

Improving Access to Health Care: *A Consensus Ethical Framework to Guide Proposals for Reform*

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As the American system of health care delivery strains under the weight of erratic coverage, inefficiency, and uncertain quality, proposals for how it should be reformed have proliferated.¹ Some proposals focus primarily on improving quality, others on restraining costs; all, directly or indirectly, address access to health care.² We present a consensus framework for eval-

uating how well a proposal addresses the issue. While access is affected by a number of factors (geography, distribution of providers, and so on), for this essay we focus primarily on ethical issues in access to health care coverage.

The framework emerges from the work of the multi-stakeholder Ethical Force Program, which uses a standardized process derived from well-accepted methods for generating consensus on clinical practice guidelines and measuring quality in health care.³ The program is a collaborative initiative led by the Institute for Ethics at the American Medical Association. It was established in 1997 “to improve health care by advancing ethical behavior among all participants.”⁴ It is motivated by the beliefs that ethical standards are fundamental to health care systems that are effective and trusted, that all stakeholders in health care should be accountable for their ethics, and that stakeholders must work together to ensure that shared ethical standards are widely promoted, understood, and followed.⁵ The program functions as a national quality improvement organization for health care ethics. As such, it produces an array of reports and tools that all stakeholders can use to assess and improve the ethical environment of health care.

The method by which it produces consensus statements has been described in detail elsewhere.⁶ In brief, it runs as follows. An oversight body provides guidance on all programmatic activities. (For a list of the members, see the accompanying box.) The oversight body comprises a diverse group of leaders from all aspects of health care delivery, including clinicians, patients, provider organizations, purchasers, and others. The AMA holds two seats on the oversight body; the Agency for Health Care Research and Quality, the American Hospital Association, The Joint Commission, and the National Committee for Quality Assurance also hold permanent seats. The remaining seats are filled to three-year terms by vote of the oversight body, which seeks to ensure diverse perspectives and involvement. To determine consensus on recommen-

Mark A. Levine, Matthew K. Wynia, Paul M. Schyve, J. Russell Teagarden, David A. Fleming, Sharon King Donohue, Ron J. Anderson, James Sabin, and Ezekiel J. Emanuel, for the Ethical Force Program, “Improving Access to Health Care: A Consensus Ethical Framework to Guide Proposals for Reform,” *Hastings Center Report* 37, no. 5 (2007): 14-19.

Table I
Ethics and Access to Care:
Ethical Obligations and Recommendations to Guide Reform of the Current System

1. Every member of society must have an adequate array of core health care benefits.

This obligation is derived from a number of core ethical values, including compassion, justice, and equality of opportunity. It is also supported by economic, political, and social considerations.

Recommendation

1.1. Reform should be comprehensive and simultaneously address access, cost, and quality issues.

2. The contents and limits of health care benefits must be established through an ethical process.

Defining an “adequate array of core health care benefits” is central to ensuring universal access. This obligation acknowledges that setting limits fairly is a requirement of an ethical health care system.

Recommendation

2.1. Reform should adhere to a detailed ethical framework for how to ensure fair coverage decisions (see Table 2).

3. The health care system must be sustainable.

No society can devote unlimited resources to health care; therefore restraining cost increases is an ethical obligation. While health care holds special importance in society, ensuring universal access over time should not come at the undue expense of other core social goods and services.

Recommendations

3.1. Reform should include a process to set goals for the allocation of shared societal resources to health care, which should incorporate explicit measures of total societal costs of health care; total societal costs of preventable ill health; and total societal benefits derived from health care.

3.2. Shared resources for providing core health care services for all should be explicitly defined in order to determine the content of the core benefit package.

3.3. The health care system should be revisable and responsive to changing circumstances.

3.4. Universality should not be sacrificed to achieve sustainability; excluding individuals or populations from access to the core health care benefits package should not be used to restrain cost.

4. The health care system must ensure that its stakeholders have clear responsibilities for which they are accountable.

This obligation derives from the ethical principles of autonomy and beneficence, which are intertwined with the core American values of justice and individual and social responsibility.

Recommendations

4.1. Reform should recognize both individual and societal responsibilities for providing resources toward health care.

4.2. Reform should encourage patients, practitioners, and health care organizations to use health care resources efficiently.

4.3. Reform should promote quality health care and provide incentives to carefully monitor and improve quality.

4.4. The system should include mechanisms to monitor and reduce waste, fraud, inequitable use, overuse, underuse, and other misuses of health care resources.

4.5. The system should encourage practitioners, providers, patients, and communities to engage as partners in health care, and it should encourage mutual respect, healthy lifestyles, adherence to treatment plans, active self-management, and effective communication for better health.

dations, the oversight body votes on whether members support each recommendation using a one to ten scale. A statement is rejected if it fails to achieve an average score of greater than seven or if any member gives it a vote of less than three.

We used this consensus process to come to agreement on four core ethical obligations for health system reforms that aim to improve access to care. We present these obligations with a number of more specific consensus recommendations that follow from taking the four ethical obligations seriously.

Access to Health Care as an Ethical Issue

As the number of Americans without health care coverage continues to increase, access to care is a major political, economic, and policy problem. Unequal access to health care is also an ethical issue. Most Americans understand this: 72 percent think our society should ensure universal access to

health care, and 60 percent consider it to be a moral rather than a strictly political or economic issue.⁷ We hold that three core American values are at stake: equality of opportunity, justice, and compassion.

Equality of opportunity is essential for each of us to fulfill the American promise of life, liberty, and the pursuit of happiness, and personal health is an essential ingredient to ensure opportunity.⁸ Equality of opportunity is compromised whenever identifiable subpopulations of American society are disproportionately affected by limited access to care. For instance, it belies the American ideal that all are created equal when disparities in access to care lead to consistently poorer health outcomes for specific racial and ethnic groups.⁹ In addition, the young—sometimes without coverage themselves—pay for coverage of the old. While social cross-subsidies are ethically defensible—even desirable—for health

insurance, it is inequitable for the uninsured to subsidize those with coverage.

Justice demands a fair allocation of social resources toward vital needs. It is unjust to neglect other social investment needs because our inefficient medical care system greedily consumes resources.¹⁰ The injustice is compounded when these other potential investments profoundly affect the health of Americans. Tragically, inadequate social investment in areas such as education, environmental protection, housing, and nutrition not only limits opportunities for Americans, but also reduces the health of the population.¹¹ All stakeholders—including patients, purchasers, businesses, regulators, investors, policy-makers, and health care institutions—feel the weight of poor health care access through its effects on health care premiums, productivity, and global economic competitiveness.¹²

Finally, the traditional value of compassion for the least fortunate among us demands attention to the well-known effects of inadequate access to health care on individuals and families. Compared to those with insurance, the uninsured and underinsured are less likely to see a physician when needed and more likely to forgo regular checkups and screenings.¹³ They are more severely ill when they finally seek care, receive less therapeutic care, and suffer worse health outcomes.¹⁴ Crushing medical debt related to uninsurance and underinsurance limits both individual and social opportunities.¹⁵ A compassionate society cannot tolerate such avoidable suffering.

Ethical Obligations

In view of these considerations, there is consensus within our wide-ranging group of stakeholders on four ethical obligations regarding access to health care in a just society. These obligations use the term “must” to reflect their fundamental ethical importance. From these core obligations, we derive a number of specific consensus recommendations for health system reform. These use the more permissive language “should” to reflect that they are suggested means of living up to the ethical obligations. Taken together, these obligations and recommendations form an ethical framework that can provide guidance for proposals to reform the health care system to improve access to care. (The obligations and recommendations are also listed in Table 1.)

1. Every member of society must have an adequate array of core health care benefits.

To put this point another way, every member of society deserves an adequate level of protection from illness and avoidable pain and suffering related to health problems. This fundamental obligation is plausible even given that Americans hold differing beliefs about whether health care is a right and endorse various social, religious, economic, or political values. Rather, it can be derived from the sum of the diverse though interrelated and converging ethical considerations noted above.

Universal access to a core package of health care benefits does not mean access to every potentially useful service. Accepting an obligation to provide health care services also does not argue for any particular means or method of organizing or delivering them (such as a single-payer or a mandate and voucher plan). It does, however, suggest that reform plans should be *comprehensive*, in the sense that they simultaneously address the inseparable and interrelated concerns of access, cost, and quality.

Comprehensiveness is not merely a practical consideration. It is also an ethical consideration because any effort to reform access will inevitably affect cost, quality, and the many financing and delivery mechanisms at play in health care. For instance,

changes in private coverage can lead to increased demands on public programs such as Medicaid and uncompensated care pools.¹⁶ If a reform plan to expand access is not comprehensive, it is likely to result in ethically unacceptable effects on cost and quality, or even reduced access overall. Hence, a proposed reform that fails to consider the interconnectedness of access, cost, and quality in the health care system should be judged as incomplete or ineffective at best, and deceptive at worst.

An ethical reform proposal should result in measurably improved care for those segments of society that are currently disadvantaged with regard to access, such as the self-employed, low-wage workers, the homeless, and those with pre-existing conditions, disability, mental illness, limited English proficiency, or low health literacy. Under the current system, sadly, those with the greatest need for health services often have the greatest difficulty obtaining coverage. A reform proposal would be blatantly unethical if it improved access for the well-off but failed to improve access for those who are cur-

Every member of society must have core health care benefits that have been established through an ethical process. The health care system must be sustainable, and its stakeholders must be accountable.

rently disadvantaged. A reform proposal that entails only an incremental improvement in access for a vulnerable population such as children might still be ethical, but it risks diverting attention from the larger obligation to provide universal access.

2. The contents and limits of health care benefits must be established through an ethical process.

Making decisions about the specific health care services that will be covered and under what circumstances is difficult, but it is essential to defining an “adequate array of core health care benefits.” Setting limits—what some call rationing—is necessary in the face of limited resources, and it can be accomplished ethically.¹⁷

We prefer the term “setting limits” because “rationing” implies that the only way to set limits is to predetermine each person’s fair share of resources—their “ration.” By contrast, in our prior work on this issue, we have proposed a set of five ethical expectations (namely, that limit-setting should be transparent, participatory, equitable and consistent, sensitive to value, and compassionate) and more than fifty specific recommendations for an ethically defensible process to set limits on benefits in a legitimate and accountable manner (see Table 2).¹⁸

3. The health care system must be sustainable.

The current rate of increase in societal resources devoted to health care is widely thought to be unsustainable.¹⁹ Setting coverage limits through an ethical process, as noted above, will go a long way toward ensuring sustainability. But taking sustainability seriously also means that a reform proposal would be unethical if it knowingly created or perpetuated a system with massive future payments; saddling today’s children with debts for the current care of their parents and grandparents is unsustainable and unethical.

Placing limits on individual spending on health care would be controversial ethically, economically, and politically; we do not recommend it. But setting limits on expenditures of *shared* societal resources is ethically required for sustainability. It is also incontrovertible that any reform that calls for additional expenditures of shared resources on health care will entail restricting spending on other important social goods. This relationship makes sustainable spending on health care a matter of justice.

Creating a sustainable system will require setting explicit goals for how much of our shared resources we should devote to health care, and how we should spend these resources. The goals should derive from the wide array of social benefits of health care spending, not merely from calculations of short-term costs, and they should recognize the many costs of preventable ill health to society. Since goals should be based on explicit measures of cost and benefit that will change over time, the goal-setting process will need to be revisable and responsive to changing circumstances.

Table 2
Setting Limits: Ensuring Fairness
in Coverage Decisions
Consensus Expectations

Expectation 1: Transparent

The processes for designing and administering health benefits should be fully transparent to those affected by these processes.

Expectation 2: Participatory

Organizations should purposefully and meaningfully involve all stakeholders in creating and overseeing the processes for designing and administering health benefits.

Expectation 3: Equitable and Consistent

Processes for designing and administering health benefits should result in similar decisions under similar circumstances.

Expectation 4: Sensitive to Value

Processes for designing and administering health benefits should take into account the net health outcomes of services or technologies under consideration and the resources required to achieve these outcomes.

Expectation 5: Compassionate

The design and administration of health benefits should be flexible, responsive to individual values and priorities, and attentive to the most vulnerable individuals and those with critical needs.

Each expectation is accompanied by a set of consensus recommendations for policies and actions to ensure fairness in health care coverage decisions. Details are available at www.EthicalForce.org and in M.K. Wynia and A.P. Schwab, *Ensuring Fairness in Health Care Coverage: An Employer’s Guide to Making Good Decisions on Tough Issues* (New York: AMACOM, 2006).

In addition, tensions between sustainability and universality must be recognized. While placing limits on the core benefits package is ethically appropriate—even necessary—placing limits on which members of society can access these core benefits is not. It would be unethical, indeed nonsensical, to try to sustain universal coverage by dropping individuals or groups from coverage. Instead, when cost reductions are needed, they should be accomplished by changes in benefit design or pricing, or through improvements in the efficiency of care delivery.

4. The health care system must ensure that its stakeholders have clear responsibilities for which they are accountable.

This final ethical obligation ties the others together and further highlights how access, cost, and quality are intertwined ethically because accountability should encompass all of them. Recognizing broad-based accountability as an ethical issue means admitting, for example, that using shared health care resources in a wasteful or suboptimal manner is not only uneconomical, but also unethical.

All stakeholders in health care—including patients—should be held to a balanced system of accountability for the effective and efficient operation of the system. For patients, reform plans should encourage healthy lifestyles and patient and community engagement to improve adherence to agreed-upon treatments and self-care. An ethical system should accomplish this by understanding and addressing the many factors that can influence lifestyle and health behaviors. However, programs that impose a blunt sort of “accountability” on patients—for example, penalizing “nonadherent” patients by removing their access to certain services²⁰—are treading on ethically thin ice.

Plans to impose additional accountability on patients should be carefully designed and monitored to ensure that they do not harm the most vulnerable. Some patients might be more likely to miss appointments exactly because they are in need of additional services, such as mental health care, child care, or transportation. And it is clearly unethical to hold patients accountable for issues over which they have little or no control. Finally, schemes that call on health professionals to report “nonadherent” patients to authorities (who might then reduce the patient’s health care coverage) are also problematic.²¹ Such schemes might damage the trust that is the foundation of the patient-physician relationship.²²

For professional accountability, we recommend that assessments of the quality and outcomes of care be built into system-wide, integrated performance monitoring mechanisms. Realistic and meaningful performance measures for providers should include measures reflecting ethics²³—such as equity, efficiency, and patient-centeredness—as well as clinical quality. Moreover, just as it is important to hold patients accountable only for factors they can control, individual professionals should be held accountable only for clinical factors they can control. Accountability for measures that are a shared responsibility should be shared among the responsible parties. For instance, both hospital-managed systems and physician decisions are responsible for many clinical outcomes of inpatient care. An ethical system of performance measurement should promote high-quality care by rewarding teamwork in such situations.

Like programs for patient accountability, professional accountability programs should also be carefully designed and monitored to ensure that they do not disadvantage high-risk individuals or populations or the providers who care for them.²⁴ Such system-wide accountability can be fostered by regular assessments of the health outcomes of vulnerable populations relative to others.²⁵

Providing access to health care for all is one of the most critical and widely discussed social objectives in America

today. Yet the policy debates now occurring at the local, state, and federal levels, as well as in the private sector, often seem to be driven by widely divergent ethical principles or to lack a coherent ethical grounding. We hope that a shared ethical framework, accepted by a diverse group of key health care stakeholders, will prove useful as disparate parties necessarily come together to make progress toward universal access.

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