VIEWPOINT

Ethical Issues in Healthcare Financing

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ABSTRACT

The four goals of good healthcare are to relieve symptoms, cure disease, prolong life and improve quality of life. Access to healthcare has been a perpetual challenge to healthcare providers who must take into account important factors such as equity, efficiency and effectiveness in designing healthcare systems to meet the four goals of good healthcare.

The underlying philosophy may designate health as being a basic human right, an investment, a commodity to be bought and sold, a political demand or an expenditure. The design, policies and operational arrangements will usually reflect which of the above philosophies underpin the healthcare system, and consequently, access.

Mechanisms for funding include fee-for-service, cost sharing (insurance, either private or government sponsored) free-of-fee at point of delivery (payments being made through general taxes, health levies, etc) or cost-recovery. For each of these methods of financial access to healthcare services, there are ethical issues which can compromise the four principles of ethical practices in healthcare, viz beneficence, non-maleficence, autonomy and justice (1, 2).

In times of economic recession, providing adequate healthcare will require governments, with support from external agencies, to focus on poverty reduction strategies through provision of preventive services such as immunization and nutrition, delivered at primary care facilities.

To maximize the effect of such policies, it will be necessary to integrate policies to fashion an intersectoral approach.

Keywords: Ethics, healthcare, financing mechanisms

Problemas Éticos en el Financiamiento de la Atención a la Salud

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RESUMEN

Las cuatro metas de la buena atención de la salud son: aliviar los síntomas, curar la enfermedad, prolongar la vida, y mejorar la calidad de vida. El acceso a la atención a la salud ha sido un desafío perenne para los proveedores de atención a la salud, quienes tienen que tener en cuenta factores importantes tales como la equidad, la eficacia y la efectividad a la hora de diseñar sistemas de atención a la salud que permitan alcanzar las cuatro metas de la buena atención a la salud enumeradas arriba.

La filosofía subyacente podría definir la salud como un derecho humano básico, una inversión, un artículo que puede ser comprado y vendido, una demanda política o un gasto. El diseño, las políticas y las disposiciones operacionales normalmente dirán cuales de estas filosofías anteriores sirve de base al sistema de atención a la salud, y por consiguiente, al acceso.

Los mecanismos para el financiamiento incluyen el pago por servicio, costos compartidos (seguro, privado o patrocinado por el gobierno) libre de pago a la hora del servicio (pagos que se hacen a través de los impuestos generales, impuestos de salud, etc.) o recuperación de costos. Para cada uno de estos

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métodos de acceso financiero a la atención a la salud, hay problemas éticos que pueden comprometer los cuatro principios de la práctica ética de la atención a la salud, a saber, la beneficencia, la no maleficencia, la autonomía y la justicia (1, 2).

En tiempos de recesión económica, brindar atención adecuada a la salud requiere que los gobiernos – con apoyo de agencias exteriores – pongan su mira en las estrategias para reducir la pobreza, ofreciendo servicios preventivos – tales como la inmunización y la nutrición – en los centros de atención primaria.

Para maximizar el efecto de tales políticas, será necesario integrar las políticas con una perspectiva intersectorial.

Palabras claves: Ética, atención a la salud, mecanismos financieros

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INTRODUCTION

The evolution of healthcare from the non-scientific to scientific medicine (3) aptly demonstrates the changing relationships between carer and user, and the origins of specialization and organizations.

Primitive medicine, which represented a move towards a set of beliefs and practices becoming the special province of a differentiated group of recognized healers, ushered in the era of the specialist. The stage was set for individual and group interest to take precedence over society's needs. This further control of knowledge became a predominant influence in determining how healthcare services were to be provided.

The traditional definition of health is set within a social context, and responses are usually in relation to these perceptions; there are thus "user expectations" and ethical considerations dimensions, which are relevant to current approaches to designing healthcare delivery systems. Within these systems and by their methods of organization, health can be seen as a human right, a political demand, an expenditure or an investment in development.

When health is seen as a human right, policy and planning actions are directed to ensuring equitable access to all the available range of services and resources in the sectors engaged in health activities.

Where political demand is the major determinant, equal access is less a feature of the system's organizational design, and more responsive to those with access to the power base and decision-makers to the virtual exclusion of vulnerable groups.

If health is seen as an expenditure, the pattern of healthcare financing reflects this by having a built-in cost recovery mechanism. The consequence of this latter approach is limited accessibility based on both willingness and ability to pay for these services with the result that where poverty is pervasive, many are denied access to healthcare. By providing different qualities of care to different social groups, scientific medicine thus served to further widen the existing gap between the poor and the wealthy and reinforced the early notion of a two-tiered healthcare system based on economic access to healthcare providers.

Bioethics/health policy ethics

Bioethics is the term used to distinguish traditional medical ethics from ethical issues, which arise from recent progress in biology and medicine. Health policy ethics concern ethical issues relevant to the organizing, financing and delivery of healthcare services.

A significant factor which has influenced the cost of healthcare in recent times relates to advances in biomedical sciences resulting in the development of new and costly medical technology.

The advances in diagnostic and treatment modalities have made interventions in these domains more accurate and provide more treatment modalities options with the end result of better prognosis and quality of life. The question is, however, how are these advances to be made available and accessible so that all may benefit from them?

Financing the health sector

Philosophically, one may agree with the notion that health is a basic human right and no one should be denied access. The reality has been that even when resources of all kinds (money, material and manpower) are in relatively adequate supplies, that nation's health status still shows that the distribution/allocation of these resources are inequitable when data are disaggregated by social class, geographical location, gender, *etc* and health indicators such as infant mortality rates. Maternal mortality rates *etc* reflect limited access to services as evidenced by morbidity/mortality profiles consistent with lower utilization levels of the available services due to a range of "barriers to access".

Real/potential barriers to access

Data/information have been available to alert us to why people become ill and what is requried to attain and manitain wellness. Good health/wellness is built upon an intersectoral approach for the provision of potable water, proper sanitation and waste disposal – these being the basic building blocks of good health, along with proper nutrition.

Improvement in quality of life among the majority of people in industrialized countries was popularly attributed, at that time, solely to medical advances. However, McKeown

challenged this perception and contended instead that provision of basic amenities such as water and sanitation, along with improved nutrition, were perhaps more important than preferential access to medical care (4). He further lamented the fact that because of this misconception, it had become the fashion to employ resources in a manner which bolstered personal medical care systems, this resulting in the misuse of resources and distortion of the role of medicine. It was McKeown's further view that for most diseases, prevention by control of their origins was more cost-effective, more humane and more effective than intervention by more expensive treatment after the occurrence of the disease. Implicit in this dissertation are ethical issues related to affordability (to state and individuals) and equitable access.

Affording equitable access to good quality health

Healthcare is an expensive item in terms of achieving universal coverage and meeting minimum standards of quality with the requisite resources. Competing demands from other sectors have put pressure on the per cent gross domestic product (GDP) which a government needs to allocate to the health sector. Challenges to balance equity with efficiency and effectiveness involve trade-offs between the sometime "rhetoric" of policy enunciations and translation into programmes. Invariably, when planning is guided by priorities and prioritization, some programmes are less well-funded (some not at all) and the consequence of this is that usually vulnerable groups are most adversely affected.

In recent times even when governments continue to contribute a reasonable share of GDP to the health sector, it is not enough to provide universal coverage. Additional taxation to bridge the gap is a finite measure since taxes *per se* will not yield adequate sums to forestall the need for fees to be charged to provide and/or access these services.

Cost sharing/cost recovery

The experience has been that a significant portion of the population is unable (and may be unwilling) to pay for basic health (primary healthcare). This requires that governments identify its indigent population and be prepared to underwrite this cost and provide a safety net for this group.

This approach is the basis of a national health insurance system, which will require co-payments for a specified set of services (basic/essential healthcare). Usually, a health insurance scheme requires that employed persons contribute *via* salary deductions, then a minimally agreed amount is paid by the patient at the point of delivery of the service. This system discriminates against the unemployed, and to some extent the under-employed and self-employed who again, may be unwilling or unable to pay fees however small they may seem.

When this system fails, health conditions, which are eminently suitable for treatment at the primary care level, will worsen without timely interventions and in a majority of cases, may well require more expensive hospital-based care. National health insurance schemes may cover one or the other level, *ie* primary care *versus* hospital care resulting in an economic barrier to access to one or both.

The cost-effective approach where both cannot be accommodated, or the funds will partially support both, priority should be the given to primary care with strong support from health education and health promotion programmes. Arresting disease progress by promotive and preventive interventions have the potential to reduce demands for hospital services and perhaps reduce the overall cost for providing the more expensive curative services.

Sources of finance for healthcare

The most important source of financing for the health sector is the government; there are four principal sources of finance for the health sector: governments, private sources, health insurance and external sources.

Government financing for healthcare includes health expenditure at all levels of government. User fees, whether for government-provided or for privately-provided health services, are an out-of-pocket payment and are therefore considered as health finance from another source.

Whereas user fees are direct payments, indirect payments by large and privately owned industrial complexes or sharing of healthcare costs are also examples of private financing.

Health insurance is a mixed source of financing as contributions are made by both employers and employees, and sometimes from government.

Another major source of financing for healthcare is from multilateral and bilateral aid donors. The fact that health systems rely on more than one source of financing makes the achievement of health policy goals more complex (5).

The ethics of healthcare financing

Those who pay for healthcare, *eg* the government and private insurance industry, have great influence in the distribution of medical care. This "power" raises important ethical issues, *eg* an insurance company rather than the attending physician can determine what kind of medical care can be received. Premiums usually cost more for groups with higher risk of illness; in essence, people with chronic diseases are less likely to be able to purchase afforable health insurance. This can be regarded as a violation of the justice principle because those in most need of services have the least chance of gaining access to affordable services.

Light is of the opinion that it is unfair to force one person or group to pay for the needs of others – mixing low-risk persons with high risk persons will mean that low risk persons would have to pay higher rates (6).

Distributive justice, however, holds that young and healthy people should pay more in health costs than they use in health services so that older and less healthy persons can receive health services at a reasonable cost. It makes sense to

pay more for healthcare while young and healthy, and to pay less when advanced age creates a greater risk of becoming sick (7).

The way forward

The principle of justice refers to universial rights of persons to receive basic needs and to have equal opportunity to realize their human potential.

Allocating resources fairly within the concept of distributive justice does not follow a formula, *eg* should the proper formula be "to each according to ability to pay", or "to each according to need"?

In allocating costs, should each person pay an equal share or should those with greater wealth pay more? The social-ethical dilemma is the conflict between the individual's (patients) rights to autonomy and society's claim to distributive justice (recognizing that resources for healthcare are limited and should be fairly allocated among the entire population). This can result in physicians denying legitimate services or patients having to forgo rightful claims (7).

Some policy recommendations

Poverty reduction should be based on increasing savings and improving efficiency in resource allocation with the ultimate aim of expanding productive employment opportunities for the poor and at raising incomes. Redistributive policies should be aimed at providing basic social services to the poor, *eg* primary healthcare, sanitation, family planning, nutrition, primary education and basic housing.

To maximize the effect of such policies, it is necessary that they be properly integrated. Preference should be given to preventive care to address common diseases of underdevelopment. By reallocating state subsidy to healthcare, the redistributive impact of the subsidy can be enhanced by increasing the budgetary allocation to the health sector to support preventive services and rural development (8).

Economic recession makes it unlikely that the solution to providing adequate healthcare lies in economic recovery in the short to medium term. The increase in unemployment invaribly leads to growth in the informal sector and increased demand for welfare and public health services.

Governments' commitment to poverty reduction strategies with support from external aid will be important to maintain an acceptable standard of well-being. External aid should be tied to national efforts to reduce poverty and to provide healthcare to the poor, *eg* rural health facilities that serve the poor through immunization and nutrition programmes.

Decentralization should address the issues of inefficient bureaucracies, waste, lack of effective accountability and supervision – all of which have militated against success in the past (9).

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