

By JUDITH FEDER, PhD

The Role of the Professional



Dr. Feder is dean, Policy Studies, Georgetown University, Washington, DC. This article is adapted from the transcript of a talk she gave to the Negotiating the Healthcare Market with Integrity Conference.

The problem of the uninsured in the United States is, first and foremost, a moral problem. I believe our goal should be to live in a society in which no one is unable to get health care because he or she cannot pay for it. Achieving that goal means that everyone should have health insurance. We are a sufficiently wealthy nation to make health insurance available to everybody. What follows is a discussion of the policy choices we need to make to achieve this moral objective, the politics necessary to ensure that the choices are made, and the political roles and responsibilities of health care professionals themselves.

Looking at a few facts concerning the uninsured will help us put the policy issues into perspective. About 80 percent of the uninsured are working, most of them full-time.¹ About 70 percent of uninsured workers lack coverage because their employers (or family members' employers) do not make insurance available to them.² More than half of the uninsured have incomes below twice the poverty level, which is about \$16,000 dollars for an individual and about \$28,000 dollars for a family of three.³ Without employer coverage, such people simply cannot afford an insurance policy that costs, on average, \$2,300 for an individual and \$6,000 for a family.⁴ For older adults or people with pre-existing conditions, the price is even higher.

The extraordinary national prosperity of the late 1990s did not make health insurance more affordable. In fact, those several years of enormous prosperity failed even to fix the decline in employer-sponsored coverage we saw in the late 1980s and early 1990s. Low-wage workers in particular bore the brunt of that decline and, despite recent improvements, smaller proportions of low-wage workers are covered today than were covered a decade ago.

Moreover, public programs have significant gaps in their ability to address this problem under current law. Medicaid, which was designed as a part of the welfare system, distinguishes between "deserving" and "undeserving" poor and is directed primarily at children, along with the recently enacted State Children's Health Insurance Program (SCHIP). To some extent,

the mothers of such children are also covered, mostly when they are pregnant. In theory, Medicaid allows states to cover parents, but in 32 states those parents who earn the minimum wage earn too much to be eligible for Medicaid benefits. And under the federal Medicaid statute, childless adults are not eligible for Medicaid, regardless of their income—unless they are disabled or otherwise unable to work.

Public recognition is growing that large numbers of people will remain without insurance coverage unless federal policy changes and the government intervenes. Neither prosperity nor the market will solve the problem. And the evidence of the past tells us that, without government intervention, people who lack insurance coverage will get less health care, will get care later, and as a result will be more likely to suffer poor health or die because of it than people who are part of the insured population.

GOOD NEWS, BAD NEWS

The good news is that President Bush has recognized lack of health insurance as a problem that needs policy intervention. He has proposed providing the uninsured the money they need to purchase insurance through a tax credit geared toward the low- and modest-income population. Although some question whether a tax credit—as against, say, expansion of Medicaid—is the best way to reach low-income people, the fact that the administration recognizes that *some* kind of public subsidies are needed is a definite plus. Until this year, the other good news was that the federal budget had a surplus that could be used to support those subsidies. But the bad news is that tax cuts have largely eliminated the surplus and the uninsured remain relatively low on the list of claimants on available federal resources. Why is that so? Generally speaking, most Americans have health insurance coverage. The Clinton administration, when it talked about the need for health care reform in the early 1990s, often noted that many people are only one paycheck away from losing their coverage. If the economy again deteriorates as it did in 1991-1992, people at risk of losing their employer-sponsored coverage will get

scared again. They will then recognize that this is a situation anybody can fall into.

However, whether we see a new recession or not, low-wage people are disproportionately likely to find themselves without coverage. As far as health insurance is concerned, the United States has an "us" and "them" situation. The "us," the vast majority of working Americans, have coverage through their employers; those who are left out, the "them," are a disadvantaged minority. In political terms, we need to find a way to get the money from "us" to pay for "their" coverage. Put another way, we need to get the money from those of us who vote, to give to those who do not.

This us-versus-them situation dates back at least a half century. Employer-sponsored coverage began to expand after World War II and did, in fact, take care of most working Americans. In the 1960s, Medicare was developed to take care of retirees. The creators of that program originally hoped it would be the first step toward national health insurance, covering the entire population, but their plans were frustrated. The nation did develop Medicaid for children and (sometimes) their mothers. As yet, there is no social consensus that the rest of the uninsured population matters very much. That lack of consensus is why we are where we are today.

THE PROVIDERS' ROLE

The role of health care providers in today's political constellation varies from organization to organization. Some providers as organized groups—such as the American Hospital Association and the American Nurses Association—are fairly good about advocating expanded coverage. The strongest advocates tend to be nurses, pediatricians, internists, family physicians, and the unions for the health care workers.

There is a difference, however, between advocating a position issue rhetorically and being willing to put your money where your mouth is. It is easy enough for providers to voice support for expanded coverage—and quite a different matter for them to put all their political resources behind it.

Expanded coverage is not a top-tier issue for many associations; indeed, their top-tier issues usually relate to their members' incomes. They tend to be focused on Medicare payments because Medicare is the largest payer for health care in the public sector. Some providers care about Medicaid, but since most do not get much money from Medicaid, they don't care much about it.

For example, we can say that organizations representing hospitals obviously care about the

rates they get paid. Those representing teaching hospitals care not only about the standard payment rates for Medicare beneficiaries but also about the way graduate medical education is treated. Nurses' groups care about whether advanced practice nurses are able to bill independently of physicians. Groups for home health agencies care enormously about the rate home health agencies get paid. Psychologists care about whether they get paid on the same basis as psychiatrists. There are no particular good guys here. Every organization is out to protect the economic interest of its membership, which is what one would expect them to do.

Providers' concerns about their revenue compound the difficulties in finding resources to

Why Doesn't the United States Have Universal Care?

After Judith Feder, PhD, finished her presentation to the Conference on Organizational Ethics, she took questions from the audience. Here are two questions she fielded.

Why doesn't the United States have universal health care for all its residents? Is this the fault of economic pressures?

Economic pressures certainly limit the delivery of care. Look at uncompensated care, for example. The money to pay for it has got to come from somewhere—or else it simply will not be given. Some institutions provide as much uncompensated care as they can. But many others do not. I don't believe that a health care system that ultimately relies on altruism is ever going to live up to the social commitments that I would advocate. If we truly want everybody to have health care, then it is incumbent upon me as a member of society to help pay for it.

Could you explain why some hospitals seem uninterested in expanding coverage to the uninsured? After all, they provide care for such people.

Any hospital naturally wants to get paid for every person it treats. If that were all that is involved in expanding care for the uninsured, all hospitals would be for it. Unfortunately, the package is rarely that neat. Most hospitals don't do a lot of charity care, and they limit the care they do provide. They can thus control their liabilities for the uninsured. What interests them more is the reimbursement they receive for the patients they do serve—Medicare patients, for example. Medicare is bread and butter for such organizations. Hospitals cannot refuse to serve Medicare beneficiaries. Thus their political priorities: They care much more about what they are paid for Medicare than they do about expanding coverage. A bird in the hand is worth much more than a bird in the bush, as the old saying goes.

Then, too, when policies are developed to cover everybody, as they were under the Clinton health care reform plan of 1993-1994, those policies include mechanisms to contain costs for those who are already insured, as well as to expand coverage to those who lack it. The Clinton proposal was quite aggressive in the efforts it envisioned to slow down the rate of growth of payments for the currently insured. Providers, looking at their bottom lines, thought they had more to lose than to gain from the expansion of coverage under the Clinton plan.

The moral of this story is simple: In order to get everybody insured, the United States must be willing to put new money into the system to pay for coverage for everyone without it.

finance coverage expansions. Not only do their organizations devote more energy to payment issues than to expansion of coverage; they are also likely to oppose expansion proposals that would partially finance new coverage by limiting payments to providers. As a result, we cannot count very much on provider organizations to help us solve the problem.

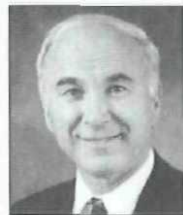
Though we may forget it, each of us is in one way or another a part of the health care system. That being so, we must look beyond our private interests toward the kind of society we want to live in. Considering one's *social* interest is critical if one intends to take an ethical role in a public policy debate. Individuals must recognize what it is they are willing to give up. The thing given up may be money—settling for a smaller Medicare payment, for example. But it may also mean giving up the

time and energy needed to hold one's professional organization and political officials accountable for achieving the goal one believes in. If we really believe in it, we will make that sacrifice. ■

NOTES

1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey," *EBRI Issue Brief*, no. 217, Employee Benefit Research Institute, Washington, DC, December 2000.
2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6, pp. 142-149.
3. Paul Fronstin.
4. J. Gruber and L. Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, vol. 19, no. 1, pp. 72-85.

By Sr. TERESA A. MALTBY, RSM, DMin, & JOHN F. TISCORNIA, MBA, CPA



Sr. Maltby is a member of the Leadership Team, Sisters of Mercy of the Americas, Regional Community of Chicago; Mr. Tiscornia is U.S. director of Andersen's Healthcare Practice.

The Dynamics of Value

In closing her keynote address to last spring's conference on integrity in the health care market, Ann Neale, PhD, challenged the health care community "to make of the market a graced instrument through which we advance the noble ends of health care." Earlier in her address, Neale named some of the fundamental differences between the approaches of a pure market economy driven by self-interest and the classic concerns for human need and the common good that have traditionally guided a member of the medical profession.

On one hand, Neale noted, is the pure market philosophy, which holds that "all goods and services, including health care, are fungible products that can be bought and sold. Nothing has intrinsic value." On the other hand, she observed, medical people have a "calling, a quasi-religious commitment" to their profession. Self-interest and material advancement take second place to the concerns of patients and community, social concerns with intrinsic value.

Within Catholic health care, the distinction between the two approaches has often been cast in terms of a tension between profession/ministry and margin/market. Given the fundamental

differences in perspective, Neale said, tension between ministry and market is inevitable in the health care setting—but there should be no question which is dominant. The teachings of the Catholic Church make it clear that "the economy and production are for the good of the person and the community, and not the other way around."

To better serve the community, Neale said, Catholic health care must develop new models for managing its business. The ministry needs approaches that, first, open the way for more productive dialogue between ministry and the market and, second, reshape the way Catholic health care organizations allocate their time and money. As an example of such an approach, she cited the new "Value Dynamics" economic model developed by Andersen Worldwide SC.*

Like any other business, a health care organization creates value by making the most of its assets. Fundamentally, the value of a business is the value of its assets, both tangible and intangible. This value is determined by the marketplace and reflected in a for-profit's stock price and in the cost of borrowing for a not-for-profit.

The balance sheet—the traditional way of mea-

*Value Dynamics is a registered trademark of Andersen Worldwide SC.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September-October 2001
Copyright © 2001 by The Catholic Health Association of the United States
