Special Communication

Moral Values In Health Care Reform: Implications For Family Practice

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As of October 1993 the Clinton administration had largely completed work on its health care reform proposal and released the plan officially to Congress. It is, of course, too early to tell whether Congress will enact a version of this plan and how radically the plan might be modified in the process. Nevertheless, it is worth studying both the Clinton plan itself and some aspects of the process that produced it because I want to make two points: health care reform represents a moral decision, not purely an economic or political decision; and the decision is likely to have a major impact on family practice.

I will argue that the moral values embodied in the Clinton plan are thoughtful and defensible and that the plan deserves the support of family physicians. The plan in its present form promises to create an environment in which we, as family physicians, will be allowed to provide the care that we have been trained to provide, but with much more support and reinforcement than we have been accustomed to from other parts of the delivery structure.

A good deal of my argument rests on the managed-care aspects of the Clinton plan. Even if the Clinton plan never passes or is radically changed by Congress, market forces seem to be pushing US health care rapidly toward larger managed-care systems; so in many ways the implications for family practice will remain similar, no matter who "wins" the health reform debate. I would, however, argue that a system emerging from piecemeal changes driven by market forces is unlikely to embody the most important moral values that underlie the Clinton plan.

The Problem and the Process

The forces driving the United States toward serious health reform are by now well known. It is widely agreed that health care costs are essentially out of control in the US and are claiming funds from our gross domestic product that could otherwise be used to make our nation more competitive industrially. We are not receiving an enhanced level of health commensurate with the increased money we are spending on care, and a substantial number of our citizens lack guaranteed access to any sort of care at all.

These things have been known for years. Why did health care reform suddenly become a *political* priority in the 1992 elections? Perhaps the simplest answer is insecurity of the middle class. Those who receive health insurance through their employment now no longer feel so different from the Medicaid recipients or those lacking insurance totally. They have heard many stories of families losing their health coverage because of a job change or a leveraged buyout of a corporation or of sick persons being denied coverage for their illnesses because of some small print in what had seemed to be an adequate policy (or because of how the insurance carrier renegotiates with the employer next year). The Clinton administration has made it clear that it sees this insecurity among middle-class voters as the most potent weapon on its side in this debate.

Having seen a political opportunity to press for meaningful health reform, the Clinton task force proceeded to define its role at least in part in moral terms. Of the 35 or so working groups convened in spring 1993, one was designed to address the ethical foundations of the plan, and that working group was assigned the task of drafting a general

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preamble to the entire proposal. I served as a consultant to that working group and will be drawing upon that experience in what follows.

Ethical Foundations of Health Reform

The ethics working group specified 14 moral values that it thought ought to be embodied in any national plan for health care reform (Table 1).[1,2] The group argued that these are *American* values and therefore would help distinguish any plan developed for the US from possible templates that exist in other countries, however helpful those templates might be. The group was fully aware that deep conflicts might arise among those values when put in practice (obviously, for instance, the value of containing costs will conflict with the values of increasing the quality of care and enhancing the choices of the individual consumer), but members nevertheless believed it important to point out *which* values were in conflict so that the inevitable tradeoffs could be made in an ethically responsible manner.

Both to outline the Clinton proposal and to indicate how the proposal might embody these particular moral values, I will discuss in some detail the proposed implementation of the first two major sets of values, called "caring for all" and "making the system work."

Table 1. Ethical Foundations for the New Health Care Plan.

General
Fundamental moral importance of health care
Caring for all
Universal access
Comprehensive benefits
Equal benefits
Fair burdens
Generational solidarity
Making the system work
Wise allocation
Effective treatment
Quality care
Efficient management
Choice and responsibility
Individual choice
Personal responsibility
Professional integrity
Fair procedures

Adapted from Brock and Daniels.[1]

Caring for All

Universal Access

All American citizens would receive health coverage by becoming members of the very large purchasing cooperatives called health alliances that "buy" care for their members from the local organizations of providers and hospitals, termed *accountable health plans* (AHPs). The money to buy the care, in the case of employed workers and their families, will come from payroll taxes assessed partly upon the worker and partly upon the employer; no employer would have the option of failing to provide any health coverage for workers. The costs for the unemployed would be paid for by tax revenues, including the money now spent on Medicaid (which would disappear as a distinct program).

Being a member of the health alliance determines the care one can purchase, so there will not be lower tiers of coverage for the unemployed or the poor. At least in more populated areas, each health alliance member would be provided with a list of several AHPs and would personally select the one he or she wished to join; how care was financed would not restrict choice.

Comprehensive Benefits

The Clinton goal is to mandate at the national level a benefits package as generous as that enjoyed by roughly the 90th percentile of workers at large US corporations, thus reducing the likelihood that any worker will wish to purchase additional coverage through riders or supplemental policies. Although the broad outlines of the benefits package will be set nationally, AHPs will still have considerable discretion at the local level in filling in the details of covered benefits.

Long-term care is a major problem because of its high price tag. The moral value would demand that comprehensive long-term care be part of the proposal; political realities guarantee that the fight over the plan will be all the more bitter if this high-cost item is included. Currently the goal seems to be to provide some long-term care benefits up front (such as home care) and to hope that the evolving political process will allow further aspects of long-term care to be added later.

Equal Benefits

Great care would be taken to assure that no American receives less care because of financial,

geographical, or personal illness factors. All insurers would be required to use community rating; they could not refuse to cover those with preexisting illnesses or charge them higher rates. AHPs would be required to draw a certain percentage of their clientele from among the lower-income, higher-illness populations; an AHP could not turn a profit by enrolling only the healthy, well-educated workers in the suburbs, for instance. AHPs would receive special financial incentives to provide friendly and accessible care to inner city, rural, and other populations considered to be vulnerable.

Fair Burdens

Ability to pay, rather than one's own employment status or level of health need, would determine how much one pays to support the new plan. Because Americans feel strongly that those who make personal choices which worsen their own health risks ought to be responsible for some of that increased burden to the care system (see the choice and responsibility set of values in Table 1), "sin taxes" on cigarettes and other items would pay for some of the costs of this plan.

Generational Solidarity

At first glance it might seem that this value is being undermined by the political decision not to incorporate the Medicare plan into the new system, at least at the outset. The general idea, however, is to assure that we approach difficult allocation decisions in health care as a community, committed to caring for all of our fellow members as they pass through various portions of the life cycle. To frame health care allocation issues as the old versus the young and then to resort to an adversarial, special-interest-group strategy that undermines community solidarity represent both political and moral failings.

Making the System Work

Wise Allocation

Global budgets are seen as the only reliable way to assure that costs are controllable. AHPs will be strongly encouraged to assume capitated, managed-care modes. In urban areas, where several AHPs will be competing for the same pool of patients, one AHP might be permitted to offer fee-for-service care, but the members of the health alliance who selected that AHP would be forced to make higher co-payments.

A principal feature of the new plan is to encourage primary and preventive health care in every way possible. The architects of the Clinton plan clearly believed that primary care has proved itself as the lowest cost way to provide the greatest access to personalized, high-quality care.

Effective Treatment and Quality Care

Because the benefits package, in its broad outlines, would be set nationally, the best national research could be devoted to deciding which forms of care are truly effective for various conditions. Enhanced support for primary care and outcomes research seems an inescapable part of the plan.

The purchasing power of the large health alliances is a principal guarantee of quality of care at the local level. Because AHPs cannot compete by offering lower benefits or by selecting the healthiest patient pools, they will (presumably) be forced to compete on quality; and the health alliances will be able to force upon the AHPs reasonably accurate quality audits, the results of which will be provided to the consumers before they choose whether to re-enroll or switch to a different AHP.

Efficient Management

There appears to be a deep commitment at the highest levels of the Clinton task force to eliminate the wasteful and burdensome micromanagement of medical decisions. As just noted, quality improvement and quality monitoring will be an important part of the daily function of AHPs. AHPs will also have strong incentives to function efficiently, however, and within the plan there will be many opportunities for providers to adopt those systems of monitoring and audit that are least intrusive and burdensome and that yield data of the greatest clinical utility.

Paperwork will be reduced because of the reduced number of third-party payers, and a single standardized billing form is very likely.

Some have supported a single-payer system as demonstrably the most efficient way of delivering health care.[3,4] The Clinton plan envisions a good deal of discretion at the state level, allowing experimentation with a variety of models. A state can implement its own single-payer plan merely

by mandating the formation of one and only one health alliance.

I should mention in passing that efficiency in management is a moral issue, not purely an economic or organizational issue, especially when the health care system is working within a global budget. Money spent on administrative overhead is money not available for the direct provision of care to the sick. If management is wasteful, eventually some sick persons will be denied care that is potentially of benefit to them, so that the plan can pay for the increased administrative costs.

The Role of Family Physicians

This brief sketch of the Clinton proposal reveals a number of family-practice-friendly features. Inevitably funds would be shifted more toward primary outpatient care and away from expensive tertiary and subspecialty care. Management structures designed today to keep subspecialists happy and to capture the revenues subspecialists can generate in a fee-for-service market will be replaced by management structures that, if they are not actually run by primary care physicians, at least will respond to the absolute centrality of primary care to the healthy functioning of the enterprise and to patients' satisfaction. Whenever a primary care physician can do what a subspecialist does, the economic incentives will strongly favor replacing the latter with the former.

For family practice as a specialty to take the fullest advantage of this shift in the winds of the US health care debate, three particular changes from business as usual seem essential. First, the future of US medical practice (whether driven by Clinton reforms or by marketplace pressures) seems clearly to lie in the direction of organized groups of providers. Family physicians wedded to a model of solo practice will find it increasingly hard to thrive and to exert any influence upon the larger systems.

Second, individual physicians will increasingly be held accountable for the quality of their practice, and that accountability will increasingly occur in the form of practice guidelines and other formal protocols. Instead of resisting these guidelines, family physicians should work to assure that the guidelines are based on the best scientific data that closely mirror the realities of daily practice in primary care.

Third, a reformed system will need many primary care providers to operate efficiently, especially to respond to the increased demands from more open access. There is no conceivable way that we can train enough family physicians, at least during the next 20 years, to meet fully that need. The leaders of the Clinton task force have shown themselves to be very friendly toward family nurse practitioners and physicians' assistants. To exert appropriate political influence, the family practice community must similarly regard these fellow primary care providers as potential partners and team members rather than as threats or as competitors.

Navigating Ethical Conflicts

With a capitated, managed-care model destined to be ever more firmly in control of US health care, family physicians will increasingly face an ethical tension already experienced by many of us — the tension caused by the gatekeeper role, with its conflict between the duty to advocate on behalf of the individual patient and the duty to try to lower costs and conserve resources for the entire population of patients. Some in the past have argued that the tension is so great that it is simply unethical for physicians to work within such a role.[5,6] Others have argued that physicians can deal with the tension, but only through a radical shift in their thinking and acting.[7]

Implicit in much of the ethical discussion about gatekeeping is the assumption that the sole danger for patients lies in the threat of undertreatment. Gatekeeping looks somewhat different when one assumes that the present US health care system imposes a major risk of unnecessary or harmful treatment upon many patients, so that patients often benefit from the vigilance of the primary physician-gatekeeper.[8] But, presumably, future reforms will mitigate at least some of this overtreatment risk, leaving the denial of potentially beneficial treatment as a major threat to patient well-being. How will family physicians respond to that ethical challenge?

To a great extent the ethical rules that will distinguish good from bad gatekeeping will have to be formulated once one knows a good deal more about the specific institutional contexts within which clinical decisions will be made. One can, however, distinguish some broad factors that suggest how family physicians will be better able to

deal successfully with the ethical tensions inherent in the gatekeeper role.

Training

Physicians who are trained in the subspecialist model, that more is better and that all possible rare diseases must be excluded before proceeding to treat a patient for a common condition, will have the most difficulty accommodating themselves to a gatekeeper role and indeed might be incapable of it. Family physicians function as natural gatekeepers largely as a result of how we have been trained to think and behave. We do not need to adopt a foreign mindset to keep costs lower while still providing high-quality care to our patients.[9]

Ongoing Relationships

Patients can become allies in gatekeeping — once informed of a low level of benefit they might freely consent to forgo a treatment they would otherwise have requested. They are most likely to become allies after working for an extended period with a primary care physician whom they have come to trust and who has educated them on the nature of their respective roles.

In a continuous relationship, the physician will assume different characteristics of the gatekeeper role at different times — on some occasions becoming a strong patient advocate, requesting additional care when the patient seems very likely to benefit; on other occasions recommending against an unnecessary diagnostic test or referral. Patients are much more likely to accept the gate being closed when they have seen, on other occasions, the same physician being willing to open the gate for them.

Fairness of the System

Patients who are denied access to care under present gatekeeping arrangements in the US have little reason to believe that they are treated fairly. They have no guarantee that any money saved on their care will be reinvested down the road in more care for themselves or for their families or for the care of those in even greater need.[10]

Within a reformed health care system, especially one embodying the moral values listed above, patients can be expected to have an enhanced sense of the fairness of the system as a whole. Therefore, when gatekeeping decisions are made within that reformed system, patients might have a greater sense of having implicitly consented to those decisions beforehand.

Administrative Input

Gatekeeping in general will be more ethically defensible to the degree that the physician is not influenced by intrusive financial incentives to control costs at the patient's expense. At the level of the AHP, family physicians ought to be able to exert considerable administrative pressure to assure that they are given appropriate discretion for individual clinical decisions, while still being held accountable at year's end for their overall practice spending patterns. A physician who habitually orders excess tests and treatment might appropriately be sanctioned by the system, while a physician should not be pressured merely because of one patient who is sicker and who therefore requires more expensive care.

Future Research

In the end, gatekeeping will be ethically justifiable to the extent that we accumulate solid, usable data on which medical treatments truly work for various groups of patients. A reformed health care system that diverts a greater percentage of research support toward outcomes research will create a climate in which physicians can make gatekeeping decisions with greater confidence.

Conclusion

There are many reasons for family physicians to remain cynical about health care reform, especially any reform that incorporates as many untried elements as the Clinton proposal. The recent performance of the resource-based relative value scale is merely a case in point. Family physicians were promised that at long last the gap in reimbursements between us and the subspecialists would be narrowed, but in practice the system seems to have had exactly the opposite effect.[11] It is easy to assume from these experiences that the rich and powerful forces within US health care will never get out of the way and allow family medicine to assume the influence that it rightfully ought to have.

This cynicism, while understandable, could rob family medicine of its best opportunity to help to shape the reformed health care system. Enthusiastic and strong support for the Clinton proposals

from family medicine could help to show the policy makers which physicians are ready to move into the future and which are mired in the past, which physicians value high-quality patient care and which value their own pocketbooks, which physicians are prepared to work collaboratively and which want to circle the wagons to defend their traditional privileges. Perhaps if family medicine sets the right example of leadership, our subspecialist colleagues will surprise us by rising to the challenge and showing that they too wish to be part of something better for our patients, even at the cost of some personal loss of income.

The recitation of the ethical values that underlie the proposals for reform is designed to show that enthusiastic support is far more than currying favor with the political forces who are temporarily dominant within our country. Rather, it is a rediscovery and reaffirmation of the moral values that probably led all of us first to seek a career in medicine and later to elect to train in family practice.

During the entire history of our specialty, family physicians have been used to swimming against the current.[12] We knew that what we did was good and that our patients needed and wanted it, but too often the systems within which we worked seemed to value everything but what we did. A proposal for a major overhaul of US health care now comes along, promising to encourage us to provide the sort of care we were trained to provide while opening its doors to the entire community and allocating more resources for us to use to meet patients' needs. I believe that we should become enthusiastic advocates for this plan and should help to articulate the moral foundations upon which our support rests.

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