

CHAPTER 7

TIERS WITHOUT TEARS: THE ETHICS OF A TWO-TIER HEALTH CARE SYSTEM

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THE American health care system is a mess. The cost of the system has increased to nearly \$2 trillion, over 16 per cent of the GDP (Levit et al. 2004; Smith et al. 2006). At least 45 million Americans are uninsured, while over the last few years more than 5 million jobs have lost health coverage (Holahan and Cook 2005). The demands of Medicaid are forcing the states to cut other services, especially education, forcing tuition hikes at public universities, and prompting states to consider ending Medicaid entirely (Coughlin and Zuckerman 2005; O'Dell and Goodwin 2005). The Medicare Trust Fund will be empty by 2020, and, according to the Medicare Trustees, enormous change is needed immediately to establish fiscal balance in the next seventy-five years: cutting benefits by 48 per cent or more than doubling the Medicare tax (Snow et al. 2005). While it may not be inevitable or imminent, escalating insolvency makes health care reform seem more probable. Indeed, leading conservatives including former Senate majority leader Bill Frist, Representative Bill Thomas, former chair of the House Ways and Means Committee,

and Bill McGuire, chief executive of United Health Group have publicly called for comprehensive health system reform to repair inefficiency and under-coverage in the current health care system (McGuire 2004; Thomas 2004; Frist 2005).

American health care reformers face a number of ethical issues, including familiar debates over the merits of a single-payer system and publicly provided universal health insurance. No matter how these debates are resolved, a further ethical question must be addressed. Both universal coverage and a single-payer system are compatible with permitting some patients to pay more for faster, better, or more health care choices. Should the United States continue to have a two-tier health care system in which wealth grants some patients access to medical services that others with the same needs cannot obtain? Critical evaluation of both principled objections to inequalities and practical objections to anticipated social and medical consequences of a two-tier health care system are needed.

DIVERGENT VISIONS

In the United States public health coverage is currently limited. Most Americans rely upon whatever insurance they receive from their employer or can afford to purchase on their own. Many American insurance products are specifically designed with different tiers of service. For more money, people can access more services, have limited prior approvals and gate-keeping, and have greater choice of physicians and hospitals.

Israel, the Netherlands, and the United Kingdom also have two-tier systems. Each provides an extensive public tier of health care that can be supplemented with market tier coverage. Patients may pay extra for private hospital rooms or longer stays, more treatment options, and faster access by jumping queues for procedures with long waiting times, like hip replacement or cataract surgery. In Israel as much as 70 per cent of the population purchases additional coverage (Boaz Lev, personal communication, 2006).

Norway and Canada strive for a single tier of health care, though, short of draconian restrictions, completely eliminating the influence of wealth in health care may be impossible. For instance, wealth allows the affluent to obtain medical services out of country that are unavailable to their compatriots. Nevertheless, Norway and Canada each have explicitly egalitarian systems that prohibit a private market for any services covered by their universal national health care plans. However, in the 2005 decision *Chaoulli v. Quebec*, Canada's Supreme Court ruled some of Canada's egalitarian restrictions on health care distribution to be unconstitutional, requiring the expansion of private markets for health care. Ethical controversy in Canada pits those who support 'equal access for equal needs' against those who defend a

tiered health care system that allows some medical services to be distributed by the market (Flood and Sullivan 2005).

Reformers in America must consider whether it just for a system to allow a market tier of health care services, a tier in which a set of services or amenities are available only to those who can afford them. Do Canada and Norway's prohibitions on payment for greater access to medical care provide an ethical model that the United States should follow? Does the two-tier British and Israeli model offer a more just alternative? **What are the ethics of a two-tier health care system?**

The remainder of this chapter reviews the main ethical arguments against a **two-tier health care system, and then presents a rebuttal of those arguments** (Table 1). The chapter concludes that justice not only permits but requires America to retain two tiers of health care, though significant changes are required in order to meet five criteria for an ethical two-tier system.

OBJECTIONS TO A TWO-TIER SYSTEM

Opponents of a market tier usually begin their objections by noting that health care is special. Health is 'a necessary condition for pursuing nearly all the goals around which we organize our lives' (Brock and Daniels 1994). Health care is a universally recognized need and is central to the opportunities involved in leading a normal human life (Scanlon 1975; Walzer 1983; Daniels 1995). **Without good health it is difficult to achieve and enjoy valuable ends: rich family life, meaningful work, the arts, nature, athletics, hobbies, and leisure.** This makes access to health care more important than access to other resources. As Descartes claimed more than 400 years ago, 'the preservation of health is undoubtedly the first good and the foundation of all the other goods in this life' (Descartes 1988: 143). While market influences on many goods may lead to inequalitarian outcomes that are nevertheless ethical, such inequality is unjust when it comes to matters as fundamentally important as health.

This conclusion is often left to stand on its own; however, it might be motivated by several considerations:

Only Need Matters

Bernard Williams argues that wealth is morally irrelevant when it comes to **distributing health care (1962).** Justice, notes Williams, requires treating relevantly similar cases alike, and relevance, he claims, is determined by the goal of the activity in question. In hiring a lawyer, the goal is finding qualified representation, so experience is a relevant difference but race is not. In grading students, the goal is to assess academic achievement, so demonstrated knowledge is the relevant difference

TABLE 1 Objections to a two-tier health care system and replies

Objection	Description	Response
Only need is relevant	Need should be the basis for distributing health care. Wealth is not a relevant basis for the distribution of important services	Justice requires providing a certain level of medical services to all, but the liberties of health care workers cannot be ignored. Since providers have valid claims to compensation, patients' need cannot be the only morally relevant consideration
Level of opportunity	Health must be restored for people to have a fair level of opportunity. This requires ensuring universal access to all medical services, or exhausting all public and private funds in the attempt	Health is not the only important good, and beyond a certain point further taxation and the resulting economic inefficiency limits more opportunity than it restores
Equality of opportunity	Only an equal share of opportunity is fair, and medical benefits increase opportunity. Therefore, there must be equal access to medical services	The priority of the health care system should be improving health, not equalizing it by lowering everyone to the level society can afford
Difference principle	Inequalities are only just when they are to the benefit of the worst off. A market tier of health allows inequality that does not benefit the worst off	The difference principle permits people to earn and spend unequal shares of wealth on desirable goods because it provides incentive for economic efficiency that benefits the worst off
Public good	Public funds extensively subsidize the health care system, so medical services must be equally available to all members of the public	Public health care subsidies are partial, and even full public ownership does not require that services be free or equally available
Undermining	A market tier will undermine access to health care for the disadvantaged by reducing physicians' incentive to treat the poor and by limiting the incentive of the upper class to support adequately funding public health coverage	Undermining is avoided by meeting the five criteria outlined for an ethical health care system, including public funding for universal non-means tested coverage with an adequate core benefits package

but sex is not. In treating a patient, the goal is preserving and restoring health, so medical need is the relevant criterion for distribution, but wealth, race, and sex are not. A market tier is 'straightforwardly the situation of those whose needs are the same not receiving the same treatment, though the needs are the ground of the

treatment' (Williams 1962: 122). Like racial or sex discrimination, a market tier is unjust because it allows different treatment for relevantly similar patients.

Fair Opportunity

A strong entitlement to health care is most often defended by appealing to the principle of fair or equal opportunity (Daniels 1995). Rawls famously defends one version of this principle, which states that before any market produced social or economic inequalities can be just, they must be 'attached to offices and positions open to all under conditions of fair equality of opportunity' (1999: 266). Rawls argues further that society must take positive steps to ameliorate 'social contingencies and natural fortune' that arbitrarily stand in the way of opportunity (1999: 63). Ill health seems to be one component of natural fortune that arbitrarily limits opportunity. Someone who is sick will not have the same opportunity to attain advantaged offices or positions as someone who is healthy.

Fair equality of opportunity may be construed with emphasis on the *level* of opportunity or emphasis on the *equality* of opportunity. Daniels takes the former approach to health care, and Rawls has endorsed his general method (Rawls 1996: 184). Daniels holds that there is an absolute level of health—'normal species functioning'—that allows for fair opportunity when met or exceeded. Some might argue that if species' typical functioning is required for fair equality of opportunity, economic inequalities cannot be just until society does everything possible to eliminate deficits in normal species functioning; in effect to eliminate ill health. After meeting this requirement, there will either be no medical advantages over the public tier that a market tier could provide, or there will be no disposable wealth left with which to pay for them.

Alternatively, some hold that what matters for fairness is not the level of opportunity but rather that everyone have an equal share of opportunity. To the extent that health care improves health and increases opportunity, allowing a market tier of health care is unjust because it enables those who are already privileged to achieve an even more unequal share of opportunity.

The Difference Principle

Rawls argues that once fair equality of opportunity has been achieved to the extent possible, inequalities are regulated by what he calls the 'difference principle'. The difference principle states that economic and social inequalities must be 'arranged so that they are . . . to the greatest expected benefit of the least advantaged' (Rawls 1999: 1972). Unequal distributions are unjust unless the worst off are better off with the inequality than without it. Allowing the affluent to pay for greater access to a good as important as health care is unjust because it produces significant inequality without benefiting the poor. As one commentator explains Rawls's position, a

market tier ‘effectively severs the moral and economic bonds linking the “have nots” with the “haves”. . . Whereas Rawls insists that any inequalities enjoyed by the rich should also benefit the poor’ (Arras 1981: 32).

Non-mutually beneficial inequalities of this kind are made worse by undermining the self respect of the less affluent (Gutmann 1981; Dickman 1983; Daniels 1998). Social cooperation and solidarity fosters a sense of self worth, and flourishes when the advantages of the most fortunate serve also to bolster the standing of the least. On the other hand, a market tier in health services distances the fate of the ill and wealthy from the fate of the ill and poor, diminishing social solidarity. A means tested public tier of health care imposes further indignity by requiring proof of poverty before granting access to services.

A Public Good

Two further objections are raised against a market tier of health care. Some have argued that health care workers owe their products and services to all, regardless of patients’ ability to pay, because of significant public subsidies of the health care system. In the United States tax revenue and deductions account for nearly half of all spending on health care (Smith et al. 2006). The American health care system is subsidized at every level—through funding research, construction of medical facilities, supplementing medical education, public health measures, and provision of medical services. Critics of a market tier object to making health care a public good in its creation and funding but a private, market good when distributed. It is claimed that ‘so long as communal funds are spent, as they currently are . . . the services that these expenditures underwrite must be equally available to all citizens’ (Walzer 1983: 90). And ‘it is unethical [for a physician] to take publicly-provided skills and use them on behalf of only those who can pay him whatever he charges, as though his education and skills were entirely his own to do with as he likes’ (Marcia Angell, personal communication, 2004). Those involved in the health care system are indebted to the public, and obligated to ensure that all medical services are equally available to all patients.

Undermining the Health Care System

Finally, many opponents of a market tier emphasize a practical argument: A market tier inevitably makes the level of health care services provided to the poor inadequate. It is an old adage in American politics that programs for the poor become poor programs because when the relatively affluent are allowed to purchase more, they have no reason to support funding an adequate public tier. At the same time as a market tier undermines funding for an adequate public tier, it produces greater demand for the best medical practitioners to treat the richest patients,

Two-tier doesn't let poor get proper help

'decreasing the quality of medical care received by the majority of citizens confined to the publicly funded sector' (Gutmann 1981: 552). Rejecting a market tier is necessary to ensure the poor and others in the public tier get adequate coverage.

DEFENSE OF A TWO-TIER SYSTEM

Defenders of a market tier usually begin their arguments by noting that public funds are scarce. Though the United States is a wealthy nation and can afford to spend massive amounts on health care, the fiscal instability of Medicare and Medicaid serves as a reminder that health care is expensive, and resources are inherently finite. Even wealthy nations must make tradeoffs—overtly or otherwise—between funding for health care, economic stability, and funding for other vitally important goods that government has obligations to provide: infrastructure, food, housing assistance, the environment, security, law enforcement, and education. America can no more afford to fund every possible medically beneficial service than it can afford to fund every possible highway project, educational opportunity, or security measure. This is not to say that health care costs might not be lowered by eliminating waste or fraud, or that the current level of taxation and distribution of funds is ideal. But even a rational economy would have to make tradeoffs in which needs are weighed against needs (Daniels 1995).

Were health care available in unlimited abundance, a national health care system could provide comprehensive coverage: all medically beneficial services for everyone at any time. Unfortunately, inescapable scarcity prevents everyone from getting everything they may need or want (Eddy 1994)—which, as Rawls argues—is precisely why justice is needed to determine those goods to which people are entitled (Rawls 1999). In a nation as wealthy as the United States, there is considerable consensus that people are entitled access to a broad spectrum of health care that is both fundamentally important and compatible with providing other vital goods. But while health is clearly important, this 'does not mean that all health care is of equal importance or that every beneficial service must be provided no matter how small or unimportant the benefit and how high the cost' (Brock and Daniels 1994).

Efficiency and Incentive

Scarcity and the need for tradeoffs lead Daniels to reject interpretations of his opportunity view as requiring comprehensive health care services (Daniels 1998). In making tradeoffs between public services, absolute priority should not be given to health care. This is especially true when the same amount of resources that could restore a marginal amount of species' typical functioning could protect more

opportunity for more people if spent on housing or education or some other good. After providing some level of services, society will reach a point at which further taxation and expenditure on services to promote opportunity becomes self defeating—a point at which economic inefficiency limits opportunity more than further services would restore and enhance it. A commitment to increasing opportunity requires *not* taxing every available dollar for spending on health care and other public services. This leaves medical services that are not socially guaranteed to be included in a market tier, and allows the retention of private wealth needed to pay for them.

A similar appeal to economic efficiency is at work in applying the difference principle. Rawls recognizes that allowing some inequalities is to the benefit of the disadvantaged because the prospect of greater wealth provides an incentive for greater productivity and efficiency (1999: 68). But do the disadvantaged benefit in any way if the affluent are allowed to spend their legitimately earned wealth on health care? On the face of it, there may be no direct or obvious way that the poor benefit when the rich are allowed to spend their money on most goods. This, however, is no truer of orphan drugs than of riding lawnmowers, and the difference principle permits the wealthy to spend on either for the same reason: allowing the expenditure of wealth on desirable goods is an incentive for productivity that is to the benefit of the worst off. Provided that spending money on a market tier of health care is no worse for the poor than stuffing it under a mattress, a market tier is consistent with the difference principle. The difference principle may even provide reasons to prefer that the affluent spend on market tier health care than on luxury items: additional health benefits might make the wealthy even more productive, permitting a market tier is likely to stimulate medical innovation, and the expenditure of private funds instead of tax revenue for some medical services saves the public tier money that it can devote to expanded coverage for the poor (Fried 1976; Hoel and Saether 2003).

Greater Health, Not Equal Health

A two-tier system is not compatible with a fair opportunity principle that requires equality of opportunity, but such a principle should be rejected, especially when applied to health care. In almost all cases, access to medical care is limited by fiscal scarcity, not by scarcity of material goods, like scarce vaccines or transplantable organs. When patients pay for brand name drugs or an MRI scan, they do not in any meaningful way exhaust the amount remaining; ‘as much and as good’ is left for others. Further, when fiscal scarcity limits access to a medical service, access to that service cannot simply be redistributed from those who can pay to those who cannot. In such cases, why should we prefer that the affluent spend on another luxury car than on an extra MRI? Should we also prohibit payment for other

meaningful goods that not all can afford—like side impact airbags or Ivy League educations?

It may be reasonable to prefer that, when possible, access to scarce resources be granted to the poor. But when this is not possible, as when cost is the limiting factor for access, it is perverse to regard the receipt of good things by the affluent as an evil to be avoided. To do so runs counter to the presumptive goal of the health care system to increase the health of the population, not to make everyone equally healthy, especially when this means limiting medical benefits by prohibiting access to care. The idea that we should increase equality by making some worse off and none better—the notion that if everyone cannot have something then no one can—is the basis of the powerful ‘leveling down’ objection to strict egalitarianism (Parfit 2000). Increasing equality by bringing everyone down to the level that society can afford deprives the rich of liberties and benefits without regard to helping the poor. Many share the goal of increasing equality by raising the level of health care available to the disadvantaged. However, there is at least the appearance of envy and resentment in preferring that some medical services benefit nobody than that they benefit those who are willing and able to pay for them. A just health care system focuses on whether all have enough, not on preventing the rich from getting more.

Costs are Relevant

Even if medical services need not be distributed equally, however, it is still of concern that medical services be distributed on an ethically relevant basis. Patients’ ability to pay is one morally relevant consideration for determining the distribution of care. The argument that the only relevant ground for distributing services is the potential recipient’s need leads to the notorious conclusion that ‘the only proper criterion for the distribution of barbering services is barbering need’ (Nozick 1974: 234). The contention that only need is relevant fails to recognize that service providers, and not just recipients, have legitimate claims and interests. Saint-like selflessness may be a greater virtue in medicine than in barbering, but professional medical ethics do not demand, nor would it be just for the state to require, that physicians *never* consider compensation in accepting patients for treatment. While there is room for disagreement over what constitutes fair compensation for medical services, whether fair compensation is provided is clearly a relevant ethical concern.

No Unrestricted Access to Partial Public Goods

Health care providers should be expected to provide some measure of public service in recognition of their reliance upon public support of the health care system (Astor

and Sreenivasan 2003). However, public funds have been invested in the American health care system without any agreement from or expectation that recipients of funds ensure equal access to all subsidized products and services. Further, it is not reasonable to think that participation in a system 45 per cent funded with public dollars requires health care workers to provide 100 per cent of their products and services regardless of whether patients can pay. Even if the public fully owned the health care system, Americans are reminded each time they pay the postal service for shipping that public ownership of a service provider does not require free or equal availability of the service.

Freedom of Choice

In a free society, people have the liberty to spend more of their money on enormous houses, designer clothing, travel, personal computers, and the arts. An argument claiming that private hospital rooms, shorter waiting times for cataract surgery, or Acyclovir for oral herpes are too important to be distributed by the market would, seemingly, also rule out the free exchange by market of cell phones, gourmet food, sporting goods, fancy cars, and innumerable other non-medical goods and services. At the margin, health care is simply not more important than many commodities that people should be free to buy and sell.

Among more important medical services, some require too great a sacrifice of other necessary goods to justify public funding. Education and security are fundamentally important, but this does not mean that everyone is entitled to publicly funded postdoctoral education or a personal police escort. Similarly, justice does not require socially guaranteed access to full mouth reconstruction instead of dentures, Macugen for macular degeneration, lung volume reduction surgery for emphysema, or implantable cardio defibrillators.

In distributing scarce *public* funds, justice requires consideration of the cost and value of medical services relative to other important goods. Respect for individual liberties and autonomy leads to an inherently different standard for *private* spending (Fuchs 2004). While government must avoid spending disproportionately for the value it receives in order to make prudent tradeoffs, individuals are free to spend in accordance with their own priorities. Indeed, principles of justice are devised precisely to determine what people should be socially guaranteed and what should be left to them to purchase with their own money based on their own values. Some people who are risk averse may prefer to buy coverage for every available health care service; others will prefer cooking lessons or skiing trips to a wider range of doctors or more vision coverage. So long as the objects of public and private spending are held to different standards—the state required and entrusted to make prudent policy level tradeoffs while the individual is free to pursue personal projects—there will inevitably be some medical services, including some with a substantial impact

on health, that can and should be available only if patients pay for them. As a matter of individual liberty, patients should be allowed to pay for these medical services, and physicians who have worked and studied hard should be free to meet the demand for additional medical goods (Gutmann 1981; Ames 2003).

DESIGNING AN ETHICAL TIERED SYSTEM

If the current US health care system is unjust, it is not because it has a market tier, but because it fails to ensure access to adequate health care for all Americans. The proper standard for evaluating the justice of the health care system is not whether everyone has access to the exact same services, or whether the rich can buy more services, but whether everyone is guaranteed, in a sustainable manner, an adequate set of benefits—a core benefits package. In a nation with America's resources, universal coverage with a core benefits package is affordable, morally imperative, and compatible with allowing a market tier of health care (Emanuel and Fuchs 2005).

A market tier would not simply be an add-on operating in parallel to an adequate public system. There are complex interactions between the market tier and the public tier that have unfortunately been subject to little empirical analysis (Hurley 2001). Largely without the benefit of data, critics have nonetheless reasonably speculated that a market tier could undermine public coverage for the poor. On the other hand, there is good reason to think that steps can be taken that would prevent a market tier from weakening the public system, and potentially even strengthen it by increasing medical innovation and reducing the public burden of paying for the health care of the affluent (Fried 1976; Hoel and Saether 2003).

Problems arise in America's two-tier system because the public tier is viewed as a safety net for the unlucky few who slip through the cracks in what is regarded as normal market tier health coverage. Consequently, few have a stake in ensuring an adequate minimum tier, and doctors have an incentive not to treat public tier patients. The solution is for the public tier to provide a solid floor that serves as the norm for health coverage, with the market tier serving as a ladder upward for those who want and can afford more.

A sustainable and ethical tiered health care system should meet five criteria:

1. The core benefits package should cover an adequate level of health care.
2. The core benefits package should be guaranteed to all Americans, without means testing.
3. The core benefits package should be designed to attract a sizable majority of the population to use it without supplementation to the market tier.
4. Purchases of market tier services and coverage should be made with after tax dollars and should not provide exemption from tax obligations to support the core benefits package.

5. Easy adjustment of the core benefits package should be possible in response to changes in technology, data about efficacy, and demand for market tier services.

A tiered system that meets these criteria would dramatically decrease the incentive for doctors to serve only rich patients. With everyone covered by adequate health insurance, treating patients from the 'lowest' tier would no longer be a financial burden, and limiting a practice to the market tier would rarely be fiscally sound; only a small minority of physicians could be financially successful catering to the 'rich and famous'.

Political difficulties would also be avoided by making the system non-means tested, ensuring that a substantial majority of citizens have a stake in socially guaranteed service. A universal core benefits package would offer benefits to everyone, and even the minority who choose to pay for market tier services will pay less for supplemental health insurance than they would for a full health insurance plan. While means tested welfare programs face an uphill battle for popular and political support, non-means tested Medicare and Social Security enjoy broad popularity, despite the ability of recipients to upgrade with Medigap insurance and private retirement savings. Allowing a market tier would be a political strength rather than a liability (Pauly 2004).

Any concerns about the impact of tiering on social solidarity and self respect should also be allayed by a system in which the majority utilizes the public tier for their healthcare needs. Indeed, Americans prefer and regard two tiers with an adequate minimum as the most just structure for the health care system (Frohlich and Oppenheimer 1992). Eliminating means testing circumvents the need for patients to prove that they are poor in order to receive benefits, and stigma associated with the public tier would cease when the public tier is the norm.

The criteria offered are general and require elaboration. What is an adequate core benefits package? It should begin with services that, given a fair share of society's wealth, many people would pay out of pocket to cover for themselves (Eddy 1991; Nord 1996; Dworkin 2000: 307–50; Danis *et al.* 2002). Such a core benefits package is likely to ensure that a small proportion of Americans buy market tier services. Importantly, determining the threshold level of participation for a sustainable universal public tier will be a challenge for policy makers who have speculated but produced little data on the topic (Rashi Fein, personal communication, 2005). While encouraging widespread use of a publicly provided core benefits package should not be difficult, the requisite threshold level of participation can be sustained by providing incentives to rely upon the core package and disincentives to buy into the market tier: eliminate the current tax exemptions for purchasing more health coverage, ensure diverse choices in the core benefits package, keep co-pays low in the core benefits package, or potentially tax higher tier medical care. A single-tier

system is not required to ensure adequate health care for the poor. Indeed, of the top ten rated health care systems in the United Nations' equality oriented 2000 World Health Report, all ten allow a significant market tier (World Health Organization 2000).

CONCLUSION

What sort of replacement should Americans want for their troubled health care system? Many who are rightly concerned with the ethical foundations of the American health care system look to Canada and Norway's prohibition of a market tier of health care as an ethical model for the United States to emulate. This egalitarian approach, while well intentioned, is unjust. People should not be concerned that some of their neighbors might have 'too much' access to health care, but rather that many of their neighbors might have too little. A better example is provided by Britain, the Netherlands, and Israel's two-tier systems with universal public coverage. Limited resources prevent the public from paying for access to all health care for all people at all times. Allowing a market tier of medical services above an adequate but necessarily finite universal public tier preserves freedom of choice and achieves more equitable health care by improving access for the disadvantaged, not by limiting access for the affluent. Many questions remain for American health care reformers, but on the question of tiering, justice calls for a two-tier health care system.

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