a more comprehensive benefit package. However, these hopes were all but dashed when the day arrived to implement the program. On that day—August 1, 2003—only 1 person signed up. As of May 2005, Covered at Work has enrolled only 79 workers. This experience has only confirmed what we already knew from research on premium assistance programs: that $50 per month is not enough to make employer-based coverage affordable for low-income workers because their share of the monthly premium is usually significantly higher than $50 [4].

Meanwhile the PCN enrollment is now closed—give or take a few open enrollment periods and the 6000 slots being held for the disappointing CAW program.

The PCN and Cost Sharing

Evidence that the $50 annual enrollment fee presents a barrier for applicants is substantial: 23 percent of application denials are related to failure to pay the fee [5]. A recent report on disenrollment from the PCN found that 29 percent of those who did not re-enroll listed "finance" as a reason for dropping PCN. A report on application denials also shows a sizeable number of applications categorized as "incomplete." Some of these applicants might be failing to complete the application because of the fee [6].

PCN's Reliance on the Charitable Sector for Specialty Care

When Molly enrolled in the PCN she was not aware that a case manager could work to get specialty care donated. At her orientation Molly was simply told that specialty care and inpatient services were not covered by the PCN and she was given a list of other services that were not covered.

From the start, a major concern about the primary-care-only approach of the PCN has been that it created the potential for a cruel medical paradox. A low-income person might be diagnosed with a serious disease—such as cancer, chronic obstructive pulmonary disease, HIV, or severe mental illness—and then be unable to access the specialty or inpatient hospital care needed to treat the disease.

The PCN benefit package has undeniable value for younger, healthier enrollees. Covering up to 4 prescriptions a month, the pharmacy benefit alone can compensate for any hardship caused by the $50 enrollment fee. However, the typical former UMAP client has copious and ongoing health care needs, particularly for mental health and substance abuse services and case management. The DOH has acknowledged some of the problems of not covering specialty care and has developed an informal network of physicians who will do some charity work, but the reality is that this donated care is not enough to fill the significant gaps in PCN coverage.

Casey, a young woman suffering from manic depression, was interviewed by a caseworker close to the time she was supposed to renew her PCN coverage. She laughed when asked whether she intended to renew. "Heck, just about everything I needed wasn't covered!" Her PCN-covered doctor did help her qualify and apply for Disability ("Traditional") Medicaid.

For Casey and other chronically ill individuals, prevention-oriented coverage without *guaranteed* access to specialty care or inpatient hospital coverage is virtually useless. After the first 6 months of PCN, former UMAP recipients comprised 15 percent of PCN enrollees. As of March 2005, only 3 percent of PCN enrollees were former UMAP recipients [2, 7]. Clearly, the PCN does not speak to their needs.

After the PCN refused to cover another visit to the ER, Molly developed what turned out to be gallstones: "I was in so much pain but didn't go to the ER because I knew the PCN would not cover the visit." When she had several suspicious moles removed at a local community health center, it was billed to the PCN; again, no payment. "The doctor had no idea it would not be covered, and he was not familiar with the process for getting donated care."

Anecdotal evidence shows serious flaws in programmatic arrangements for securing donated specialty and inpatient care. To this day PCN staffers give out inconsistent information about what is covered. Until recently, little effort was made to educate providers about the referral process. Primary care professionals have their own concerns about liability in the event they are faced with diagnosing serious conditions requiring specialty care that they know cannot be obtained. The hospitals have so far been willing to donate the $10 million worth of inpatient care per year that was assumed in the original waiver design. They have also been cooperating with local health departments to make sure that more hospitals across the state shoulder the burden of charity care, but they have grown increasingly disgruntled with this arrangement. Together hospitals and health departments have tracked $13 million worth of inpatient care provided to PCN clients over the last year, $3 million over the amount requested. As a result, Utah hospitals are the most vocal critics of the PCN.

A recent DOH-sponsored health outcome evaluation found that, while most enrollees were able to get more needed care than before by using the Primary Care Network, former UMAP recipients had more trouble seeing specialists under the Primary Care Network than under UMAP. Moreover, the survey found minimal change in enrollees' physical health status over the first 12 months of enrollment in the PCN [8]. The Kaiser Commission on Medicaid and the Uninsured has initiated a research study to examine the extent to which PCN meets the needs of its beneficiaries, and the results, which should be available soon, ought to offer more evidence about the adequacy of Utah's waiver program [8].

Robbing Petrina to Pay Paul

As a Medicaid 1115 waiver demonstration program, the PCN must be revenue neutral to the federal government, meaning that the federal government will not have to pay more for Medicaid after the "expansion" is implemented than it would have before the waiver. To meet this fundamental requirement, Utah reduced the benefit package and raised the cost sharing for a portion of Medicaid participants—the parents—while leaving benefits and cost sharing the same for the rest of adult Medicaid enrollees. Then, to maintain the distinction between the 2 groups, the DOH renamed Parent's Medicaid "Non Traditional." Other states often financed their Section 1115 expansions of comprehensive medical care by making Medicaid more efficient through shifting to capitated managed care. Utah was the first state to use reductions in benefits and increases in cost-sharing for existing beneficiaries to finance partial care for an expansion group, members of which often earned higher incomes than the existing Medicaid beneficiaries.

The group of very low-income parents who are essentially financing the limited PCN coverage have considerable health and financial needs. This population includes parents receiving welfare and those who have recently left the welfare system.

Recent studies have underscored the unique health care needs of parents in transition out of the welfare system. In their interviews with "welfare leavers," the University of Utah-based Social Research Institute found that 2 to 5 months after leaving the welfare system, the majority (63 percent) remained unemployed and 47 percent had been uninsured at some point since losing their cash benefits; 55 percent currently had physical health problems, and 42 percent rated their mental health as poor [9]. Low-income parents' need for cost-effective preventive care cannot be overemphasized, but some evidence suggests that higher copays reduce parents' utilization of otherwise cost-effective preventive services [10].

Now that PCN is having an open enrollment, Molly decides to re-enroll: "Only because there's nothing else out there. At least it will pay for 4 of the most expensive medications I now need."

We can do better.

For young adults in reasonably good health, the benefits of the PCN are undeniable, though the participants cannot be considered adequately insured. For the program in general, the risks of providing limited or illusory coverage to a small slice of the neediest group probably outweigh the benefits. There are better ways for states to cover the uninsured than approaches like the PCN [11], just as there are also proven ways to design Bush-era waivers that do not involve cutting services or raising cost sharing for vulnerable populations like working parents [12]. When political options are limited, as they are in Utah, the PCN might make sense as a temporary solution at best, but diligent efforts for a more permanent solution must continue. Other states have done, and clearly can do, better.

References

1. Betit R. *Background on Utah's New Medicaid Waiver*. Salt Lake City, Utah: Utah Department of Health. 2002.
2. Utah Department of Health. *Access Initiatives. Primary Care Network and Covered at Work Enrollment as of March 12, 2005*. Salt Lake City, Utah: Utah Department of Health; 2005.
3. Kaiser Commission on Medicaid and the Uninsured. *The New Medicaid and CHIP Waivers*. Washington, DC: Kaiser Family Foundation; 2002b.
4. Kaiser Commission on Medicaid and the Uninsured. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity*. Washington, DC: Kaiser Family Foundation; 2003b.
5. Utah Department of Health. *Access Initiatives*. Salt Lake City, Utah: Utah Department of Health; 2004.
6. Office of Health Care Statistics. *Utah PCN Disenrollment Report*. Salt Lake City, Utah: Utah Department of Health; 2004.
7. Utah Department of Health. *Access Initiatives. Primary Care Network and Covered at Work Enrollment as of December 2002*. Salt Lake City, Utah: Utah Department of Health; 2002.
8. Xu W, Martin M. *Health Outcome Evaluation of Utah's Primary Care Network*. Paper presented at: the Academy Health Annual Research Conference; June 6-8, 2004; San Diego, Calif.
9. Vogel-Ferguson MB. *TANF Review Study: Health Data (unpublished raw data)*. Salt Lake City, Utah. Social Research Institute, University of Utah. 2005.
10. Ku L, Deschamps E, Hilman J. *The Effects of Nominal Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*. Available at: http://www.cbpp.org/11-2-04health.htm#_ftn1. Accessed June 21, 2005.
11. Holahan J, Pohl MB. *States as Innovators in Low-Income Health Coverage*. Available at: http://www.urban.org/UploadedPDF/310519_DP0208.pdf. Accessed June 21, 2005.
12. Kaiser Commission on Medicaid and the Uninsured. *Assessing the Role of Recent Waivers in Providing New Coverage*. Washington, DC: Kaiser Family Foundation; 2003a.

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Medicaid Reform: Implications for the Health Care Safety Net

by Sara Wilensky, JD, MPP, and Sara Rosenbaum, JD

Health care is not considered a right in the US, and health insurance coverage is not universal. In 2003, 45 million Americans were uninsured for the entire year [1] while an equally large number were uninsured for part of a year [2]. Over a 24-month period, 80 million people experienced some absence of coverage [3]. Among those with private health insurance, an estimated 10 to 25 percent are *under*insured, meaning their insurance plan is inadequate to cover the cost of their health care needs [4]. A recent study traced 50 percent of all filed personal bankruptcies to medical care costs, and three-quarters of those filers actually had health insurance [5].

There are 2 major causes for this state of health care coverage. First, the private, primarily employment-based, health insurance system is voluntary and so costly (the annual premium for family coverage is estimated to be approximately $10 000 in 2005) that millions cannot afford it. Second, the absence of a widely available public insurance system for those who cannot afford private coverage leaves many with no health care benefits.

Eighty percent of those who are uninsured live in families with at least 1 wage earner, and 60 percent are wage earners themselves, yet they remain uninsured because their employers offer either no coverage or no affordable coverage [6]. Medicaid, the federal-state government program, is the nation's largest insurer; it covered more than 50 million people in 2004 but that included only half of the poor and low-income individuals of working age. Adults are ineligible for Medicaid unless they have severe disabilities that prevent work. Even with coverage, millions of Medicaid beneficiaries remain medically underserved either because they live in communities without physicians or because local physicians do not accept Medicaid. Only half of all physicians report unlimited participation in Medicaid [7].

The "health care safety net" serves millions of low-income, uninsured, and publicly (ie, government) insured persons.The Institute of Medicine (IOM) has defined the health care safety net as "[t]hose providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations" [4]. The IOM also identified a subset of the safety net—"core" resources such as federally funded community health centers and public hospitals—which serve the aforementioned population *and* have an open door policy of offering services regardless of ability to pay. The "core safety net" includes an estimated 1300 public hospitals, 1000 community health centers, federally supported family planning clinics, and local public health agencies whose patients are likely to be on Medicaid, uninsured, poor, and members of racial or ethnic minority groups [8, 9]. The far larger noncore safety net, comprising community and teaching hospitals, some private health professionals in office-based practices, and school-based health clinics, supplies the majority of all health care to vulnerable populations.

The core safety net depends greatly on public funding. One-third of all health center operating revenues come from Medicaid, while 38 percent of public hospital revenues are derived from Medicaid [10]. Public hospitals' and local clinics' legal obligation or rigorous mission to serve persons who cannot afford necessary health care, along with their typically heightened efforts to offer culturally appropriate care that includes patient support services such as social work, translation, and transportation, would be impossible without Medicaid revenue.

The uninsured are at risk for serious health consequences. They experience many barriers to obtaining health care, and they are more likely to delay care because of cost than are the insured [6]. Persons without health insurance tend to be sicker and more likely to die from preventable causes than those with health insurance [6]. Without the core safety net, uninsured individuals would continue to go without needed care, and millions of publicly insured persons would have no access to health care.

Yet, the safety net does much more than simply administer sporadic care for the uninsured. These health centers and other publicly supported clinics are the "neighborhood doctors" for many medically underserved communities, acting as a regular source of quality health care. Having a consistent source of care is positively associated with better and more timely access to care, better chronic disease management, fewer emergency room visits, fewer lawsuits against emergency rooms, increased utilization rates, and increased cancer screenings for women [11]. Numerous studies show that the care medically underserved populations receive in safety net settings is of high quality [4], although physicians and support staff often struggle to identify affordable sources of specialty care for their uninsured patients [1].

In some respects, support for the core safety net has never been greater. For example, President Bush has supported a major expansion of health centers, and as a result the number of patients served is expected to grow from 10 million in 2001 to more than 16 million by 2006 [2].

At the same time, as part of the federal budget for fiscal year 2006, the Bush administration and congressional supporters are calling for major cuts in the Medicaid program, deep reductions in critical grant programs that help support the safety net (eg, the National Health Service Corps), an elimination of the Preventive Health and Health Services Block Grants awarded to the states, and significant reductions in CDC preventive health programs [3].

Medicaid cuts would have the most far-reaching effects, not only because Medicaid is an essential source of revenue for physicians and clinics alike, but also because it is virtually the only source of insurance coverage for safety net patients. These proposed reductions would further swell the ranks of the uninsured and simultaneously imperil critical funding to safety net providers when it is needed most.

In April 2005 the House of Representatives voted to cut Medicaid even more deeply than recommended by the President, while the Senate rejected all cuts. The subsequent budget resolution passed by both the House and Senate lowered Medicaid funding by $10 billion. Regardless of how the Medicaid financial debate is eventually resolved, major reductions in smaller grant programs are inevitable. As the number of uninsured Americans continues to grow, the survival of the safety net will become an even more pressing health policy matter.

References

1. US Census Bureau. *Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States.* Washington, DC: US Census Bureau; 2003.
2. Families USA. *One in Three: Non-Elderly Americans without Health Insurance, 2003-2004.* June 2004. Available at: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641. Accessed May 9, 2005.
3. Hoffman C, Rowland D, Carbaugh A. Holes in the health insurance system—who lacks coverage and why. *J Law Med Ethics.* 2004;32:391-396.
4. Institute of Medicine. *America's Health Care Safety Net: Intact but Endangered.* Washington, DC: National Academy Press; 2000.
5. Himmelstein D, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff.* February 2005, Web Exclusive. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1. Accessed June 22, 2005.
6. Institute of Medicine. *Coverage Matters: Insurance and Health Care.* Washington, DC: National Academy Press; 2001.
7. Cunningham PJ. *Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured. 1997-2001*. Center for Studying Health Systems Change: Washington, DC; December 2002. Tracking Report, No. 6.
8. NAPH Issue Brief. *What Kinds of Patients Go to Safety Net Hospitals?* Washington, DC; 2003. Available at: http://www.naph.org/Template.cfm?Section=Books_and_Monographs&template=/ContentManagement/ContentDisplay.cfm&ContentID=3417&CFID=375871&CFTOKEN=70783616. Accessed April 19, 2005.
9. National Association of Community Health Centers. *America's Health Centers Fact Sheet*. Washington, DC; 2004. Available at: http://www.nachc.com/research/Files/IntrotoHealthCenters8.04.pdf. Accessed April 19, 2005.
10. Siegel B, Regenstein M, Shin P. Health reform and the safety net: big opportunities; major risks. *J Law Med Ethics.* 2004;32:426-432.
11. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics.* 2004;113:1493-1498.

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Medicaid's Untallied Costs

by Michael F. Cannon

Medicaid occupies a special place among government programs for the poor. Public support for Medicaid is broader and deeper than for other safety net programs because the consequences of inadequate medical care can be much more immediate and severe than a lack of cash or even food. This may be one reason voters have heretofore accepted the rapidly growing tax burden Medicaid imposes.

Yet Medicaid's financial burden has become so severe that Tennessee has cut tens of thousands of beneficiaries from its program. Missouri is looking to replace its program by 2008. Medicaid has become states' largest expenditure, eclipsing elementary and secondary education. What was intended only to provide medical care for the truly needy has now grown larger than Medicare. Congress is struggling over how to cut less than 1 percent of Medicaid spending over the next 5 years. But cutting Medicaid simply adds to the number of uninsured…doesn't it?

Unfortunately, that's as far as today's debate goes. The untold story of Medicaid is that its greatest costs are not fiscal, or even primarily economic. But Medicaid's other costs rarely penetrate the current debate over the program's future.

Medicaid is welfare. Like other forms of welfare, it discourages work and charitable effort among the taxpayers who fund it. More troubling, though, is that it discourages self-sufficiency and encourages dependency among beneficiaries.

The phenomenon of "crowd-out"—where the presence of "free" public coverage pulls people away from private coverage—is the most-researched way that Medicaid encourages dependency. Researchers at the Robert Wood Johnson Foundation surveyed 22 leading studies and concluded that crowd-out "seems inevitable." Over half of these studies found evidence of crowd-out, and some even found that growth in public programs was completely offset by reductions in private coverage [1].

For those on Medicaid, income and asset tests deter work effort and wealth accumulation—both crucial tools for escaping poverty. Recipients who earn too much risk losing an average $6000 in Medicaid benefits. Aaron Yelowitz of the University of Kentucky and MIT's Jonathan Gruber found that, rather than accumulate assets, non-elderly Medicaid-eligible households increase consumption in order to remain eligible. In 1993, Medicaid eligibility was associated with reduced wealth holdings equal to $1600 to $2000 in today's dollars [2].

Even when recipients try to climb out of poverty, Medicaid frustrates their efforts long after they have left the rolls. Medicaid's annual tax burden is now over $1000 per capita. Half of Medicaid spending is financed by states, which rely heavily on sales taxes. Sales taxes are widely considered regressive in that they place a proportionally larger burden on lower-income earners.

In addition, Medicaid increases the cost of private medical care and health insurance. A program that offers services effectively free of charge to tens of millions of beneficiaries cannot help but fuel demand and medical inflation. Cost-shifting adds more fuel to the fire: Mark Duggan of the University of Maryland and Fiona Scott Morton of Yale University found that cost-shifting from Medicaid increases the price of non-Medicaid drug prescriptions by 13.3 percent [3]. Thus if granny's pills cost $1000 per year, more than $117 of that represents Medicaid costs that are shifted to a private payer.

These costs are magnified by Medicaid's financing structure. States receive an average of $1.30 from Washington for every dollar they spend; spending $1 on Medicaid buys $2.30 of health care. This encourages states to expand their programs beyond what is necessary to assist the truly needy. According to the Urban Institute, about one-fifth of Medicaid-eligible adults and children have private coverage [4-5], which suggests that Medicaid currently provides coverage to many who could obtain it on their own.

A significant body of research suggests that, as it exists today, Medicaid encourages recipients to become dependent on government; encourages people to behave in ways that increase the cost of government and of health care, which makes self-reliance more difficult for their neighbors; and encourages state policymakers to get more people to behave that way. A worthwhile attempt to cut Medicaid costs would look beyond state and federal budgets and seek to minimize other costs as well.

Fortunately, the federal government has a roadmap for doing just that. In 1996, it ended the entitlement to federal cash assistance; block-granted to the states funds that were previously given out in proportion to what each state spent; and gave states greater flexibility in setting eligibility and benefits. The idea was first to stop encouraging states to foster dependency, and then to give states the flexibility they needed to discourage dependency instead.

Opponents predicted this would be disastrous for the poor. Yet caseloads plummeted and poverty decreased. By 2003, the poverty rate remained lower than at any point in the 17 years leading up to welfare reform [6]. Although the robust economy played a part, many who opposed the 1996 law have since admitted that it accomplished a large measure of good.

The federal government could build on this success by applying these lessons to Medicaid. First, Congress could let states set their own rules regarding eligibility and benefits as it proposed to do in 1996. Next, it could stop encouraging Medicaid expansions by freezing payments to states at the 2005 amount, just as welfare reform froze payments to states at the 1995 amount. By itself, that would wipe out 96 percent of the cumulative 10-year federal deficit [7]. Finally, Congress could give states maximum flexibility to use federal Medicaid funds to meet a few broad goals, such as:

1. Targeting medical assistance to the truly needy;
2. Reducing dependency;
3. Reducing crowd-out of private effort, including charitable care; and
4. Promoting competitive private markets for medical care and insurance.

At the same time, states and the federal government should refocus Medicaid on its original mission: aid for the truly needy. This means eliminating eligibility for those most likely to land on their feet. While some will call any such steps "draconian," Harvard economist George Borjas found that there may be a reverse crowd-out effect: when Congress cut immigrants from the Medicaid rolls in 1996, a surge in private coverage *increased* overall coverage levels for immigrants—a result that Borjas says cannot be explained by a robust economy [8]. A good way to start refocusing Medicaid funds on the truly needy would be to prevent well-to-do seniors and their heirs from using Medicaid to pay for long-term care.

Opponents may argue that those who move from Medicaid to private insurance would end up with less coverage. Yet this is less than certain. The Urban Institute reports that "Medicaid-eligible adults with private health insurance coverage…are less likely to report unmet medical needs than their Medicaid-enrolled counterparts" [9].

But just as important as how much coverage people have is how they obtain it. When people work and become more productive, both they and society benefit. Offering people Medicaid in lieu of (allegedly) inferior private coverage, on the other hand, tells them that the way to get more is by doing less: work less, save less, cultivate less self-reliance. That is a recipe for dependency.

Providing medical assistance to the poor without fostering dependency is a delicate balancing act. And the costs incurred by getting it wrong don't get a line-item in the federal budget. Reforming Medicaid along the lines of the 1996 welfare law would allow the states to strike a better balance for all involved.

References

1. Davidson G, Blewett LA, Call KT. *Public Program Crowd-out of Private Coverage: What are the Issues?*" Princeton, NJ: Robert Wood Johnson Foundation; 2004. Research Synthesis Report No. 5. This survey reports on 22 studies that found some evidence of crowd-out of public insurance, with results ranging from no evidence of crowd-out to crowd-out levels as high as 177 percent of increased enrollment in public programs.
2. Gruber J, Yelowitz A. Public health insurance and private savings. *J Polit Econ.*1999;107:1249-1274.
3. Duggan M, Morton FS. *The Distortionary Effects of Government Procurement: Evidence from*

Medicaid Prescription Drug Purchasing. NBER Working Paper No. w10930; November 2004.
4. Davidoff AJ, Garrett B, Yemane A. Medicaid-eligible adults who are not enrolled: who are they and do they get the care they need? *Urban Institute Policy Brief*. 2001;A-48:2. Twenty-one percent of Medicaid-eligible adults and 27 percent of Medicaid-eligible children are reported as having private coverage.
5. Davidoff AJ, Garrett B, Schirmer M. Children eligible for Medicaid but not enrolled: how great a policy concern? *Urban Institute Policy* Brief. 2000;A-41:1-2. The study reports, "Dual Medicaid and privately insured children were counted in the privately insured category," but does not state what portion of the privately insured category duals represent.
6. US Census Bureau. *Poverty Status of People by Family Relationship, Race, and Hispanic Origin: 1959 to 2003. Historical Poverty Tables; Table 2.* Available at: http://www.census.gov/hhes/poverty/histpov/hstpov2.html. Accessed June 27, 2005.
7. Congressional Budget Office. *The Budget and Economic Outlook: Fiscal Years 2006 to 2015.* Congressional Budget Office. 2005;56. See also: Congressional Budget Office. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006*. Congressional Budget Office. 2005;24 and author's calculations.
8. Borjas BJ. Welfare reform, labor supply, and health insurance in the immigrant population. *J Health Econ.* 2003;22:956-957.
9. Davidoff AJ, Garrett B, Yemane A, 1.

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Medicine and Society

Culture Within a Culture: US Immigrants Confront a Health System that Many Citizens Can't Manage

by Ann O'Fallon, BSN, MA

Nearly a quarter of the US population is either foreign-born or has foreign-born parentage [1]. In Minnesota, the foreign-born population more than doubled, from 110 000 to 240 000 during the 1990s, an influx of immigrants that brought many ethnic Hmong, resettled from refugee camps in Thailand.

The Refugee Act of 1980, a humanitarian bill passed with strong bipartisan support, guarantees funds to states to ensure that all new refugees are covered by Medicaid for their first 8 months in the US. A refugee is defined as someone who has fled his or her homeland and cannot return because of a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. This act recommends that, within the first 90 days, each refugee have a comprehensive medical exam for 2 main reasons: (1) to determine conditions or illnesses that may interfere with the individual's ability to adjust to life in the US and (2) to screen for and treat common infectious diseases for the protection of the existing population.

Many refugee groups suffer a higher rate of infectious diseases such as tuberculosis and hepatitis than do other members of the communities they enter. It is also a fact that, as refugees acculturate to life in the US, they tend to fall prey to many of the chronic diseases that plague the American poor: diabetes, hypertension, obesity, and other conditions that require ongoing care. Members of this population are often predisposed to psychiatric symptoms and disorders due to their exposure to war, state-sponsored violence and oppression, internment in refugee camps, displacement to a new country, loss of family members and prolonged separation, low socioeconomic status, and unemployment. In addition, they must adapt to new societies that almost always present an unfamiliar language and culture.

Gaining access to western health care is complex and difficult for new immigrants. Many seek to combine traditional remedies from their own culture with standard American treatment. As the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care states:

> The increasing diversity of the nation brings with it a host of opportunities and challenges that are experienced with increasing frequency and immediacy in health care facilities, from small rural clinics to large urban medical

> centers…personal efforts are usually not enough to overcome the common organizational barriers presented by mainstream health care organizations. These barriers affect how diverse patient populations navigate their health care and how health care organizations and providers deliver that care [2].

The following are some of the most significant barriers faced by foreign-born new arrivals to the US :

1. Language barriers. A recent civil-rights complaint claims that the lack of basic translation services at 4 New York City hospitals endangers immigrant patients and violates state and federal law [3]. While many states require that interpreters who work in the judicial system must complete certified training, few states require the same for those who work in the medical field. The use of untrained interpreters who are bilingual, but who may not know much about anatomy, physiology, pharmaceuticals, or medical terminology is generally insufficient. Few hospitals or clinics provide prescription labels in languages other than English, making compliance with medication all but impossible. Some recent immigrant groups, eg, Somalis and Hmong, have relied for generations on oral traditions of sharing information and have only recently developed written languages, a cultural fact that renders them functionally illiterate in their new home.

2. Cultural barriers. Most developing countries do not use an appointment system for delivering health care services. Instead, people who are sick go to the doctor and wait to be seen. Many people have no tradition of going to the doctor when they are well and find it difficult to understand why that is recommended here. Many patients expect that a pill or a shot will cure whatever is wrong with them, thinking that, in America, certainly there is medicine to cure everything. While many are familiar with infectious diseases that were common in their former home, they know little about chronic disease. Health behaviors and attitudes may be influenced by cultural and spiritual norms of accepting one’s fate as God’s will. In many cultures elders or family members are the decision makers and must be consulted for any important medical matters that can compromise treatment and frustrate time-constrained American physicians. These elders often base their decisions upon the needs of the community as a whole in addition to what is best for the individual. Overall, patriarchal thinking is common, and talking about sexual health is taboo. These many differences in health-related behavior can delay and complicate care in the Western system.

3. Logistic barriers. The ability to maneuver through the bureaucratic and administrative maze commonly found in modern hospitals and clinics is essential for accessing clinical resources. Navigating these systems is not easy for many of us who were born here, and for the foreign-born these complex networks can cause feelings of confusion and hopelessness. Western medicine works best for the compliant, sophisticated user who has time to spare and understands that he or she must go to 1 room for a blood draw, another room to get a prescription, and yet another to see the doctor, only to get a referral to see a specialist.

Unreliable transportation systems, inflexible work hours, and night time or multiple shifts make it difficult for most newly arrived foreign-born workers to keep strict Western style medical appointments. This is compounded by the fact that minority patients are more likely than whites to live in communities with fewer physician offices [4].

4. *Societal barriers*. Many foreign-born refugees feel marginalized in American mainstream society, sensing they are not a part of it and acknowledging that they do not understand it. Physicians and community workers must work actively to develop respect for varying languages, skin color, personal beliefs, and cultural traditions in order to deliver sensitive and effective health care services. The Institute of Medicine report, Unequal Treatment, concurs with this line of thinking:

> Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patient's insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants…[5].

Some foreign born, especially those who are undocumented, may avoid seeking health care until illness or injury has reached emergency levels, hoping to avoid contact with "the government" or "the system" for fear of deportation.
Last year Minnesota concluded a 2-year Immigrant Health Task Force that looked into improving health care for the immigrants of Minnesota. The task force came up with 8 recommendations for improving access to and higher quality of health care for immigrants [6].

1. Provide equal access to care for all, regardless of immigration or insurance status.
2. Collect information on race, ethnicity, and language preferences of all patients and on health care organizations' ability to meet the needs of immigrant patients.
3. Eliminate financial disincentives to health care for recent immigrants.
4. Diversify the health care workforce to include more immigrant and minority providers.
5. Use trained interpreters.
6. Develop clinical guidelines and best practice orders for immigrant health care.
7. Use community health workers, bilingual, bicultural individuals to serve as a bridge between the health care system and immigrant patients.
8. Train physicians and other staff on immigrant health issues and best practices and teach immigrant patients how to navigate the Western health care system.

These recommendations, the rationale behind them, and the practical steps listed in the full report offer guidance in focusing efforts to effect change. While implementing these recommendations presents significant challenges, projects at every level raise awareness and build capacity for next steps.

References

1. Ewing W. *Economic Report of the President.* Washington, DC: US Government Printing

Office, February 2005.
2. US Department of Health and Human Services Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report.* March 2001, Washington, DC.
3. Bernstein N. Language Barrier Called Health Hazard in ER. *New York Times.* April 21, 2005. C-20.
4. Ku L, Matani S. Left out: immigrants' access to health care and insurance. *Health Aff.* 2001;20:247-256.
5. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care.* Institute of Medicine: Washington, DC; 2003.
6. Minnesota Department of Health Refugee Health Program. Available at: http://www.health.state.mn.us/divs/idepc/refugee/immigrant/immhealthrpt.pdf. Accessed June 23, 2005 .

Additional Resources
www.hmongnet.org. This site serves as a gathering place for references to Internet resources and is aimed at anyone seeking more information about the Hmong people.

www.learnabouthmong.org. A unique multicultural education site devoted to teaching about the Hmong experience for the purposes of promoting cross-cultural awareness and understanding. *Learn about Hmong* is also intended to provide greater exposure to the Hmong folk arts tradition.

http://www.diversityrx.org/HTML/DIVRX.htm. Diversity Rx. Promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities.

http://www.omhrc.gov/clas/. Recommendations for national standards for culturally and linguistically appropriate services (CLAS) in health care. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

www.Ethnomed.org. This site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle or the US, many of whom are refugees fleeing war-torn parts of the world.

Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, Solberg MM, eds. *Healing By Heart, Clinical and Ethical Case Stories of Hmong Families and Western Providers.* Nashville, Tenn: Vanderbilt University Press; 2003.

Fadiman A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures.* New York, NY: Farrar, Straus and Giroux; 1998.

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Medicine and Society

Hope Is a Public Health Resource: the Collective Challenge of "3 by 5"

by Aaron Shakow

Over the last 2 centuries, technology has brought different regions of the world closer together. Trends like urbanization and cross-border migration—often consciously promoted through national economic policies and international treaties—mean that people, goods, words, and ideas are circulating further and more rapidly than ever before.

Unfortunately, the negative consequences of this large scale social and economic change seem to weigh as heavily in the balance as the positive. Entrenched inequalities within and between countries often contribute to development that is pathogenic in character rather than therapeutic. We see that integration of the human community can spread illness as well as healing, destruction as well as hope. The ancient aphorism that "God provides the cure along with the disease," rings hollow in many poor countries where the medicines developed to combat emerging infectious diseases are either unavailable or unaffordable.

The HIV/AIDS pandemic is both a high profile example of this troubling state of affairs and a significant factor in perpetuating it. Of the 8 key areas in the Millennium Development Goals, 6 are being undermined by the high rates of HIV in poor and middle-income countries [1]. The latest estimates suggest that in the last year alone, approximately 4.9 million human beings became newly infected with HIV, and 3.1 million died of AIDS. Some 39.4 million people are now living with the virus, whose cumulative death toll since the first cases were identified in the early 1980s is now well over 20 million [2].

The toll of AIDS morbidity and mortality is geographically and sociologically uneven. The situation is particularly frustrating because, while a cure for the disease still eludes medical science, there are nevertheless good tools to slow or arrest its clinical course. AIDS is unusual in the history of epidemics because proven, effective ways of interrupting the course of the disease have existed since shortly after its emergence. Those methods, however, are foreclosed to most of the world's population. Of the world's unmet need for antiretroviral therapy (ART), an estimated 72 percent is in sub-Saharan Africa and 22 percent is in Asia, accounting for more than 9 out of 10 people in need of treatment.

Treating the sick appears to have significant epidemiological consequences. After the clinical efficacy of "triple therapy" was first demonstrated in the mid-1990s, the Brazilian legislature guaranteed all AIDS patients in the country—regardless of their financial or legal status—access to necessary medications for HIV treatment, including ART. Between 1995 and 1999, AIDS-related mortality in Brazil dropped 50 percent, incidence of new cases declined sharply, and prevalence was cut to half the rate projected in 1992 [3,4]. Eight years after the program was initiated, a cross-sectional study of patients in treatment at public HIV clinics in Rio de Janeiro showed rates of response and adherence to ART comparable to rates reported by more developed countries [5].

Beginning with the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS), an emerging international consensus on the urgency of fighting the pandemic inspired sharp increases in funding. Resources channeled through the Global Fund to Fight AIDS, tuberculosis, and malaria, and later through bilateral programs such as the US President's Emergency Initiative for AIDS Relief, marked a new era in international public health. This sense of possibility led WHO, UNAIDS, and their partners to challenge the UN system and the global community as a whole. Launched in late 2003, the "3 by 5" project aims to make make ART accessible to half of those in immediate need of treatment in each high burden country—an estimated 3 million people worldwide—by the end of 2005.

The announcement of "3 by 5" came from a widespread sense that inequalities in access to AIDS treatment and care have unacceptable economic, political, moral, and epidemiological consequences. Driven by grassroots community activists, the renewed commitment by UNAIDS and WHO was both an admission of guilt by the international system for its tardy response to the crisis and a grim recognition of the need for an accelerated response, with clear outcome measures helping to assess the strategy's success and failure.

The "3 by 5" target is founded on 4 key principles: (1) urgency; (2) accountability through consensus interim targets; (3) simplified diagnostic and program tools; and (4) treatment as a core element of the response. It is important to stress that while treatment is the most concrete element of the intended goals of "3 by 5" it is not the only goal. Treatment provides a clear focus and an inspiration for the communities hardest hit by the epidemic and the international community as a whole, but this will only be effective within the framework of a comprehensive public health response, including chronic care infrastructure and prevention of further transmission. For example, treatment programs cannot expand without effective measures to scale-up testing and counseling—which is equally important for preventing HIV transmission at the population level.

From the outset, "3 by 5" has been driven by a sense that we must begin immediately to move towards universal access to HIV care, treatment, and prevention. It recognizes that the best way to do so is to agree upon clear, measurable targets at the country level. The natural history of HIV and the political history of AIDS demonstrate that any delay in confronting the disease makes the task progressively more daunting. Early interventions, by contrast, can provide large cost savings to the public sector and prevent devastating losses of human capital [6].

A comprehensive response including treatment, care, and prevention is inevitably expensive. Despite significant price declines for antiretroviral medicines in recent years (a generic 3-drug regimen can now be procured for as little as $150 per patient per year, although generally costs are much higher), even the lowest price exceeds per capita health expenditure in many countries, both from private and public sources, sometimes by an order of magnitude.

Although drug costs have gotten most of the publicity, they are by no means the only barrier that people in developing countries face when attempting to secure access to HIV-related services. In much of the developing world, the community-level infrastructure necessary for public outreach by health professionals and diagnosis of those infected has been undermined by sharp cuts in government health sector spending over the last 2 decades. This impedes not only care and treatment but also proven prevention strategies such as community outreach to promote monogamy and condom use, harm reduction for vulnerable populations, and diagnostic testing and counseling. Moreover, while "triple therapy" can encourage a shift from acute to chronic care models, the absence of a cure requires that the commitment to the patient be lifelong. For most high-burden countries, meeting that challenge alone is inconceivable.

The sustainability of programs designed to fight the HIV/AIDS pandemic must therefore be thought of as global in scope. If financing and technical support are not forthcoming to adapt existing clinical and public health tools to conditions in high-burden countries, those tools will remain accessible only to a fortunate few. Such a failure of international political will would not only deny millions their fundamental right to benefit from the advances of science, but would set back social development in high burden countries by decades and would undermine political and economic security for all countries. However, a transnational program model for HIV/AIDS interventions demands unprecedented cooperation among high burden countries, donors, providers, and community members—including people living with HIV/AIDS.

The "3 by 5" deadline is now 6 months away, and, as might be expected given the range of countries affected by the AIDS epidemic, rates of HIV/AIDS program expansion have varied widely. In many countries, such as Zambia, Malawi, Uganda, Botswana, and Thailand, infrastructure and collaborative frameworks have been implemented that now allow hundreds of thousands of people to access a level of medical care that, just months ago, was unimaginable. By throwing an antiretroviral lifeline to communities and individuals ravaged by AIDS, the "3 by 5" target has given us a crucial insight: hope is a public health resource. Countries fractured by the epidemic have united under the banner of treatment access, emphasizing how much effective treatment, care, and especially prevention depend on active mobilization by all sectors of society.

Meanwhile, under the pressure of "3 by 5" many technical and organizational challenges to expanding AIDS interventions have come into focus. The acute care model that still dominates the health sector in most resource-limited settings simply does not work for AIDS. In the absence of magic bullets, fighting AIDS requires new systems.

After effective dialysis revolutionized the approach to diabetes and other causes of renal failure in the 1950s and 1960s, health systems in industrialized countries underwent a similar shift. Increased access to effective HIV treatment is predicated on improvement in health worker training, clinical referral systems, drug supply chains, community outreach, and other facets of an integrated response. These systems are not unique to HIV/AIDS—"3 by 5" has jump-started a process that can make lasting contributions to the healthcare infrastructure in developing and transitional countries.

Understanding the reasons for success and failure of HIV/AIDS interventions in different settings is critical as we race to meet the December deadline set by the "3 by 5" strategy. Perhaps more importantly, that understanding is key to the real aim of ensuring universal access to HIV treatment, care, and prevention. The lessons learned so far have reinforced our certain knowledge that social, economic, and technological development do not happen easily or automatically. They are not the responsibility of any single country, organization, or individual. They are a collective project of the human community.

References

1. UN Millennium Project. *About the Goals.* Available at http://www.unmillenniumproject.org/goals/index.htm. Accessed June 27, 2005.
2. WHO, UNAIDS. *AIDS epidemic update.* Geneva, Switzerland: World Health Organization, UNAIDS; December 2004.
3. Oliveira-Cruz V, Kowalski J, McPake B. The Brazilian HIV/AIDS "success story": can others do it? *Trop Med Int Health.* 2004;9:292-297.
4. Rüppel J. *Universal and Free Access to Antiretroviral Therapy: the Experience of Brazil.* Paper presented at: Access to ART in Developing Countries workshop; August 24-26, 2001.
5. Hofer CB, Schechter M, Harrison LH. Effectiveness of antiretroviral therapy among patients who attend public HIV clinics in Rio de Janeiro, Brazil. *J Acquir Immune Def Syndr.* 2004;36:967-971.
6. Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva, Switzerland: World Health Organization; 2001.

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Op-Ed

Wrong Turn: The Wayward Path of Health Care Reform

by Jonathan Oberlander, PhD

Optimism is a justifiably rare commodity in health policy. After all, the history of health care reform in the United States has time and again vindicated the pessimists. Efforts to enact national health insurance have come and gone for almost a century, leaving each successive generation of reformers casting about for new solutions (or recasting old ones) to break the impasse [1]. It can hardly be reassuring to those willing to renew the fight that some of our most skilled presidents—Clinton, Nixon, Truman—have tried and failed at the task. And while the winning political formula has remained elusive, proposals for universal coverage have languished in obscurity for most of the past decade.

What is the current outlook for health care reform? Is there any reason for optimism amidst the rising tides of uninsured and health care spending? If by reform we mean either adoption of universal coverage or moving close to that, as well as serious action to control health care costs, then reformers can prepare for more disappointment. Indeed, I believe that if one cares about expanding insurance coverage and providing health security for all, contemporary American health policy is moving in the wrong direction, even as the existing patchwork health insurance system continues to fray.

The Politics of Reform

The political system, it would seem, is badly out of touch with the worsening realities of the health care system, judging by its lack of attention to the uninsured. Why the disjunction? Current political alignments in Washington, a burgeoning federal budget deficit, tax cuts that have drained potential revenues, and a continued focus on national security issues make comprehensive health reform a political nonstarter. Even if Washington were to belatedly turn its gaze to health care reform, success is hardly assured. Looming as large as ever is a gauntlet of perennial hurdles: fragmented political institutions that make enactment of any major legislation in Congress—let alone a policy as controversial as national health insurance—difficult; intense opposition from well-heeled and well-connected interest groups invested in the status quo that trumps the weak political pull of the medically disenfranchised; and a strain in American political culture and public opinion that is skeptical of centralized authority and federal government power in social policy [1].

Given these formidable obstacles and the current political environment, probably the most that can be hoped for in the short run is tax credits for private health insurance, a strategy likely neither to control costs nor to substantially improve coverage for the uninsured. Quite simply, the amount of tax credits generally discussed is insufficient to enable much of the uninsured population (which is disproportionately low-income) to afford health insurance. There is also a chance of incrementally expanding existing public programs like the State Children's Health Insurance Program (SCHIP) or Medicaid (universal coverage for children would be 1 politically palatable version of this strategy), though for reasons discussed below this option confronts sobering fiscal barriers. More comprehensive reform proposals, such as single-payer or all-payer models similar to Germany's sickness fund system, that would impose cost controls and secure universal coverage, are presently marginalized, and there are few, if any, signs to indicate their political progress.

Eroding Coverage in Medicaid and Private Insurance

Health care reform, though—If reform means simply significant changes in health policy—is hardly dead, but, unfortunately, it's mostly going in the wrong direction. Indeed, if there is 1 trend emerging from the health care system in both public policy and the private sector, it is the movement toward eroding rather than expanding health insurance coverage.

In the public sector, Medicaid costs are rising faster than tax revenues at a time when states are still scrambling to put their budgetary houses in order following the economic downturn that began in 2001. The resulting strain on state finances—Medicaid now has surpassed education in many states as the most expensive budgetary commitment—is generating pressures across the country to cut Medicaid spending, and in some states that means dramatically curtailing enrollment. Tennessee's governor, Democrat Phil Bredesen, has proposed cutting 323 000 enrollees from the state's pioneering Tenncare program (that number may be reduced to a still sizable 226 000, depending on ongoing court proceedings) [3]. And in Missouri, legislators have enacted a bill that would end the existing Medicaid program altogether by 2008 while a state-appointed commission considers a new framework for the program; in the mean time, Republican Governor Matt Blunt has proposed dropping over 90 000 people from Missouri Medicaid [1]. Medicaid "reform" in these states, and in others that follow this path, will mean increasing the uninsured population among the most vulnerable groups in the health care system.

With recently enacted federal cutbacks in Medicaid spending, rising health care costs that make purchasing Medicaid services more expensive, pressures from growing numbers of the uninsured, and an aging population that will further strain the program's budget, Medicaid's financial future is shaky. This reality has been recognized by the National Governors Association, which is reportedly considering a proposal that would permit states to impose a greater cost-sharing burden on Medicaid recipients [5]. Yet such a move could endanger access for low-income patients who are sensitive to even modest copayments. And as Medicaid spending continues to rise, the appeal of systems with limited coverage like Utah's Primary Care Network (PCN) that redefine and contract the boundaries of Medicaid benefits will likely grow (see Judi Hilman's description of Utah's PCN in this month's policy forum) [6].

Meanwhile, in the private sector, workers and their families are losing health insurance at an alarming rate as premium costs increase and employers search for a "magic bullet" to stem the tide. The solution *du jour* (replacing managed care) is consumer-driven health care, especially in the form of Health Savings Accounts (HSAs) that are coupled with high-deductible catastrophic insurance. Advocates believe HSAs will control health care costs, but high deductibles are unlikely to prove successful in restraining spending over the long run [7] given: the concentration of medical care spending among a small percentage of patients; that HSAs don't address the diffusion of medical technology or the immense price-tag for administrative waste; and that providers and the supply-side of American medicine can be expected to respond aggressively to any slowdown in income. HSAs will, however, shift the costs of medical care directly onto sicker enrollees, who will have to pay out of pocket for their bills before they hit the catastrophic threshold (HSAs have even been proposed for Medicaid patients, a particularly ominous combination).

HSA's significance is as much philosophical as it is economic. At their core, HSAs represent a radically new vision of what health insurance should be and what type of coverage patients should have. That vision, boiled down, is of limited coverage and a shifting of the burden of rising medical care costs to patients under the rubric of "personal responsibility." In exchange for ownership over their medical care, the sick are, in financial terms, punished for being sick, an arrangement that is then justified under the theory that patients control and are thus responsible for their own health and health care. This theory can be expected to find little favor, with, say, a newly diagnosed breast cancer patient with overwhelming medical bills who has fate or genes rather than "bad behavior" to blame for her condition.

It is too early to know how far consumer-driven health care and HSAs will advance and, if they go far, they threaten to further undermine the pooling of risk in commercial health insurance [8]. But their rise may herald a shift in the terms of debate over health care reform that calls into question the meaning and purpose of health insurance itself.

Is there hope for the future?

If the thinning of health insurance coverage described above accelerates, it could paradoxically catalyze a new push for national health reform. The well-insured middle class is unlikely to take kindly to "consumer-driven" reform that cuts their health insurance coverage and increases their cost sharing, especially if economic uncertainty persists. The erosion of health insurance coverage could substantially increase the numbers and insecurity of underinsured Americans, thereby broadening the health reform coalition beyond the more politically expendable uninsured. In addition, a Medicaid financing crisis fueled by rising health costs could lead states to plead for federal action (calls that could be buoyed by businesses trying to get out from under soaring employee and retiree medical care bills) or initiate their own ambitious reforms (as Maine has done). In other words, as things get worse in the health care system, the political fortunes of health reform could actually improve.

Changing political tides from the 2006 and 2008 elections could also alter the balance of power and provide a more conducive environment for comprehensive reform. But the dire problems in the health care system will make the issue harder to ignore regardless of who is in power, especially if the "solutions" discussed above make things even worse. The stage seems set, then, for another round of the health reform debate.

Still, the United States has shown a prolonged ability to live with a health care system replete with profound inequities and staggering inefficiencies. These compelling realities have never been enough to force decisive political action. There is, as of yet, little to indicate that anything has changed.

References

1. Gordon C. *Dead on Arrival: The Politics of Health Care in Twentieth-century America*. Princeton, NJ: Princeton University Press; 1993.
2. Oberlander J. The politics of health reform: why do bad things happen to good plans. *Health Aff.* Web exclusive. Available at: http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.391v1. Accessed June 14, 2005.
3. Tenncare goes under the knife (editorial). *The Commercial Appeal* [Memphis, Tenn]. June 6, 2005; B6.
4. Young V. Blunt plans deep cuts that slash benefits to state's needy. *St. Louis Post-Dispatch.* February 6, 2005; B1.
5. Pear R. States propose changes to trim Medicaid by billions. *The New York Times.* May 9, 2005; A1.
6. Johnson K, Abelson R. Model in Utah may be future for Medicaid. *The New York Times.* February 24, 2005;1.
7. Reinhardt U. *Consumer-Directed Health Care.* Available at: http://www.nightlybusiness.org/series/ofc/Reinhardt_files/A%20PRIMER%20ON%20CDHC%20JANUARY%2020051.htm. Accessed June 14, 2005.
8. Fuchs V. What's ahead for health insurance in the United States? *N Engl J Med*. 2002;346:1822-1824.

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Op-Ed

HSAs: A Great Tax Shelter for Wealthy, Healthy People but Little Help to the Uninsured, Underinsured, And People with Medical Needs

by Mila Kofman, JD

In 2003 Congress passed legislation allowing people to pay their out-of-pocket medical expenses from a tax-exempt personal account. These accounts, called health savings accounts (HSAs), can only be opened if one is already enrolled in a qualifying high-deductible health plan (HDHP). The tax deduction for annual contributions to the HSA, interest on the deposited account balances, and other earnings (dividends, investments, interest, etc) are not taxed if the account is used for qualified medical expenses.

The new "above the line" tax deduction will benefit people in the upper income tax brackets more than it will other income earners by allowing the wealthiest to decrease their taxable income. The biggest benefit comes when the money in the HSA is not spent and grows, tax-free. Transaction and set-up fees charged by the financial institutions that manage the accounts are high [1] so people with HSAs have an incentive to limit the use of the account: minimizing fees that could diminish the tax advantage. If you are 1 of the 125 million Americans with a chronic condition, HSA tax savings are unlikely to exceed your out-of-pocket expenses. Moreover, your out-of-pocket expenses will probably be greater than they would have been under low-deductible health coverage.

But what does all this mean for the way we finance medical care? Can HSAs help uninsured people or will they create a greater underinsurance problem? Will requiring patients to make decisions about which medical procedures to pay for make them smarter consumers of health care? Can physicians rely on patients rather than health plans to pay huge bills, or will there be more uncompensated care? Stakeholders should be asking these and many other questions before encouraging the growth of HSAs. Although HSAs are projected to cost taxpayers only $7 billion in lost revenue to the treasury over 5 years, their impact on how Americans finance medical care might carry a bigger price tag and affect people's lives adversely, resulting in a decline in health, financial ruin, and limited or eventually no comprehensive coverage for millions of Americans with medical needs.

Uninsured

HSAs have been promoted as a way to address the problem of 45 million Americans without health insurance. It is unclear, however, how HSAs will help. Two-thirds of uninsured people are in families with incomes of less than 200 percent of the federal poverty level (FPL) [2] —200 percent FPL for a family of four in 2005 is $38 700. These low-income uninsured people are unlikely to have federal tax liability, so the tax advantage of an HSA for them would be 0. If a moderate-income family wanted to open an HSA and receive a tax benefit, they would need to deposit funds to open the account and have $2000 available for services not covered until the annual deductible is met; $8200 for co-insurance and other medical expenses not covered ($10 200 is the maximum out-of-pocket limit, however not all expenses count toward the limit); plus money to pay premiums for health insurance. Consider expenses for food and shelter and other necessities like transportation to work, and, financially, HSAs are not an option for low- and moderate-income people.

Forty percent of the uninsured report that their health is not very good [3]. The law does not require insurers to sell health insurance to people with past or current medical conditions. In 46 states, people can be turned down for an individual policy even if they can afford it. So, even for the uninsured with incomes above 200 percent of the FPL, coverage options remain limited.

Cost Containment or Cost Shifting?

Proponents of HSAs believe that the accounts would help contain costs by creating a financial incentive for people to avoid over-utilizing medical services. That assumption, however, is not supported by data. According to a RAND study, for example, doubling co-payments for long-term prescription drug use caused patients to decrease the recommended dose, which resulted in more frequent and longer hospital stays, including more emergency room visits [4]. Other studies have shown that, instead of a decline in over-utilization of services, high out-of-pocket expenses lead to: delays in care, medical debt, and bankruptcy. One study found that half of those surveyed with an annual deductible of $500 had problems with medical bills and medical debt (HSAs require an annual deductible of $1000 for individuals and $2000 for families) [5]. In fact, medical bills are the leading cause of personal bankruptcies in the US [6]. Instead of reducing unnecessary medical procedures, HSAs are likely to contribute to more medical debt, more personal bankruptcies, and delays in or lack of medical care for people who need it.

Neither do HSAs address the reasons why health coverage is expensive. If utilization rates decrease because of forgone or delayed necessary care, then ultimately HSAs will lead to more spending on high cost care for illnesses that could have been prevented. HSAs do not remedy the fact that a minority of people—typically the elderly and individuals with chronic conditions—account for the vast majority of health care costs. Without any mechanism for meeting the specific needs of the elderly and the chronically ill, elevated medical expenditures will remain a substantial issue.

Patient Empowerment?

Proponents assume that individuals can make informed medical decisions about their medical care and will, if forced to spend their own money. However, this assumption may not be realistic given the low rate of medical literacy in the US. There are nearly 90 million adults who have difficulty understanding and acting on health information [7]. Those who *are* capable of making decisions soon discover a disconnect between the information they need to make informed decisions and what is available (eg, it is difficult to compare the cost and benefits of various procedures because that information is not available from health plans or physicians). Even if better information were available, it would not necessarily be helpful for patients with serious illnesses. A cancer patient undergoing radiation or chemotherapy, for example, may have an hour of energy per day to take care of life's needs—cooking, cleaning, paying bills. It is unlikely there would be time to research the cheapest labs or physicians, nor would the patient always opt for the cheapest. A key premise underlining HSAs is that consumers will choose the "cheapest" options. But medical care is not like milk; if you need heart surgery, you do not shop for the "cheapest" heart surgeon but for the best one.

The HSA Threat to Comprehensive Health Insurance

When individuals are given a choice between low-cost, high-deductible coverage and more costly comprehensive health insurance, healthy people are more likely to choose the low-cost, high-deductible coverage. Thus, if HSAs become more widely available, healthy people may opt for them leaving fewer healthy people covered under traditional insurance; premiums for traditional insurance could rise as a result. Insurance works when a mix of healthy and sick are covered. Over time, comprehensive job-based coverage for older workers and those with medical needs would become more expensive and eventually disappear, absent legislative interventions to subsidize it.

Ironically, although proponents of HSAs claim to be supporters of the private market, this latest legislative intervention may help to disrupt comprehensive, job-based insurance and may ultimately lead millions of Americans to demand more real reform. The public is too smart to believe that HSAs empower the consumer. When America's consumers are asked to pay more for fewer benefits, they know that it's not empowerment but merely cost shifting and will say "we've had enough." And America's physicians should do the same, because when insurers stop paying the bills and the patients can't afford to, physicians will find it impossible to care for their patients.

References

1. Henrickson K, Holmes BJ, Brown EG, McAulay SE. *Will Health Plans Profit From HSAs? Forecast of Health Savings Account Assets and Transactions*. Forester Research. Available at: www.forrester.com/research/document/excerpt/0,7211,36469,00.html. Accessed June 29, 2005. According to this source financial institutions will make an estimated $1 billion in asset management and transaction fees by 2012.
2. The Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage in America 2003 Data Update.* Kaiser Family Foundation. November 2004; 8.
3. The Kaiser Commission on Medicaid and the Uninsured, Figure 10.
4. Goldman DP, Joyce GF, Escarce JJ, et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004;291:2344.
5. Half of insured adults with high-deductible health plans experience medical bill or debt problems [Press release]. Commonwealth Fund; January 27, 2005.
6. Himmelstein DU, Warren E, Thome D, Woolhandler S. *Market Watch: Illness and*

Injury as Contributors to Bankruptcy. February 2, 2005. Web Exclusive. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1. Accessed June 29, 2005.
7. Institute of Medicine. *Health Literacy: A Prescription to End Confusion. Report Brief.* Available at: http://www.iom.edu/Object.File/Master/19/726/0.pdf. Accessed June 21, 2005.

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Op-Ed

HSAs: More Than a (Tax) Shelter, Not Quite a House

by Carla Y. Willis, PhD

Health savings accounts (HSAs) are an encouraging development in the market for health insurance, creating a new opportunity for affordable coverage, and engaging patients as allies in managing costs and achieving high value for health care spending. While HSAs have generated a flurry of market activity and media interest since their establishment in 2004, they should not be seen as the centerpiece of a strategy to expand coverage to the uninsured, but rather as complementary to more fundamental reform. This is because HSAs fail to redress *the* central distortion plaguing the US health care system—the way the federal government currently subsidizes health insurance. Specifically, because people covered through an employer (the majority of insured Americans) effectively pay for coverage with untaxed dollars, those in higher tax brackets receive the biggest tax breaks for their coverage. This mammoth tax subsidy for health insurance—hidden and indefensibly regressive—should be restructured to provide assistance to those who most need help obtaining coverage.

What Are HSAs?

Like their precursors, medical savings accounts, and their close cousins, health reimbursement arrangements, HSAs combine a tax-advantaged savings account earmarked for medical expenses with a high-deductible health insurance plan. Lower insurance premiums offset, in-part or in-full, the amount used to fund the account, which, in turn, can be used to pay expenses before the deductible has been met. The money belongs to the account holder, and unspent balances accumulate and accrue interest, tax-free, from year to year. Should the individual or family meet the high deductible, health plan coverage kicks in, typically in the form of a preferred provider organization (PPO), with little to no cost sharing and limits on total out-of-pocket costs. Because patients are literally spending their own money (most of the time), they have greater control over their health care decisions, while assuming greater financial responsibility for those decisions [1].

Overblown claims have been made about the power of HSAs to either rescue the health care system or further erode coverage. On the one hand, HSAs can counter the forces that price health insurance out of reach for growing numbers of people, but only up to a point. On the other hand, preliminary evidence generally does not substantiate fears that HSAs attract only the "healthy and wealthy," or that they lead to widespread skimping on health care. However, the jury is still out, and it is important to take such concerns seriously and continue monitoring the situation.

The Upside

An affordable coverage option. HSAs provide a coverage option to those who prefer to purchase true insurance—protection against the financial consequences of low-probability, high-cost events—rather than coverage that, to a large extent, amounts to prepayment of anticipated and routine health care. High deductibles keep premiums down, bringing coverage within reach for many low-income individuals and families. Indeed, of the more than 1 million people now covered by HSAs, roughly a third were previously uninsured, and 40 percent have annual incomes below $50 000 [2-3].

Locus of decision-making with patients and physicians. Because people are spending their own money before the deductible has been met, high deductibles shift the locus of cost-consciousness, and thus decision making, from third-party payers to patients and those who care for them. Such cost-consciousness is a welcome antidote to the widening divide between public expectations and rising health care costs and could lessen the need for heavy-handed managed care or government controls. HSAs encourage patients to comparison shop among treatment options, as well as among physicians and hospitals. Note that only a critical mass of savvy shoppers is needed to make health care markets more responsive for everyone.

Safeguards against underutilization. Several features of HSAs protect against inappropriate underutilization of care. First, the savings account itself allows enrollees to set aside money to pay for medical expenses, particularly expenses incurred before the deductible has been met. Second, federal law requires HSA high-deductible health plans to provide a stop-loss limit on patient out-of-pocket expenses, $5100 for individuals and $10 200 for families in 2005. Someone with a chronic or expensive medical condition could find an HSA more affordable than conventional coverage because of the premium savings, out-of-pocket spending limits, and tax advantages (not to mention that they would have greater control over health care decisions).

Preventive coverage. Finally, there is an important exception to the federal requirement that patients with HSAs meet the deductible before insurance coverage is triggered: preventive care. Health plans are permitted, but not required, to cover preventive services, quite broadly defined, even if the deductible has not been met. Such “first-dollar” preventive coverage appears to be the norm for HSA plans. Even without it, having HSA coverage might encourage patients to seek health information that, in turn, prompts greater use of preventive services or adoption of healthy lifestyle habits. HSAs could also increase aversion to future costs of expensive or chronic conditions. In any case, more evidence is needed on the actual impact of HSAs on patient behavior, and on mechanisms through which such impact occurs.

Second-Order Effects

State regulatory response. Perhaps the greatest impact of HSAs will be their indirect and broad effects on health care markets, particularly on the supply side. In order to conform to HSA guidelines, a dozen or so states have recently repealed certain benefit mandates, coverage requirements that contribute to high premiums [4]. The impact of such regulatory change goes far beyond the market for HSAs, creating greater scope for affordable coverage regardless of plan type.

Price transparency. HSAs can also foster systemic change by creating pressure for greater price transparency. The current insurance system, private and public, insulates and, at the same time, bars health care professionals from competing for patients on the basis of price. In the meantime, advocates for the uninsured have launched high-profile assaults on arcane hospital billing practices that charge markedly higher rates to the uninsured than to the insured (whose health plans negotiate rates). A number of states now require hospitals to post price schedules for common services, and several large hospital systems have voluntarily agreed to do so. Thus, the interests of the uninsured and the consumer-driven health care movement are converging to make price information more publicly available.

Other types of information. Of course, informed decision making requires more than just price information. Patients need to be able to compare health care providers and treatment options (again, not everyone need do so for markets to work). HSAs contribute momentum to the development of systems to evaluate and report quality, both clinical and non-clinical aspects. Similarly, HSAs generate demand for tools to help patients make treatment decisions and manage their health.

Incentives for cost-reducing technology. Looking into the future, HSAs create incentives for the innovation of cost-*reducing* technology. It is no coincidence that the historical growth of third-party payment of health care expenses has been accompanied by many impressive but expensive advances in medicine. In contrast, cost-sensitive patients seek less expensive, better value approaches to diagnosis and treatment. For example, the lack of insurance coverage for laser eye surgery has fueled vigorous competition and falling prices in that market. New technologies and strategies that contain costs and provide value will benefit everyone, not just those with HSAs.

Potential Downsides

Selection and skimping. The potential downsides of HSAs should be neither glossed over nor allowed to overshadow the upside. A special edition of the journal *Health Services Research* examined early empirical evidence on the characteristics and behavior of enrollees in consumer-driven health plans [5]. That body of research, along with more recent HSA-specific data, provides mixed or inconclusive evidence about possible skew in enrollment toward the young, the healthy, and the well-to-do, or about inappropriate skimping on care. Any such problems are certainly not glaring.

Limited impact on aggregate costs. The majority of medical expenses are generated by a small percentage of high-cost patients, and HSAs have little to no direct influence on individual spending once the deductible has been met. These realities limit the ability of HSAs to rein in aggregate health care spending. Nonetheless, as noted earlier, HSAs can serve as a catalyst for cultural change that includes greater awareness of costs. Administrative savings are often invoked as an advantage of HSAs, but this line of reasoning rests on the questionable assumption that patients effectively keep their health care receipts stashed in a shoe box, bypassing costly claims processing unless the deductible is reached. HSAs have also been viewed as a vehicle for personal retirement savings, easing fiscal pressure on Medicare and Social Security. However, even under optimistic assumptions, projected account balances fall miles short of average medical expenses in retirement [6].

Limited expansion of coverage. Although HSAs are a step in the right direction toward expanding coverage, it is a small step. The impressive portion of HSA enrollees who previously lacked health insurance represents a drop in the bucket of the 45 million or so uninsured. Rapid expansion of HSAs would have to accelerate even more and draw heavily from the ranks of the uninsured in order to appreciably increase the rate of coverage.

A regressive tax break. For all their promise, it is an inescapable fact that HSAs (like the tax treatment of employment-based coverage) provide bigger tax breaks to those in higher tax brackets. Low-income people may find ample reason to choose HSAs despite receiving little or no tax advantage. But as a matter of public policy on health care, HSA tax breaks work in the wrong direction, lack inherent virtue, and exist merely as an enticement to prudent behavior. On a related matter, some have proposed allowing health insurance premiums for HSA high-deductible plans (or all types of health plans, depending on the proposal) to be paid for with pre-tax dollars, regardless of whether coverage is job-related. This would remove the tax bias favoring employment-based coverage, but further entrench existing inequities across income groups, thwarting efforts at more fundamental reform.

Fundamental Reform to Expand Coverage

Because workers pay no taxes on compensation that takes the form of health benefits, the government subsidizes health insurance to the tune of nearly $200 billion in foregone tax revenues [7]. The lion's share of this subsidy goes to those with the highest incomes because, again, the higher the worker's tax bracket, the greater the tax break he or she realizes. Most perversely, those who earn too little to owe income taxes get no tax benefit, and neither do people who are not offered or who decline health benefits.

It would make far more sense for the government to instead give people money to buy health insurance and to base the amount they receive on their income. This is a straightforward way of saying that the tax exclusion for employment-based coverage should be replaced with income-related tax credits or vouchers for the purchase of health insurance. Allowing sliding-scale credits or vouchers to apply regardless of source of coverage would simultaneously level the tax bias favoring job-based coverage and that favoring higher-income households. Credits or vouchers could be used within, or even instead of, the Medicaid system. Of course, they would have to be generous enough to make coverage affordable for people of all income levels and be implemented in a user-friendly way, such as being available when premium payments are made [8].

In addition to being a more efficient, fair, and transparent way for the government to support health coverage, tax credits or vouchers would allow individuals and families to choose coverage that suits their needs. Because dissatisfied enrollees could switch health plans (during open enrollment periods), insurers would have to respond to demand for ready access, high quality, and lower costs. People could choose HSAs or plans with varying degrees of managed care, and insurers would innovate new, more affordable coverage options. (The tax treatment of HSAs would have to be modified to prevent "double dipping" from both a tax-free account and a tax credit.)

A critical element of market-based reform is rationalization of the current maze of market regulations, which has inadvertently contributed to the number of uninsured. Fair ground rules would include modified community rating, guaranteed renewability, and subsidization of high-risk individuals from general tax revenues (eg, through high-risk pools or risk-adjustment), and the regulatory environment should enable rather than impede private market innovation. Both free-market mechanisms and government regulations are needed to meet societal goals of collectively financing the medical expenses of people with predictably high costs, while not unduly driving up premiums for the general population.

The swift response by individuals, employers, insurers, and states to the authorization of HSAs is testament to the power of enabling legislation to achieve market-based reform. As with HSAs, the spillover effects of tax credits would be as important as the direct ones, expanding coverage and choice through affordable, high-value insurance options. To be sure, implementing such fundamental change requires overcoming daunting political and budgetary obstacles. A reduction in the number of uninsured, in and of itself, would reduce the burden of uncompensated care borne through taxes and insurance premiums, making the situation somewhat less grim [9-10].

More to the point, revenues generated by no longer shielding employee health benefits from income taxes would go a long way toward funding tax credits and vouchers. If revoking the tax exclusion seems untenable, so too do rising levels of uninsured and widespread anxiety about precarious coverage. The worsening situation could actually embolden our political leaders to at least take first steps in the right direction, such as phasing in a cap on the amount of health benefits excluded from taxable income or starting with narrowly targeted tax credits. So, while we keep an eye on how the HSA market evolves, we must also press for more fundamental reform that brings direct relief to those most at peril of being uninsured.

References

1. More detailed descriptions of HSAs can be found at http://www.treas.gov/offices/public-affairs/hsa/ and www.ama-assn.org/go/hsaglance. Accessed June 29, 2005.
2. America's Health Insurance Plans (AHIP) Center for Policy and Research. Number of HSA plans exceeded one million in March 2005. Washington, DC; May 2005. Available at: http://www.ahipresearch.org/pdfs/HSAExceedMillion050405_full.pdf. Accessed June 29, 2005.
3. eHealthInsurance. Health Savings Accounts: the first year in review, January –

December 2004. Available at: http://image.ehealthinsurance.com/ehealthinsurance/ReportNew/0215052004HSA1stYrRev.pdf. Accessed June 29, 2005.
4. Jenkins, HW, Jr. O Health-Care Leader, where art thou? *The Wall Street Journal*, June 1, 2005; A-21.
5. Gauthier AK, Clancy CM, eds. *Health Services Research. 2004;* 39:part II: 1049-1233. Available at: http://www.cmwf.org/topics/topics_show.htm?doc_id=235966. Accessed June 29, 2005.
6. Fronstin P, Salisbury DL. Health care expenses in retirement and the use of Health Savings Accounts. Employee Benefits Research Institute Issue Brief, No. 271, Washington, DC, EBRI; July 2004. Available at: http://www.emeritihealth.org/taxexempt/assets/EBRI_issuebrief_july04.pdf. Accessed on June 29, 2005.
7. Sheils J, Haught R. The cost of tax-exempt health benefits in 2004. *Health Aff.* Web Exclusive, February 25, 2004. Available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1. Accessed on June 29, 2005.
8. For detailed descriptions of a tax credit proposal, see *Expanding Health Insurance: The AMA Proposal for Reform.* Available at: www.ama-assn.org/go/insurance-reform. Accessed June 29, 2005; Palmisano DJ, Emmons DW, Wozniak GD. Expanding insurance coverage through tax credits, consumer choice, and market enhancements. *JAMA.* 2004;291:2237-2242; and Pauly MV. Keeping health insurance tax credits on the table. *JAMA.* 2004; 291: 2255-2256.
9. Hadley J, Holahan J. The Kaiser Commission on Medicaid and the Uninsured. *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* [Issue Update]. May 10, 2004. Available at: http://www.kff.org/uninsured/upload/35965_1.pdf. Accessed June 29, 2005.
10. Stoll K, Families USA. Paying a Premium: *The Added Cost of Care for the Uninsured.* Washington, DC. June 2005. Available at: http://www.familiesusa.org/site/DocServer/Paying_a_Premium.pdf?docID=9241. Accessed June 29, 2005.

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