Ethical Insurance Advising II

HealthInsuranceCE
2025

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Introduction and Overview

Our healthcare system costs $12,000 per person per year, about double other developed countries. But we're last internationally among the 17 richest countries in life expectancy and infant mortality. These trends – spending more than others but getting less benefit for our spending – have continued for decades.

How do we get out of this mess? And how can brokers operate ethically within it? What should you tell your clients? What should you advocate for?

This course focuses on ethical issues raised by single payer healthcare systems, things like Medicare and the VHA or proposals for Medicare for All or similar. We have a near-constant drumbeat for some sort of single payer healthcare system, especially when a new report comes out showing our simultaneously excessively expensive but disappointingly underperforming healthcare system. Is a single payer, Medicare for All like system the way out? We'll explore some ethical issues involved.

A previous course entitled Ethical Insurance Advising I performed the same service – evaluating ethical issues raised – by a deregulated commercial healthcare system. We won't review that information here.

Our ethical point of departure

In this course, we will adopt the classic utilitarian definition of ethics as the greatest good for the greatest number of people. This comes from the English utilitarian school of philosophy led by John Stuart Mill and Jeremy Bentham.

Utilitarians call for maximizing the overall amount of wellbeing in a community. Actions are ethical if they generate more wellbeing and unethical if they generate less or the counterpart, more suffering and pain.

Utilitarian ethics is particularly poignant in health insurance. The entire community (more or less) pays into the system via insurance premiums or taxes. The government, another word for 'the overall community', funds or subsidizes healthcare in several ways including:

- Direct payment of medical care for Medicare, Medicaid and some other programs.
- Favorable real estate tax treatment of hospitals.
- Subsidies or grants for medical research.
- Subsidies or grants for medical education.

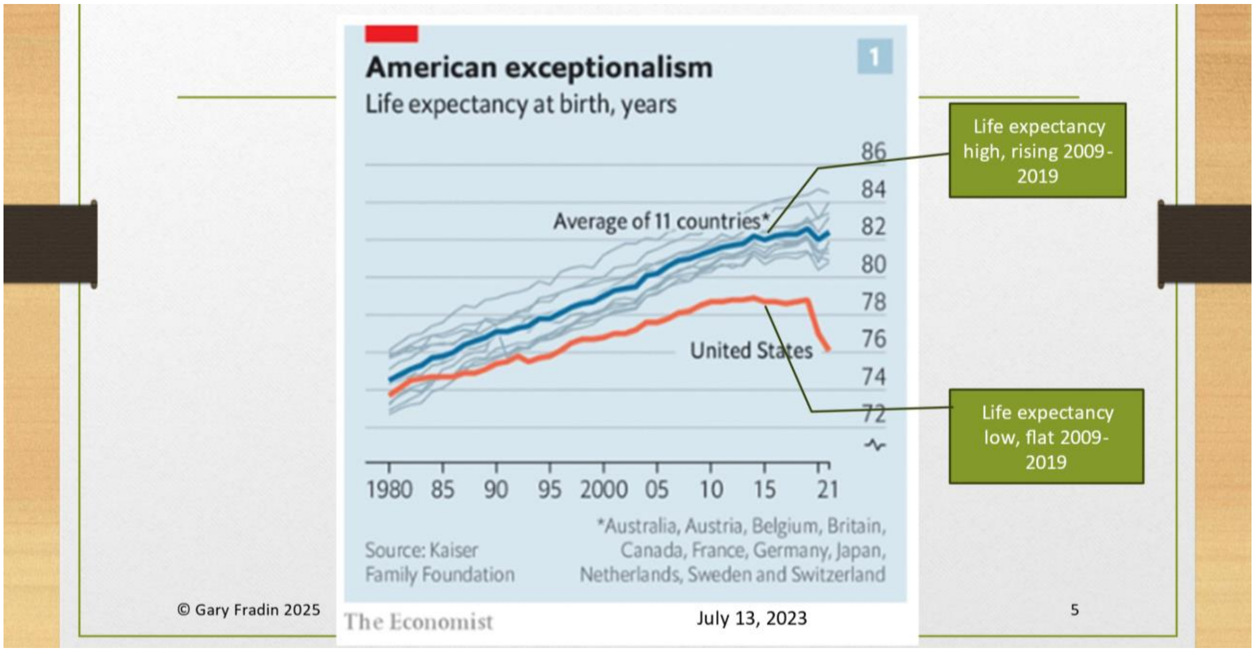
The utilitarian ethical lens thus places particular ethical responsibilities on system participants including brokers. Since everyone pays in, everyone should benefit. A system is unethical, according to utilitarians, if everyone pays in but few, if any, benefit.

> We can accuse our overall healthcare system as being 'unethical' per this utilitarian metric since it cost more in 2019 per capita than in 2009. (I use 2019 as the cut-off for

statistical clarity only; Covid that arrived in 2020 messed up the statistics for the next several years with a black swan event.) Consider these charts, from The Economist July 2023, showing flat US life expectancy compared to other counties' increasing life expectancy, and the comparative costs. Focus on the 2009 – 2019 period.

According to Utilitarians, we have a less ethical healthcare system than do Australia, Austria, Belgium, Britain, Canada, France, Germany, Japan, Netherlands, Sweden or Switzerland.

We pay more for healthcare, thus depriving / harming US policy holders and taxpayers of money to spend that they could otherwise use to increase their own wellbeing. We then live less long than other countries, thus generating less overall wellbeing in our nation. More pay-in harm, less outcome wellbeing equates to less ethical. Perhaps even unethical.



American exceptionalism

Life expectancy at birth, years

Life expectancy high, rising 2009-2019

Life expectancy low, flat 2009-2019

Source: Kaiser Family Foundation

*Australia, Austria, Belgium, Britain, Canada, France, Germany, Japan, Netherlands, Sweden and Switzerland

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The Economist

July 13, 2023

American exceptionalism

Life expectancy at birth, years

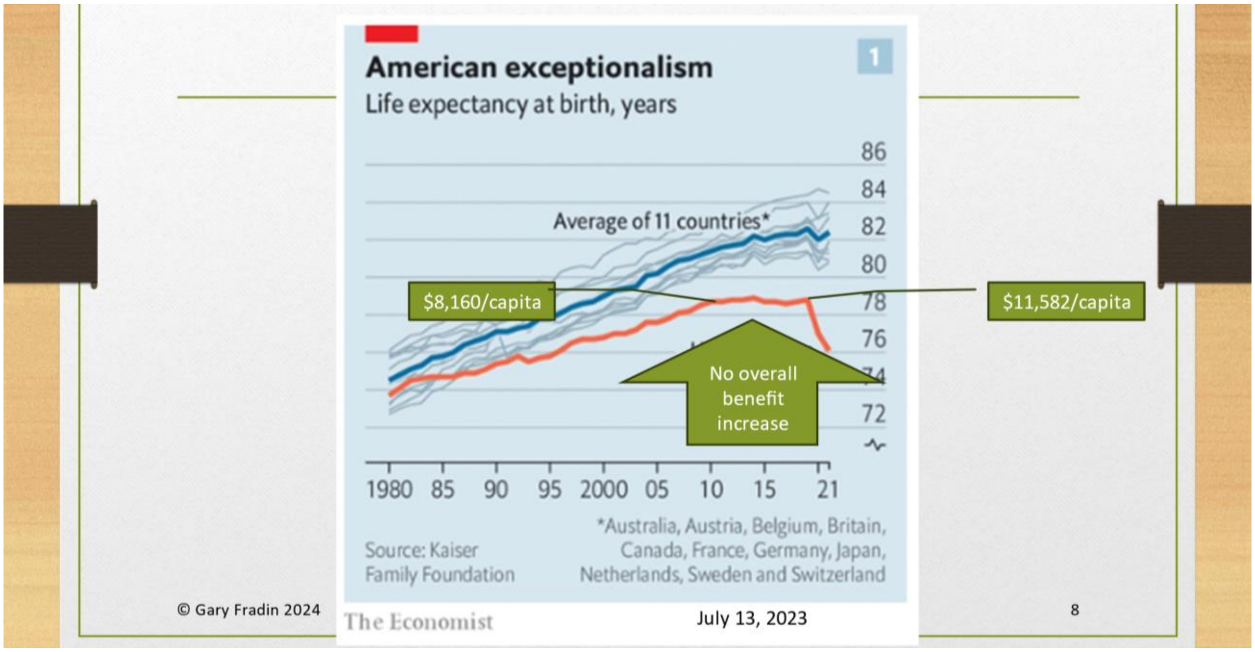
$6003/capita

$11,582/capita

*Australia, Austria, Belgium, Britain, Canada, France, Germany, Japan, Netherlands, Sweden and Switzerland

Source: Kaiser Family Foundation

The Economist July 13, 2023



American exceptionalism

Life expectancy at birth, years

$8,160/capita

$11,582/capita

No overall benefit increase

*Australia, Austria, Belgium, Britain, Canada, France, Germany, Japan, Netherlands, Sweden and Switzerland

Source: Kaiser Family Foundation

The Economist July 13, 2023

Medicare-for-all to the Rescue

maybe

Some who study our healthcare miasma call for a national single payer system. The Physicians for a National Health Program, for example, proposes a publicly financed non-profit, single payer national health program that would fully cover medical care for all Americans.[1]

The PNHP proposal in brief:

> Even after full implementation of the Affordable Care Act (ACA), tens of millions of Americans will remain uninsured or only partially insured, and costs will continue to rise faster than the background inflation rate.
>
> We propose to replace the ACA with a publicly financed National Health Program (NHP) that would fully cover medical care for all Americans, while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead. Hospitals, nursing homes, and other provider facilities would be nonprofit, and paid global operating budgets rather than fees for each service.
>
> Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets. The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs.

Dr. Brian O'Malley summarized a version of this for Massachusetts, proposed in 2023 as Mass Senate Bill S.744 and Mass House Bill H.1239, endorsed by 13 Senators and 40 Representatives: [2]

> The Medicare-for-all bills proposed in the Legislature would cover all residents for a much more comprehensive set of benefits than any private insurance with no deductibles or copayments, no networks to navigate, and free choice of providers.
>
> Financing would be through a predictable 2.5 percent employee health tax and a 7.5 to 8 percent employer tax.
>
> No more annual renegotiation of benefits and no budgeting uncertainties.

Note that the 'single payer' verbiage used by the Physicians for a National Health Program (PNHP) and the 'Medicare-for-all' verbiage used by Dr. O'Malley, mean about the same thing: government funded healthcare. In other words, 'Medicare-for-all' doesn't necessarily mean 'use the existing Medicare program and simply extend it to all Americans' but instead 'provide all Americans with full coverage for all medical care'. The system base could, in fact, be Medicare. Or Medicaid. Or something else.

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[1] This verbiage and the next paragraph come from the PNHP's website https://pnhp.org/

[2] Brian O'Malley letter to the editor https://www.bostonglobe.com/2023/05/14/opinion/letters-to-the-editor-prescription-for-aches-and-pains-of-mass-health-insurance-market/

‘Medicare-for-all’ here becomes a slogan, not a specific policy proposal as best I can decipher its meaning. Apologies for the confusion but, in this rare case, it’s not my fault.

Quick refresher on Medicare and Medicaid

Medicare is our national healthcare system for the elderly. Today it consists of 4 different components:

- **Part A**, introduced in 1965, covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home health care services. It is free for people who are American citizens or permanent aliens who have lived here for at least 5 continuous years and paid Medicare taxes for at least 40 calendar quarters. Most eligible individuals are automatically enrolled in Part A when they start receiving Social Security benefits.
- **Part B**, also introduced in 1965, covers outpatient care, including doctor visits, preventive services, ambulance services, durable medical equipment, and some home health services. It has a monthly premium that adjusts for inflation; $185 per person for most people in 2025, and an annual deductible that also adjusts; $257 in 2025. Part B is voluntary.

  Parts A and B together are sometimes called ‘traditional Medicare’.

- **Part C** introduced in 2023, often called ‘Medicare Advantage’, is an alternative way to receive Medicare benefits through private insurance companies approved by Medicare. Part C combines Part A (hospital) and Part B (medical) coverage in one plan that also usually includes Part D (prescription drug) coverage. Part C plans often include additional benefits not covered by Original Medicare, such as dental, vision, hearing, fitness memberships, and transportation services. Plans may offer lower out-of-pocket costs than Original Medicare. Part C operates with network restrictions (HMO or PPO models).
- **Part D** provides prescription drug coverage to Medicare beneficiaries. Offered by private insurance companies approved by Medicare, it can be purchased as a standalone Prescription Drug Plan (PDP) for those with Original Medicare or is usually included in Medicare Advantage (Part C) plans. Its monthly premium varies by plan. Plans generally include copayments or coinsurance for prescriptions with an out-of-pocket maximum of $2000 in 2025.
- Medicare covers about 67 million people (2024 estimate) or about 18% of the US population.

In addition to using our current Medicare program as a potential model for Medicare for all, some advocates prefer using Medicaid as the model. Medicaid is our national healthcare program for low income and unemployed people. Sometimes referred to as welfare, it is funded jointly by the federal and state governments, administered by states following federal guidelines, with coverage and eligibility varying by state. For that reason, some people say it is 50 different programs. It typically covers a broader range of services than Medicare with little to no cost to beneficiaries.

- Medicaid beneficiaries are low-income families, qualified pregnant women and children, people with disabilities, and elderly individuals who meet financial requirements.
- Covered services include inpatient and outpatient hospital services, doctor visits, laboratory and x-ray services, home health services, nursing facility services, family planning, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children.
- Medicaid covered about 80 million people (2024 estimate) or about 22% of the US population.

Together Medicare and Medicaid cover about 147 million people or 40% of our population. Some people think that's a large enough population, and that we have sufficient experience with these programs, to serve as a basis for a national healthcare system.

The Utilitarian case for single payer healthcare[3]

Let's briefly summarize the key utilitarian arguments in favor of a single-payer universal healthcare system like Medicare for All:

1. **Maximizing Overall Wellbeing and Happiness.** The core tenet of utilitarianism is to pursue the policies and actions that produce the greatest good and well-being for the greatest number of people. A universal healthcare system increases overall societal welfare by:

    - Providing comprehensive health coverage to all citizens, drastically reducing the suffering, pain, and diminished quality of life that stems from lack of insurance and access to care.

    - Offering financial risk protection by eliminating out-of-pocket costs and bankruptcies due to medical bills, reducing a major source of anxiety and hardship.

    - Improving population health outcomes and longevity through better preventative care and disease management, increasing healthy life years.

    - The increased economic productivity, job retention, and financial security that comes with a healthy workforce.

2. **Harm Reduction Principle**. Utilitarians place negative value on actions that cause pain, suffering, or a diminished quality of life. Lack of health insurance is directly linked to

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[3] This section comes primarily from Claude.ai, downloaded March 25, 2024

foregoing needed care, worse health outcomes, higher mortality rates, and financial ruin. A universal system minimizes these negative utilities.

3. **Maximizing Overall Social Welfare**. Utilitarians aim to promote policies yielding the highest net benefits across a population. Economic studies show current U.S. healthcare spending is inefficient, with high administrative costs crowding out better health outcomes. A single-payer system could cover everyone with similar or lower total costs, increasing utility.
4. **Relief of Healthcare Burdens**. Having health concerns is already an area of disutility. But the current private insurance system layers on additional hassles, paperwork, billing issues, and coverage denials that create extra psychological burdens and opportunity costs. A streamlined system removes these negative utilities.
5. **Equal Consideration of Interests**. A key utilitarian principle is considering everyone's interests equally. The current multi-payer system unevenly distributes healthcare access and financial risks. Universal coverage promotes equitable consideration of each citizen's ability to have good health.
6. **Societal Investment and Stability**. Following utilitarian logic of maximizing good consequences longterm, a healthier population increases overall economic productivity, social stability, and human flourishing. Universal healthcare represents an investment in developing human potential.
7. **Expanding the Moral Circle**. As philosopher Peter Singer argues, modern utilitarianism expands moral consideration beyond just humans to all sentient beings capable of experiencing welfare or suffering. Healthcare policies preventing pain and premature death could be viewed as an ethical obligation in this light.

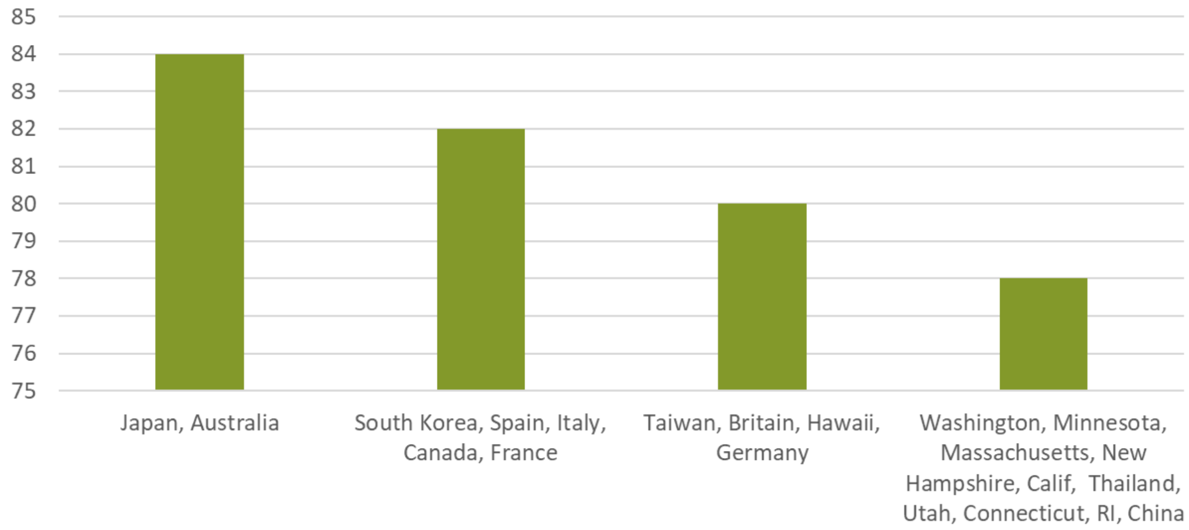
While utilitarians must consider potential economic disincentives or wait times, most analyses show these negative utilities are heavily outweighed by the large-scale benefits to public health, financial security, and societal wellbeing that a well-designed single-payer system could provide.

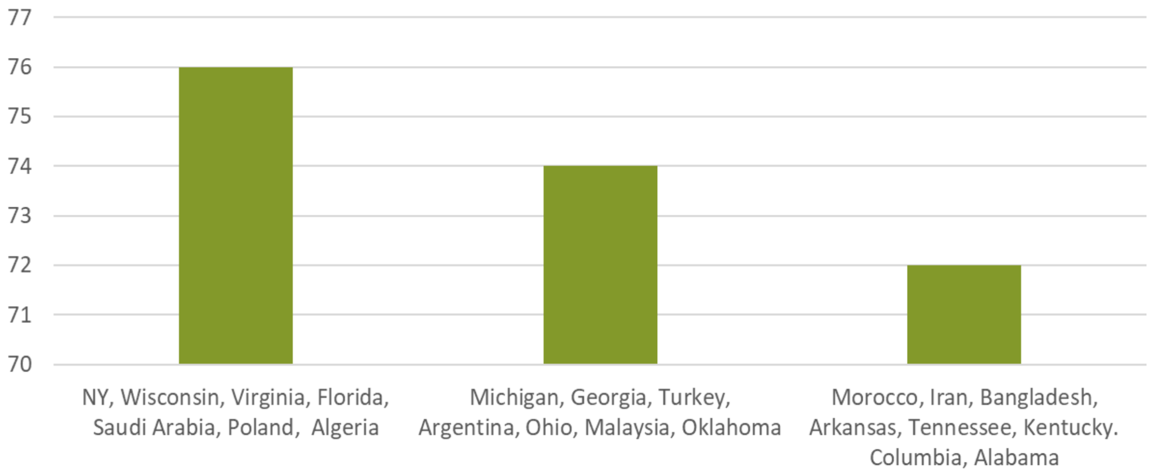
For utilitarians focused on maximizing the greatest good across society, universal healthcare represents one of the most powerful levers for improving quality of life measures and reducing suffering. This makes a strong ethical case from a utilitarian perspective despite the complexities involved.

Some evidence

One way to see the magnitude of our healthcare system unethical presentation is to see how those various countries compare to US *state* longevity at birth averages. These data were originally developed by the National Center for Health Statistics at the United Nations and presented by Nicholas Kristof in the New York Times, August 17, 2023.

Average Longevity at Birth
Various countries compared to US States
Life expectancy in 2 year age bands on the left
'82' means '82 – 84 years'; '78' means '78 – 80 years'





Our longest living states – Washington, Minnesota, Massachusetts and a few others – compare unfavorably to Japan, Australia, Italy, France, Germany and a few others, all of which have single payer healthcare systems of some form or other, and all of which pay far less per capita on healthcare than residents of those states.

Americans in our longest living states compare favorably to Poland, Turkey and Algeria plus a few others, also single payer systems that are far less costly than ours.

Meanwhile, Americans in our shortest living states – Arkansas, Kentucky, Alabama and a few others – live about as long as residents in Iran or Bangladesh, neither of which spends anything near us per capita.

- Iran spent about $142 per capita in 2020 according to the Global Wellness Institute[4]. While I'm not terribly confident in that particular figure – data from Iran are presumably difficult to obtain – I'm pretty sure they spend far less than the $9,160 per capita in Kentucky, 2022 per Medicaid.[5]
- Bangladesh spent about $37 per capita according to a 2024 report in Global Health: Science and Practice.[6] Again, not terribly confident in this particular estimate. But I'm sure the actual number is far less than the $9,280 per capita in Alabama, 2020 estimate by KFF.org, the Kaiser Family Foundation. [7]

This is all hugely unethical, per Utilitarians.

Equally or perhaps more upsettingly, we experienced **no** national life expectancy gains from 2009 – 2020, despite a 40% increase of medical spending per capita from 2009 – 2020.[8] This differs from other advanced, industrialized countries.

We started with an unethical system in 2009, then made it even more unethical!

Notwithstanding the utilitarian arguments in favor of single payer healthcare above. I'll summarize the strongest arguments here:

First, by constraining medical spending by some budgetary mechanism, single payer systems allow / encourage more public health spending than we, in the US enjoy, as a percentage of all government spending.

> 'Public' health spending includes things like public transportation, housing subsidies and food subsidies. These have tremendous impacts on health and, thus, medical spending. A good public transportation system, for example, encourages walking between home and the nearest transport stop, between transport stops when you switch modes, and from the transport stop to your final destination. Private car transport discourages all these.

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[4] https://www.iranintl.com/en/202202097261

[5] https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222022%22%5D

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC10906562/#:~:text=The%20poor%20absorptive%20capacity%20of,to%20become%20impoverished%20every%20year.&text=Even%20worse%2C%20one%2Dthird%20of,health%20is%20not%20actually%20spent.&text=The%20share%20of%20public%20sector,declined%20from%2037%25%20in%201997.&text=Per%20capita%20total%20health%20expenditure,half%20of%20what%20India%20spends.&text=Expenditure%20of%20government%20health%20funds,need%20to%20be%20closely%20regulated.

[7] https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[8] 2009 spending estimate from Kaiser Family Foundation 'Trends in Healthcare Costs and Spending' March 2009. The 2020 spending estimate comes from AMA Policy Research Perspectives, 'National Health Expenditures 2020' by Apoorva Rama

> Studies suggest that the US spends about the same on ‘medical care + public health’ as do these other developed countries that live longer than us. But we spend a far higher share on ‘medical’ while they spend more on ‘public health’.[9] A huge misallocation of resources and an unethical one, per Utilitarians, at that.

Second, by developing rational treatment rejection criteria, single payer healthcare systems avoid overspending on specific patients. ‘The greatest good for the greatest number’ means these systems don’t take lots of money from everyone to provide slight benefit only to a very few. We’ll explore this very complicated and uncomfortable issue in some depth below.

What could go wrong with Medicare for All?

I’ll answer that question by exploring two fundamental problems that all single payer healthcare systems face: (1) the need to develop a treatment rejection process that seems fair enough for the population to accept, and (2) the need to maintain the system’s hospitals, workforce and technology financially. Failure of either or both can destroy a single payer healthcare system. That’s fundamentally why we hesitate to move in this direction. (OK, healthcare lobbyists play a big role too. But we’ll focus on the system structure in this chapter rather than politics and lobbying power.)

We’ll discuss the treatment rejection problem first, the system maintenance issues second and learn from other countries’ experiences third.

Fundamental Problem #1:
The problem of ‘No’

Free, universal, comprehensive medical care for all Americans runs into the problem of **moral hazard** and creates the need for a healthcare system to reject certain patients, for certain treatments, under certain conditions. This section will introduce these issues.

Moral hazard describes why and how, when someone else pays, people use more resources than otherwise, than necessary or than their allotted share. The term moral hazard developed when home fire insurance was initially developed in Britain centuries ago. Insurers worried that homeowners with ‘poor moral character’ would purchase insurance, burn down their houses, then collect the insurance proceeds and, theoretically at least, rebuild a cheaper house, thus profiting at the insurance company’s expense. ‘Poor moral character’ became known as ‘moral hazard’.

A modern day variation, for illustration purposes, is the all-you-can-eat buffet restaurant. Customers tend to eat more in these establishments per meal than in other restaurants.[10] They

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[9] See The American Healthcare Paradox by Elizabeth H. Bradley and Lauren A. Taylor

[10] These references are provided by ChatGPT: Wansink, B. & Hanks, A. S. (2013) found that people served themselves 92% more and ate 44% more calories at a buffet with large plates compared to smaller plates, Rolls, B. J., Roe, L. S., & Meengs, J. S. (2007) discovered that increasing the variety of food available led to greater overall food intake, Research published in the Journal of Nutrition indicated that buffet diners consumed significantly more calories than those dining in à la carte restaurants.

figure 'I've already paid the entry fee, so the additional food is free to me. It doesn't cost me more if I waste it so I'll take more'.

The restaurant entry fee functions economically like a health insurance premium.

Moral hazard is a particular problem in healthcare since health is sometimes called a 'super good' in two senses. First, you can always feel better or improve your health; no one is completely and paradigmatically healthy on all metrics.

> You might have an occasional poor night's sleep, a sore shoulder after playing tennis, indigestion after eating certain foods or mild headaches when the barometric pressure falls. Or one of your annual physical test results for cholesterol, blood sugar, triglycerides, blood pressure or something else might be in the 'low normal' category instead of perfectly normal. You can always improve something about your health.
>
> 'Doing something' consumes system resources. If *everyone* wanted unlimited access to medical care each time they felt a shoulder twinge or received a slightly below average result from a lab test, the system would get overwhelmed.
>
> We need somehow to constrain utilization.

Second, 'super goods' are things that people desire increasingly as they become wealthier. What would a wealthy person want once they have a summer and winter vacation home, season tickets to the local sports teams and art programs, unlimited choice of restaurant every day, and a multitude of friends or sycophants? Better health and longer lives suggest some. In other words, as people get richer, the relative value of additional material purchases declines while the relative value of an additional year of life increases. Two researchers in this arena, Robert Hall of Stanford and Charles Jones of Berkley, suggest that 'the value of life grows roughly twice as fast as income.' [11]

According to this line of thinking, as our society gets wealthier, people will want to access more and more medical care. This becomes increasingly problematic under a single payer financing system where the financier needs to balance access, tax rates and medical care quality. The system needs to stay on budget, making the problem of 'no' increasingly difficult as we become richer and medical care more expensive.

We face two issues here. First, what criteria should we adopt to reject unnecessary treatments or patients, or restrict easy access to minor, low quality care? Second, how can the proposed single payer system generate widespread popular support for those criteria? Let's address each in turn.

Excess Demand and High Value Care

Our current healthcare system deals with excess demand in opaque and complicated ways. Plans have deductibles, copayments, and/or referral requirements that inhibit demand. Some limit

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[11] Robert E. Hall and Charles J. Jones, The Value of Life and the Rise of Health Spending', Quarterly Journal of Economics, April 2006

access by time, say 3 prescription refills per month.[12] Hospitals have bed capacity, workforce constraints or other resource limits. Physicians have time capacity limits with only so many appointments per day. All these keep system utilization rates under control more or less.

Unfortunately, none are terribly efficient. Systemic efficiency means getting the highest value or best outcomes per dollar spent. By simply constraining supply, they may reduce access to the most valuable services while allowing easy access to the least.

Supply constraints may, in other words, be systemically *in*efficient.

> **Time limitations**, the 3 prescription refills per month idea above, may prohibit some people from accessing excessive amounts of low-quality medications. But they equally might prohibit other folks from accessing necessary meds, including long term longevity promoting ones. Time access limitations don't differentiate low quality / unnecessary medications from high quality / necessary ones.
>
> **Cost sharing** is more difficult for middle- and lower-income folks than high income ones. That creates equity issues. In addition, patients often confuse 'cheap' with 'low value' medical care. Cost sharing can certainly constrain healthcare utilization, but it likely does so at the cost of people's health and lives.
>
> > **Time limitations** plus **cost sharing** can have a particularly strong negative health impact on lower income people, sometimes forcing them to choose between medicine and food.
>
> **Supply limitations** can substitute 'made appointment earlier' for 'needs treatment more today' especially in relatively inflexible scheduling systems. These limitations again fail to differentiate low- from high-quality care.
>
> > I once ran into this problem with an extremely painful tooth abscess. My dentist's scheduler said 'no, you can't come in today. All our dentists are fully booked' generally with non-emergency, routine care. When I spoke directly to my dentist, he said 'you need to come in immediately when you're in severe pain. The quicker we treat it, the less invasive our treatments, the lower your cost and the better your outcomes.' Note the tradeoff here between 'appointment scheduling ease' and 'high value care'.
> >
> > Or consider wait times in Emergency Rooms. Though Ers try to triage patients, wait times of 2 – 4 hours were frequently reported in 2023, with some 5 – 10% of patients waiting 6 hours or more to see a doctor.
> >
> > We'll discuss waiting lists in more detail below.

Ad hoc, company specific, and idiosyncratic restrictions can work, more-or-less, to control demand in our current system, artfully described by Ezekiel Emanuel, a chief architect of the

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[12] The Texas Star+ Medicaid program did this in the early 2000s.

Affordable Care Act, as “terribly complex, blatantly unjust, outrageously expensive, grossly inefficient”.[13] In our current system, however, patients can switch carrier or medical provider when sufficiently annoyed.

A universal, single payer system needs a clearer demand control mechanism to ensure fairness, improve efficiency and reduce cost prudently, a system that everyone understands and abides by.

Waiting Lists

Waiting lists are commonly used, imprudent and inefficient control mechanisms. Those reserving their spots first get treatment first, those reserving their spots later need to wait longer. While perhaps useful to keep spending down, waiting lists generally suffer from 2 main problems. First, they **fail to differentiate sicker from less sick patients**, those needing care immediately from those who can wait longer without harming their health. Some waiting platforms, of course, attempt to differentiate.

> The National Health Service in Britain, for example, utilizes a triage system to prioritize patients based on the severity and urgency of their medical needs. This helps ensure that those with life-threatening or serious conditions receive immediate care, while those with less urgent issues may have to wait longer for treatment. The system seems to work well sometimes, not-so-well other times depending, I suppose, if you’re the one on the waiting list. Here’s a general overview of how prioritization works:[14]
>
> 1. Emergency cases: Patients with acute, life-threatening conditions such as severe trauma, heart attacks, strokes, or severe bleeding are given the highest priority and seen immediately in the emergency department.
> 2. Urgent cases: Patients with serious but not immediately life-threatening conditions, such as acute infections, severe pain, or worsening chronic conditions, are seen on the same day or within a few days, depending on the specific situation.
> 3. Semi-urgent cases: Patients with conditions that require treatment within a few weeks, such as suspected cancers, hernias, or certain chronic disease flare-ups, are placed on a more urgent waiting list.
> 4. Routine cases: Patients with non-urgent conditions, such as mild to moderate chronic conditions or elective procedures like joint replacements or cataract surgeries, are placed on a routine waiting list and may have to wait several months or longer for treatment.
>
> The prioritization is typically done through a combination of factors, including the patient’s reported symptoms, medical history, and the results of any initial tests or

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[13] ‘terribly complex, blatantly unjust, outrageously expensive, grossly inefficient’ is the subtitle of Ezekiel Emanuel’s book Reinventing American Healthcare about how the Affordable Care Act will improve our system.

[14] Much of this section comes from ChatGPT

examinations. Healthcare professionals, such as triage nurses or doctors, use standardized guidelines and their clinical judgment to assess the urgency of each case.

Patients participate in this prioritization process too. See the sign below, posted outside the Royal Lancaster Hospital in Lancaster, England. 'A & E' stands for Accidents and Emergencies, the British equivalent of our Emergency Room. I hope you can read it; I took the photo and am a significantly poorer photographer than author, if that's even possible.

Additionally, the NHS has maximum waiting time targets for different types of treatments. For example, patients with suspected cancer should receive their first treatment within 62 days of referral, and most patients should receive non-urgent treatment within 18 weeks of referral.

This system is not perfect – far from it – and patients may experience delays or prioritization issues, especially during times of high demand or resource constraints within the NHS.

One 2010 study found that waiting time targets remained piecemeal and did not necessarily reflect patients' individual experience of waiting.[15] This report labelled as

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[15] The Waiting Game, Kings Fund, 2010 https://www.kingsfund.org.uk/insight-and-analysis/blogs/waiting-game-hospital-waiting-times

> ‘successful’ in June 2010 that around 90 per cent of admitted patients and 98 per cent of non-admitted patients were seen within 18 weeks. I shudder to think how Americans would react to that!

This raises the second issue: **popular acceptance**. Would Americans tolerate long waits for medical care in return for, hopefully, lower costs? I doubt it and equally doubt that our politicians would endorse this as our cost control mechanism in a single payer / Medicare-for-all type system. Already some 26% of us wait 2 or more months for treatment according to research by the American Association of Nurse Practitioners.[16]

> Sorry but as a moderately well-informed non-political scientist, I just don’t see Americans accepting waiting longer for medical care as a solution to our existing healthcare cost problems.

QALYs
Quality Adjusted Life Years

Instead of inefficient, poorly targeted cost sharing or waiting lists to control healthcare demand and thus reduce spending, some suggest an alternative methodology. The Brits, for example, ration medical care through the National Institutes for Health and Care Excellence or NICE. We’ll discuss their rationing experience in this section, then try to extrapolate lessons from it for the US.

> ‘Ration’ isn’t a dirty word. It simply means restricting access to certain treatments, generally to keep costs down or maybe to promote fairness. We in the US currently ration medical care in many ways – waiting lists (see the Nurse Practitioner study above), state regulations (abortion access for example), hospital capacity or insurance coverage among others. These are often hidden, private and subjective methods. The British National Health Service through NICE simply rations care openly, objectively and publicly.
>
> Rationing can make our healthcare system simultaneously less expensive, higher quality and fairer. Consider a hypothetical $1,000,000 treatment for a specific patient. Would we, as a society, be healthier, live longer and be better off overall, if that one patient got the million-dollar treatment, or if 100 people got $10,000 treatments instead? Review the British cost and life expectancy data above before you answer.
>
> Rational rationing criteria can help us make those uncomfortable trade-offs.

NICE in the UK employs a rigorous system to assess the clinical and cost-effectiveness of healthcare interventions.[17] It aims to ensure that NHS resources are allocated efficiently and that patients have access to effective, evidence-based healthcare interventions that represent value for

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[16] Two in Five Americans Report Unreasonable Wait Healthcare Wait Times, AANP News, July 12, 2023 https://www.aanp.org/news-feed/two-in-five-americans-report-unreasonable-health-care-wait-times

[17] Parts of this lengthy section come from ChatGPT

money. NICE’s transparent, objective, evidence-based approach seeks to balance clinical need, patient benefit, and affordability.

By many accounts, it does a pretty good job as evidenced by the high public satisfaction levels with the National Health Service among Brits.

NICE uses **Quality-Adjusted Life Years (QALYs)** as a measure of health outcomes to determine medical care cost-effectiveness. QALYs integrate both the quantity and quality of life gained from a healthcare intervention into a single measure.

1. **Definition of QALY**: A QALY is a measure of health outcome that combines both the length of life (quantity) and the quality of life (utility or health-related quality of life) experienced during that time. One QALY is equivalent to one year of life lived in perfect health. Health states considered less desirable than perfect health have QALY values less than 1.
2. **Utility Values**: Utility values represent the quality of life associated with different health states. These values range from 0 (representing death) to 1 (representing perfect health). We’ll discuss at least 1 way to determine these values below.
3. **Assessment of Health Benefits**: When evaluating a healthcare intervention, NICE considers the impact of the intervention on patients’ health-related quality of life over time. This is done by estimating the number of QALYs gained or lost as a result of the intervention.
4. **Cost per QALY**: NICE calculates the incremental cost per QALY gained. This involves comparing the costs of the intervention (e.g., drug costs, administration costs, monitoring costs) with the additional QALYs gained. Interventions with lower incremental cost per QALY gained are generally considered more cost-effective.
5. **Cost-Effectiveness Threshold**: NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money. It typically sets the value of each QALY at between $25,000 to $40,000. They determine this amount in various ways that lie outside the scope of this particular chapter; QALY determination methodology is incredibly complicated. I’ll discuss one relatively easy-to-understand method below.
6. **Decision Making**: Based on its assessment of cost-effectiveness, NICE provides recommendations on whether the intervention should be funded. Interventions generating more QALY value than cost are generally recommended for adoption, while those showing higher costs than QALY calculated benefits are generally not.

Thus, as a simple example, assume that a $100,000 treatment would increase someone’s life expectancy by 5 years of excellent health or 5 QALYs. Here, we know the cost ($100,000) and can estimate the value of those additional life years at about $150,000. (5 year at approximately $30,000 per year.) NICE would probably approve the treatment.

But change things slightly. Now the same $100,000 treatment would only increase someone’s life expectancy by 3 years of excellent health, thus generating about a $90,000 benefit. (3 years at $30,000) NICE would probably not approve the treatment. Or 4 years of moderate health (4 years at $20,000 = $80,000). NICE, again, would probably deny that treatment.

These calculations get very complicated very quickly. Imagine explaining this to Congress!

Determining QALY values

Now for the wrench in the works (*the* wrench? I can think of several.) Let's determine an American value of each QALY. We'll use a **willingness to pay** methodology as articulated by Harvard's David Cutler in his 2004 book Your Money or Your Life.

The willingness to pay idea suggests that we can determine the value of a life year based on calculations of our expenditures for various lifesaving products. Cutler used car airbag purchases as the basis of his calculations, as car airbags were once optional purchases. How much, based on aggregate spending for this lifesaving device, do we value 1 life year?

> Cutler estimated that airbags cost $300 each (this was in 2004) and saved on average, 1 life in 10,000. Thus, based on airbag purchases, our willingness to pay methodology suggests that we, on a society wide basis, spend $3 million to save 1 life.
>
> Cutler further assumed that the average person whose life was saved would subsequently live an additional 30 years. Probably a reasonable ball-park assumption.
>
> Based on these lifesaving purchases and some rather unsavory calculations, Cutler estimated that Americans would value each additional life year at about $100,000. (How has that number inflated over time? No idea!)
>
> Cutler and others then performed similar willingness to pay studies on other lifesaving purchases such as fire alarms, and salary premiums for dangerous jobs. By running multiple calculations using the same methodology on multiple products, US economists have arrived at $100,000 per QALY, far higher than the UK.

Would Americans Accept QALYs or almost any other way of saying 'no'?

I provided this introductory discussion of waiting lists, QALYs and Willingness to Pay ideas to show the richness, complexity and confusion involved in making these difficult healthcare treatment acceptance / rejection decisions. At the end of all this, I wonder how well readers understand it and if they, themselves, are comfortable explaining this to colleagues and deciding their own positions on these various issues. I know that I'm not.

Now try expanding this discussion into our political sphere or asking politicians in our sound-bite laden national discussions to articulate universal, national criteria for treatment acceptance or rejection. Too heavy a lift in my opinion.

How Does Medicare Handle This?

Medicare, our national single payer system for the elderly, is, of course, widely popular. It rations some treatments like cosmetic and dental and doesn't cover weight loss drugs like

Ozampic for many purposes as of time of writing this text. These restrictions have not provoked a national outcry against rationing. Beneficiaries can get around some restrictions by purchasing supplements or Advantage plans at different costs for different benefits. A good, though expensive safety valve.

In other words, by practicing minimal rationing, Medicare gains widespread popular acceptance at the cost of potentially breaking the US government's budget. (More on that below.) Many economists and some politicians, generally from the party not in control of the White House, argue that we need to reform Medicare. 'Reform' generally means 'cut spending', a polite way of saying either 'pay doctors less' (good luck with that one) or 'ration care'. Relatively easy for the out-of-power party to support but, as we have seen above, relatively difficult to implement.

> I'd summarize our chance of developing a widely accepted treatment rejection criteria for a Medicare-for-all system as falling somewhere between zero and 'extremely unlikely'.

Let's review. As society gets wealthier, people demand increasing amounts of medical care. That's from the 'healthcare as a super good' discussion above. We expanded on that issue to discuss how to control the moral hazard aspect of universal coverage via waiting lists or treatment rejection, and we introduced QALYs as a treatment acceptance / rejection criterion. We needed to find some national, objective, acceptable mechanism for rejecting certain medical treatments. I don't think we have. We're still left, quite unsatisfyingly, with our Problem #1: How to Say No.

With that failure in mind, let's now turn to Fundamental Problem #2 with Medicare-for-all – again, whatever 'Medicare-for-all' actually means – the need to maintain and increase funding over time.

Fundamental Problem #2: Funding Maintenance

If we adopt a Medicare-for-all, single payer type healthcare system, we will need to maintain an adequate level of funding to keep the workforce sharp and technologies current. Plus we need to increase funding over time as both inflation and medical advances add costs to the system. The failure to maintain adequate funding can destroy the system, as our case study of the British National Health Service at the end of this section below, will demonstrate.

My concern is that a federally funded, single payer healthcare system that fails to maintain appropriate funding will destroy itself 'little by little at first, then all of a sudden', to paraphrase Ernest Hemingway's description of the bankruptcy process. Would the PNHP proposed 2.5% employee health tax and 7.5 to 8% employer tax cover all expenses? What happens if that's insufficient, or if Congress approves a lower tax-and-funding level? Would / could the government step in to cover the shortfall?

Let's first discuss the US federal budget.

Federal budgetary constraints

The federal budget shows how we, as a society, allocate our public resources. Our current budget makes us look like a healthcare system with an army financed by foreigners.[18] See the breakdown below.[19] In round numbers, we allocate

- 8% of our federal budget to Medicaid
- 12% to Medicare
- 21% to Social Security
- 13% to Defense, and
- 11% to interest on the national debt.

That's almost 2/3 of our budget! A healthcare system with an army indeed!

> The last 1/3 gets more complicated to discuss, with various discretionary, mandatory and non-discretionary categories. I'll sidestep a broader, more detailed discussion of our federal budget here to focus instead on the healthcare funding implications. Apologies to any budget nerds but this is an insurance continuing education text, not a macro-economic academic exercise!
>
> The chart below shows this graphically though with some slightly different accounting allocations. The allocation components are roughly the same year after year.

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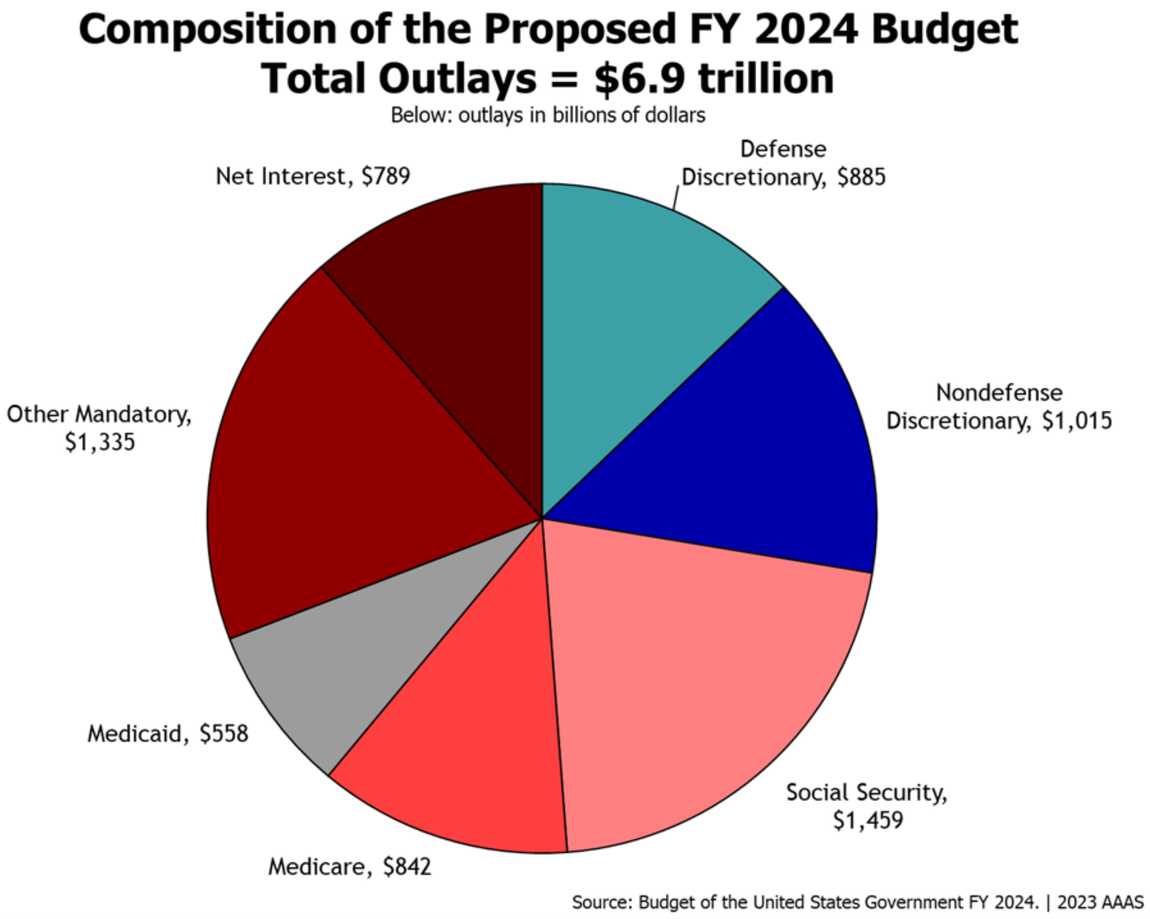
[18] That's a slight overstatement. In 2024, foreigners owned about 22% of our $35 trillion national debt, or about $7.6 trillion.

[19] This chart was downloaded in July, 2024



Source: Budget of the United States Government FY 2024. | 2023 AAAS

Developers of our annual national federal budget, or any budget for that matter, always balance at least 3 competing needs:

- The inflation and new technology-based needs to spend more money on virtually everything,
- The lobbying pressure from various groups to gain more resources for their own favored special interests, and
- The ongoing political pressure to avoid raising taxes.

Consider our Medicare budget growth over the past 30+ years in light of these issues. [20]

Year	Expenditure	% Increase Over Previous Year
1990	$98 billion	
2000	$197 billion	101%

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[20] Data from various sources including the Kaiser Family Foundation and Y Charts of US Government Spending https://ycharts.com/indicators/us_government_medicare_spending

2010	$451 billion	129%
2020	$776 billion	72%

During the same years, the number of Medicare beneficiaries grew:

Year	Number Medicare Beneficiaries	% Increase Over Previous Year
1990	34 million	
2000	40 million	18%
2010	48 million	20%
2020	63 million	31%

Interestingly, however, Medicare's spending per capita has flattened in the past few years. [21] Might this suggest that Medicare has learned how to control its expenditures so can act as a viable, national healthcare system?

Year	Medicare spending per beneficiary
2010	$11,000
2020	$13,200
2024	$13,092

The chart below from the NY Times shows actual spending (the purple line) vs. projected spending (the dotted yellow line with purple shaded area).[22] The cumulative savings was about $3.9 trillion, an enormous sum.

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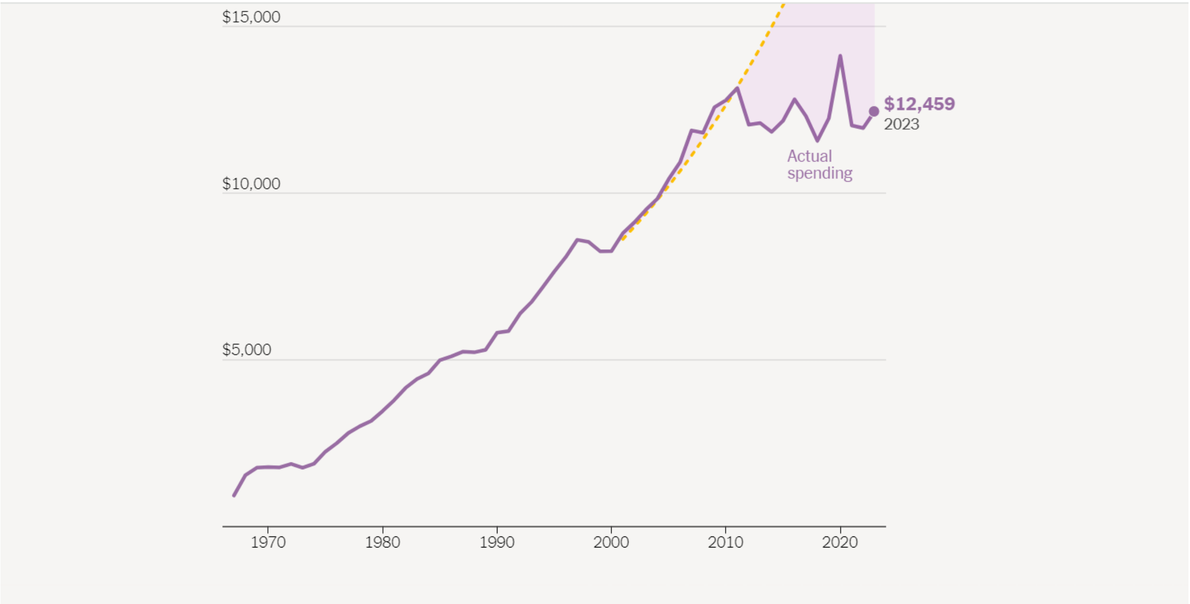
[21] I used the data posted above for 2010 and 2020. The 2024 Medicare expenditure estimate comes from the February 2024 CBO projection for the year. Medicare will have about 65.5 million beneficiaries, KFF estimate.

[22] Margot Sanger-Katz et al, A huge threat to the US budget has receded. And no one knows why., New York Times, Sept 3, 2023. This article estimated $3.9 trillion in cumulative savings.



Unfortunately for Medicare-for-all proponents, this rosy financial picture doesn’t necessarily result from brilliant system management.

Certainly some of the savings comes from various payment reforms, things like bundled payments, the Affordable Care Act that reduced Medicare’s payments to hospitals and to health insurers that offered private Medicare Advantage plans, and the budget deal of 2011 that reduced Medicare’s payments.[23] If those reasons explained most of the spending reduction, then we might feel more enthusiastic about our government’s ability to control single payer healthcare spending.

According to the Times analysis, though, that is not the case; *most* of the Medicare savings are attributable to other things including

- Preventive medical practices and inexpensive medications that have reduced the number of elderly Americans having heart attacks and strokes.
- Doctors being more cautious about adopting new treatment protocols absent solid evidence of effectiveness.
- Increasing amounts of medical care being performed outside of expensive hospital settings, and, perhaps most disconcertingly,
- Fewer expensive new treatments entering the healthcare system over the past 10 years.

Instead of expecting these cost controlling factors to continue long into the future, some suggest that we will shortly revert to our historical norm of Medicare’s cost growth far exceeding overall inflation. Those traditional cost drivers include

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[23] This paragraph and the next couple come primarily from the New York Times ibid.

- The increasing cost burden of various chronic diseases like obesity, diabetes, Alzheimer’s, cancer, chronic obstructive pulmonary disease (COPD), chronic kidney disease and arthritis,
- Expensive, newly available new drugs to treat these and other diseases like
    - Ozampic for diabetes and weight management at $10,000 per person per year
    - Leqembi for Alzheimer’s at $26,000 per person per year,
    - Keytruda and Obdivo for cancer at $150,000 per person per year,
    - Trelegy for COPD at $7,000 per person per year
    - Farxiga for chronic kidney disease at $6,000 per person per year, and others.[24]
- The impact of long covid or some other pandemic.

In addition, our political or cultural focus might migrate from simple cost cutting toward, perhaps, increased longevity as Medicare’s criteria for success. I don’t know if this will happen, but perhaps.

Bottom line: Medicare’s expenditures per capita will likely revert to about their historical rate i.e. much faster than overall inflation. Will the PNHP’s proposed 2.5 percent employee health tax and 7.5 to 8 percent employer tax cover costs? I don’t know. What happens if Medicare falls short? Again no idea. But if and when Medicare-for-all falls short on funding, I expect an increasingly intense fight among **deficit hawks** who want to control or reduce the federal government’s deficit, **tax cut enthusiasts** who want to stimulate overall economic growth via tax cuts, and **Medicare supporters** who seek more money for the system.

I can’t guess who will win.

Lessons from Other Countries

None of these funding problems are uniquely American; other countries have faced them, often for years. What lessons can we learn from their successes or failures?

We’ll focus on the British National Health System experience over the past couple of decades. I chose this because (a) the data are easily accessible, (b) publications are in English, a big deal for me, and (c) I used to live there are liked it. Consider this a cautionary tale for Medicare-for-all proponents. Why and how might the US experience in a hypothetical single payer system differ from the Uks, if it differs at all?

I’ll organize this case study around the outline from David Hunter’s July 13, 2023 article in the New England Journal of Medicine “At Breaking Point or Already Broken? The National Health Service in the United Kingdom”[25] and will add additional comments of my own.

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[24] These cost estimates from ChatGPT

[25] NEJM July 13, 2023
https://www.nejm.org/doi/full/10.1056/NEJMp2301257?query=WB&cid=NEJM%20Weekend%20Briefing,%20July%2015,%202023%20DM2266825_NEJM_Subscriber&bid=1675306684

The UK's National Health Service was in acute crisis by 2023. Four quick datapoints:

- 300 – 500 people died *per week* while waiting for emergency care, estimate from the Royal College of Emergency Medicine,
- Emergency department wait times regularly exceeded 12 hours.
- Ambulance drivers, nurses and junior physicians held their first strikes in decades, leading to "hundreds of thousands" (Hunter's words) of canceled surgeries and appointments,
- Over 10% of the British population was on a waiting list for some sort of medical care in 2023,

A key factor causing these problems was a long-term *capital* underinvestment in the system's infrastructure. Government funding hovered around 10% of GPD since about 2009 under the Conservative government's austerity program designed to keep taxes low. Essentially the government froze their contributions to the NHS from 2010 – 2023. In real terms, this funding freeze meant the NHS was underfunded by about $50 billion annually for 13 years.[26]

The number of inpatient hospital beds declined by about 10% since 2010. This resulted in insufficient system capacity to handle a public health crisis when Covid struck.

Compounding the hospital bed supply problem, the NHS also had an insufficient number of nursing home or long-term treatment beds. This led to 'bed blocking'; acute care hospitals could not discharge patients for longer term care as there were no facilities to house them. About 14% of hospital beds were blocked / unnecessarily occupied in early 2023 because the dischargeable patients had no place to go. This in turn led to hospital admission delays and the waiting lists referenced above.

In addition, and also largely due to the annual underfunding, some hospitals reserved beds or floors for 'private pay' patients, folks who didn't rely on public funding for their medical care. This generated more income for the hospital but put an additional crimp on the bed supply available to most Brits.

> An insufficient number of hospital beds + an insufficient number of nursing home beds = inadequate hospital bed supply system wide = lengthy waits for care.

A contributing reason for the bed insufficiency is the low reimbursement per patient in private facilities, meaning nursing homes couldn't compete with local businesses for employees. (This sounds like the Medicaid situation in some areas of the US.)

A second key factor in the NHS's crisis was their long-term *workforce* underinvestment, again due to that $50 billion annual funding shortfall. Three data points here:

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[26] How Britain Put One of The World's Best Healthcare Systems on Life Support, NY Times, December 7, 2023

- Nurses' salaries fell by 10% in real terms over the past decade, leading to resignations and early retirements,
- The number of General Practitioners (Primary Care Physicians in American terminology) fell by about 15% per 1000 of population while caseloads increased by 17% per GP.
- By late 2023, the NHS was more than 150,000 employees short of its staffing requirement.

Compound this with immigration restrictions, especially since Brexit in 2020. The NHS had previously imported nurses from poorer European countries including Italy, Poland and Romania. Post-Brexit, the movement of Europeans to Britain became much more difficult.

> An insufficient healthcare workforce investment + immigration restrictions = inadequate healthcare labor force = long waits for care = poorer medical outcomes.

Britain underfunded its National Health Service bit-by-bit, year after year, until it no longer provided the high-quality care the population expected. Simultaneously, politicians and some lobbyists campaigned to privatize parts of it.

How closely do these conditions resemble the US?

In the US, we face a long-term hospital bed decrease from 4.5 beds per 1000 population in 1975 to 2.8 beds per 1000 population today.

- Some of this is positive and due to system improvements, things like better outpatient care and improved technologies leading to shorter inpatient stays.
- Some, though, are due to economic pressure to keep bed occupancy rates high; empty beds are expensive.
- Overall, the reduced number of inpatient beds led to system stress during Covid and other high demand periods like flu season, and longer waits for some elective surgeries.
- This resembles the NHS during the early days of its system decline. (Remember Hemingway's comment about going bankrupt: 'Little by little then all at once.')

We have an insufficient number of Primary Care Physicians, with some 80 – 85% of medical students going into specialties, largely because specialists earn more money.

- The number of PCPs has declined slightly from 68.4 per 100,000 patients in 2012 to 67.2 per 100,000 in 2021.
- This contributes to a higher cost, poorer longevity healthcare system. Many studies show a stronger correlation between primary care and increased life expectancy than specialty

care and longevity on a population wide basis.[27] Try to find a PCP open to new patients to understand the impact in your own specific region.

- Again, this resembles the NHS early in their system decline.

We face a nursing shortage, needing 200,000 new nurses per year until 2026 according to the Bureau of Labor Statistics to maintain adequate staffing. This is caused both by increased demand (population aging, moral hazard) and burnout / job dissatisfaction in the existing nurse workforce.

- Currently about 16% of RNs are foreign born.
- Immigration restrictions could exacerbate this problem, plus reduce our system's ability to manage increasingly culturally and linguistically diverse patients.
- Again, similarities to the NHS early in their system decline.

Various political and lobbying forces seek to privatize more of our own healthcare system.

- Medicare Part C / Advantage is one attempt to privatize parts of Medicare,
- Part D is entirely managed by private insurers.
- We have a history of groups trying to privatize public social services. President George W. Bush, for example, attempted to partially privatize Social Security in 2005. I would expect these efforts to continue in a Medicare-for-all system just like in Britain.

Medicare-for-all wrap up

I hope readers understand the major points about Medicare-for-all by now:

- A national, public healthcare system needs a clear treatment rejection program that's acceptable to the population. We don't currently have that. I don't see any chance that we will develop it,
- A national, publicly funded healthcare system needs ongoing investment to maintain its capacity, technologies and workforce. I see a future of budgetary fights rather than secure ongoing funding for an expensive Medicare-for-all system. Specifically, I fear that deficit and budgetary hawks will underfund the system bit-by-bit until Hemingway's observation becomes reality.

What Would a Utilitarian Ethicist Say About This?

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[27] See, for example, the 2019 JAMA study 'Association of Primary Care Physician Supply with Population Mortality in the United States' https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2724393 and Macinko, Quantifying the Health Benefits of Primary Care Physician Supply in the United States, 2007 https://pubmed.ncbi.nlm.nih.gov/17436988/

We have here a classic ethical dilemma. The ideal ethical healthcare system in which everyone contributes fairly and those in need use only the resources necessary to treat them appears unrealistic. Real world constraints – the need to say 'no' in some sort of publicly comprehensible and acceptable way, and the need to maintain funding so the system remains robust – appear insurmountable. But other healthcare system structures appear less ethical, sometimes far, far less ethical, from the Utilitarian perspective.

Ethical Approaches to the Problem of Healthcare Rationing

Introduction

Healthcare rationing represents one of the most challenging ethical dilemmas in modern medicine and public policy.[28] The fundamental reality that healthcare resources—whether organs for transplantation, intensive care beds, physician time, or financial resources—are finite means that difficult choices about allocation are unavoidable. These choices carry profound moral weight, as they directly impact human life, suffering, and opportunity.

Healthcare rationing occurs across multiple levels: at the macro level through policy decisions about healthcare budgets and coverage; at the meso level through institutional decisions about resource allocation; and at the micro level through individual clinical decisions about which patients receive which treatments. Each level involves different stakeholders, considerations, and ethical frameworks.

This analysis explores the major ethical approaches to healthcare rationing, examining their philosophical foundations, practical applications, inherent tensions, and real-world implications. We begin with utilitarianism, which emphasizes maximizing overall welfare, then consider egalitarianism, with its focus on fairness and equality. We then explore other influential frameworks including prioritarianism, communitarianism, libertarianism, and approaches centered on rights, dignity, and procedural justice. Throughout, we consider how these ethical frameworks have been applied in various healthcare systems worldwide and the challenges they face in practice.

The goal is not to prescribe a single correct approach, but rather to illuminate the complex moral landscape of healthcare rationing and provide a foundation for more informed, thoughtful, and ethically robust decision-making in this difficult domain.

The Health Insurance Broker's Ethical Response to Treatment Rejection

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[28] Much of this chapter comes from Claude.ai

The space between medically recommended care and insurance-approved treatments creates one of the most challenging ethical dilemmas in contemporary healthcare delivery. At the center of this conflict often stands the health insurance broker—a professional who not only develops and sells insurance products but frequently becomes the primary advocate and navigator when patients face treatment rejections. This section examines the ethical responsibilities of health insurance brokers when clients experience treatment denials, exploring the unique moral terrain they must navigate while balancing multiple, often competing obligations.

The Utilitarian Ethical Approach to Healthcare Rationing

Utilitarianism, a consequentialist ethical theory developed by philosophers Jeremy Bentham and John Stuart Mill, judges actions solely by their outcomes or consequences. The core principle is to maximize overall utility—typically understood as happiness, well-being, or preference satisfaction—for the greatest number of people. When applied to healthcare rationing, utilitarianism offers a seemingly straightforward approach: allocate resources to maximize the total health benefit across the population.

Philosophical Foundations of Healthcare Utilitarianism

The utilitarian approach to healthcare rationing rests on several key philosophical premises:

1. **Impartiality**: Each person’s well-being counts equally in the moral calculus; no individual is inherently more deserving of healthcare resources than another.
2. **Aggregation**: The well-being of different individuals can be meaningfully combined into a measure of overall welfare, allowing for comparison of different allocation schemes.
3. **Maximization**: The morally right action is the one that produces the greatest total well-being, even if this means that some individuals receive fewer resources than others.
4. **Consequentialism**: What matters morally is the outcome of healthcare allocation decisions, not the procedures by which they are made or the rights they might violate.

These premises lead to a healthcare rationing approach that seeks to direct resources where they will do the most good for the most people, often operationalized through metrics like Quality-Adjusted Life Years (QALYs) or Disability-Adjusted Life Years (DALYs).

Ways to Maximize Overall Well-being in a Healthcare Rationing Environment

Utilitarian approaches to healthcare rationing employ several strategies to maximize overall well-being:

4. Cost-Effectiveness Analysis

Cost-effectiveness analysis compares the cost of different interventions relative to their health benefits. By calculating metrics like cost per QALY gained, decision-makers can allocate resources to interventions that provide the greatest health benefit per dollar spent. For example, a hypertension screening program that costs $30,000 per QALY gained would be prioritized over an experimental cancer treatment costing $200,000 per QALY.

The UK's National Institute for Health and Care Excellence (NICE) exemplifies this approach, generally recommending treatments that cost less than £20,000-£30,000 per QALY gained. This has allowed the National Health Service to maximize health outcomes within its budget constraints, though it has faced criticism when denying coverage for treatments that exceed this threshold despite individual patient needs.

5. **Population-Level Preventive Measures**

From a utilitarian perspective, preventive interventions that benefit large populations often represent efficient uses of healthcare resources. Vaccination programs, for instance, not only protect individuals but also create herd immunity, multiplying their utility. Similarly, public health measures addressing major risk factors like smoking, obesity, and hypertension can prevent numerous cases of expensive-to-treat conditions.

For example, a comprehensive tobacco control program might cost far less per QALY gained than treating the resulting lung cancer, heart disease, and respiratory conditions. However, this approach can be criticized for sometimes prioritizing future, statistical benefits over immediate, identifiable needs.

6. **Triage Systems**

In situations of acute scarcity, such as mass casualty incidents or pandemic surges, utilitarian principles often inform triage systems. These systems typically prioritize patients most likely to benefit from intervention, sometimes using criteria like likelihood of survival, years of life that could be saved, or potential for recovery to full function.

During the COVID-19 pandemic, many hospitals developed crisis standards of care that incorporated utilitarian considerations. For instance, some guidelines suggested prioritizing ventilators for patients with better prognoses and fewer comorbidities, aiming to save the most lives possible with limited resources.

7. **Age-Based Allocation**

Some utilitarian approaches incorporate age as a factor in resource allocation, typically favoring younger patients who have more potential life years ahead of them. This “fair innings” argument suggests that everyone should have an opportunity to live through the stages of a normal life, and therefore younger people who haven’t had this opportunity should receive priority.

For example, in transplant allocation systems, younger patients often receive some priority based partly on utilitarian considerations about potential life years gained. During the COVID-19 pandemic, some triage protocols included age as one factor among many, though explicit age cutoffs were generally avoided due to concerns about discrimination.

8. **Promoting Innovation and Research**

A far-sighted utilitarian approach might allocate some resources to research and innovation, even at the expense of meeting current needs. Investments in developing new treatments, vaccines, or delivery systems can yield substantial future benefits that outweigh immediate costs.

For instance, funding research into antibiotic alternatives might seem less pressing than treating current infections, but could prevent countless future deaths from antimicrobial resistance. Similarly, developing faster, cheaper diagnostic tools might initially divert resources but ultimately allow for more efficient healthcare delivery.

Ways to Measure Well-being in a Healthcare Rationing Environment

The utilitarian approach requires metrics to quantify health outcomes and well-being. Several measurement frameworks have been developed:

9. Quality-Adjusted Life Years (QALYs)

QALYs combine quantity and quality of life into a single metric by multiplying the time spent in a health state by a utility weight representing the quality of that state. These utility weights typically range from 0 (death) to 1 (perfect health) and are derived from surveys asking individuals to rate different health states.

For example, a year of life with moderate mobility limitations might be assigned a utility weight of 0.7, so living 10 years in this state would equal 7 QALYs. QALYs allow for comparison across different conditions and interventions, making them valuable for resource allocation decisions.

However, QALY calculations face several criticisms:

- They may undervalue treatments for chronic or terminal conditions where quality improvements are modest but meaningful to patients
- The utility weights may reflect discriminatory societal attitudes toward disability
- They don’t account for non-health aspects of well-being or distributional concerns
- The elicitation methods for utility weights (time trade-off, standard gamble, etc.) can produce inconsistent results

10. Disability-Adjusted Life Years (DALYs)

DALYs measure the burden of disease by combining years of life lost due to premature mortality and years lived with disability. Unlike QALYs, which measure health gains, DALYs measure health loss, with the goal being to minimize total DALYs in a population.

The World Health Organization uses DALYs extensively in global health priority-setting. For instance, cost-effectiveness analyses might compare interventions based on cost per DALY averted. Like QALYs, DALYs face criticism for potentially discriminating against people with disabilities and for the methodological challenges in assigning disability weights.

11. **Capability Approach**

Developed by philosopher Amartya Sen and economist Martha Nussbaum, the capability approach measures well-being in terms of people's capabilities—their freedom to achieve various "functionings" they have reason to value. Rather than focusing narrowly on health states, this approach considers how health affects people's ability to work, maintain relationships, participate in community life, and pursue their goals.

The Oxford Capability Instrument (OCAP) applies this framework to healthcare evaluation, assessing outcomes across domains like attachment, stability, achievement, enjoyment, and autonomy. This broader conception of well-being might better capture what people actually value about health, though it is more complex to implement in practice.

12. **Subjective Well-being Measures**

Some utilitarian approaches incorporate subjective well-being or happiness measures, using surveys that ask people to rate their life satisfaction or positive affect. These measures recognize that the ultimate goal of healthcare is not health itself but the contribution health makes to overall well-being.

For instance, the Warwick-Edinburgh Mental Well-being Scale assesses psychological well-being across multiple dimensions. Incorporating such measures into healthcare allocation decisions could help ensure that resources are directed toward interventions that genuinely improve people's lived experience, though connecting specific interventions to these broader outcomes poses methodological challenges.

13. **Economic Productivity Metrics**

Some utilitarian analyses include economic productivity as a component of well-being, measuring how healthcare interventions affect individuals' ability to work and contribute to society. This might involve calculating productivity losses averted through treatment or prevention of illness.

For example, an analysis of a depression treatment program might consider not only direct health improvements but also reduced absenteeism and presenteeism in the workplace. While this approach captures important societal benefits, it risks undervaluing interventions for populations outside the workforce, such as the elderly or those with disabilities that prevent employment.

Strengths of the Utilitarian Approach

The utilitarian approach to healthcare rationing offers several advantages:

1. **Efficiency**: By maximizing health benefits per resource unit, utilitarian approaches can achieve the greatest possible improvement in population health with limited resources.
2. **Impartiality**: Utilitarian frameworks treat each person's potential health gain as equally valuable, avoiding favoritism or discrimination based on morally irrelevant factors.

3. **Quantifiability**: Metrics like QALYs provide a common currency for comparing diverse interventions across different conditions, populations, and healthcare settings.
4. **Prevention emphasis**: The utilitarian calculus often favors cost-effective preventive measures that avert substantial suffering before it occurs.
5. **Transparency**: Well-implemented utilitarian approaches can make the rationale for allocation decisions explicit and consistent, enhancing accountability.

Criticisms and Limitations of the Utilitarian Approach

Despite its apparent rationality, the utilitarian approach faces several important criticisms:

1. **Distributive concerns**: Pure utilitarianism might concentrate resources on those who can benefit most efficiently, potentially neglecting the worst-off or those with rare conditions requiring expensive treatments.
2. **Rights violations**: Maximizing overall utility could theoretically justify sacrificing individual rights or dignity if doing so produces greater aggregate benefit.
3. **Disability discrimination**: Quality-of-life weights used in QALY calculations may systematically undervalue life with disability, reflecting and reinforcing societal biases.
4. **Age bias**: Life-expectancy considerations in utilitarian calculations tend to favor younger patients, which some consider unfair to older individuals.
5. **Measurement limitations**: Quantifying health benefits involves value judgments and methodological assumptions that may be contested or culturally specific.
6. **Rule of rescue**: Utilitarian approaches may conflict with the powerful moral intuition that identifiable individuals in immediate danger deserve rescue, even at high cost.
7. **Strategic manipulation**: Institutions might “game” utilitarian metrics by focusing on easily measured outcomes while neglecting important but less quantifiable aspects of care.

Case Study: Oregon Health Plan Prioritization

One of the most well-known attempts to apply utilitarian principles to healthcare rationing was the Oregon Health Plan in the early 1990s. Facing budget constraints in its Medicaid program, Oregon developed a prioritized list of condition-treatment pairs ranked primarily by cost-effectiveness. The state would fund treatments from the top of the list down until the budget was exhausted.

The initial attempt at prioritization produced counterintuitive results, ranking tooth capping above appendectomy based on strict cost-utility analysis. This highlighted the limitations of simplistic utilitarian calculations and led to revisions incorporating professional judgment and community values.

The revised Oregon list still embodied utilitarian principles but tempered with considerations of need, effectiveness, and community values. The experience demonstrated both the appeal of systematic prioritization and the need to complement purely quantitative approaches with other ethical considerations.

Contemporary Applications: Pandemic Resource Allocation

The COVID-19 pandemic forced healthcare systems worldwide to confront acute resource scarcity, particularly regarding ventilators, ICU beds, and later, vaccines. Many allocation frameworks incorporated utilitarian elements while balancing other ethical principles.

For ventilator allocation, most guidelines prioritized patients most likely to survive both in the short term and longer term, a primarily utilitarian approach aiming to maximize lives saved. However, many guidelines explicitly rejected purely utilitarian approaches that might have completely excluded certain groups (like those with pre-existing disabilities) or used strict age cutoffs.

Vaccine allocation similarly reflected utilitarian considerations—prioritizing healthcare workers (to maintain system capacity) and the elderly (at highest risk of death)—but also incorporated concerns about equity, reciprocity for essential workers, and fair access for disadvantaged communities.

These pandemic allocation frameworks demonstrate how contemporary healthcare rationing often employs utilitarian reasoning as one component within pluralistic ethical frameworks that also address rights, fairness, and procedural justice.

The Egalitarian Ethical Approach to Healthcare Rationing

In contrast to utilitarianism's focus on maximizing total welfare, egalitarianism centers on fairness, equality, and justice in the distribution of healthcare resources. Rather than asking "How can we produce the most health?" egalitarians ask "How can we distribute healthcare resources fairly?" This approach stems from the belief that each person has equal moral worth, deserving equal consideration in resource allocation decisions.

Philosophical Foundations of Healthcare Egalitarianism

Egalitarian approaches to healthcare rationing are grounded in several philosophical traditions:

1. **Rawlsian Justice**: Philosopher John Rawls proposed that just institutions are those that would be chosen by individuals behind a "veil of ignorance," not knowing their own circumstances. Applied to healthcare, this suggests resources should be distributed to benefit the least advantaged members of society.
2. **Equality of Opportunity**: Norman Daniels extended Rawls's theory to healthcare, arguing that fair allocation should maintain "normal species functioning" to preserve equality of opportunity. Healthcare is morally important because illness and disability restrict the range of opportunities otherwise open to individuals.
3. **Capabilities Approach**: Martha Nussbaum and Amartya Sen argue that justice requires ensuring everyone has the capability to achieve certain fundamental functionings, including bodily health. Healthcare distribution should enable all persons to develop key capabilities.

4. **Social Egalitarianism**: This view holds that justice requires treating everyone as equals, which extends beyond material distribution to include relationships of respect, recognition, and non-domination in healthcare contexts.
5. **Communitarian Perspectives**: Some egalitarian approaches emphasize the importance of community values and solidarity, arguing that healthcare systems should express collective responsibility for each member's well-being.

Types of Equality in Healthcare Rationing

Egalitarian approaches differ in what they seek to equalize:

14. Equality of Access

This approach aims to ensure everyone has the same opportunity to obtain healthcare services, regardless of irrelevant characteristics like geography, socioeconomic status, race, or gender. Policies promoting equality of access include:

- Universal health coverage systems that eliminate financial barriers to care
- Geographic distribution requirements for healthcare facilities
- Outreach programs for underserved communities
- Language services and cultural competency training
- Non-discrimination policies in healthcare settings

For example, Canada's Medicare system embodies this approach by providing universal coverage for medically necessary hospital and physician services regardless of ability to pay. Similarly, telehealth initiatives in rural areas aim to address geographic barriers to access.

However, equal access alone doesn't guarantee equal treatment or outcomes, as other social determinants and healthcare system factors may still create disparities.

15. Equality of Treatment

This approach holds that individuals with similar medical needs should receive similar care, regardless of non-medical factors. It focuses on consistency in the application of clinical standards and resource allocation protocols. Examples include:

- Clinical practice guidelines applied consistently across patients
- Standardized formularies and coverage policies
- Uniform waiting list criteria for scarce resources like organ transplants
- Blinded review processes for allocation decisions

The Veterans Health Administration's national formulary exemplifies this approach, ensuring that veterans receive consistent medication access regardless of which facility they visit.

Similarly, organ allocation systems attempt to standardize criteria nationwide to ensure similar patients have similar chances of receiving transplants.

Challenges to equality of treatment include legitimate clinical variation in patient needs and preferences, regional practice variations, and the difficulty of determining which patient differences are medically relevant.

16. **Equality of Outcomes**

Perhaps the most ambitious egalitarian goal is equality of health outcomes across population groups. This approach recognizes that equal access and treatment may not produce equal results due to social determinants of health, genetic factors, and cumulative disadvantages. Policies promoting outcome equality include:

- Targeted interventions for groups with poor health outcomes
- Social programs addressing upstream determinants like housing and education
- Progressive resource allocation that directs more healthcare to disadvantaged communities
- Health equity impact assessments for new programs and policies

New Zealand’s Māori Health Strategy exemplifies this approach, allocating specific resources to improve indigenous health outcomes and reduce disparities. Similarly, the UK’s health inequalities strategy targets areas with the poorest health indicators for additional investment.

Critics argue that perfect equality of outcomes may be impossible given genetic variation and individual choices, and that pursuing it could require excessive resource concentration or restrictions on personal liberty.

17. **Equal Consideration and Respect**

This form of equality focuses on the decision-making process, ensuring that each person’s interests receive equal consideration and that allocation decisions treat everyone with equal respect. This includes:

- Transparent decision-making processes
- Meaningful stakeholder participation in allocation decisions
- Clear appeals processes for challenging decisions
- Non-stigmatizing language and practices

For example, some healthcare systems include community representatives on coverage decision committees to ensure diverse perspectives are considered. Patient advocacy groups may be formally consulted on allocation frameworks, and many systems provide mechanisms for patients to appeal denial of services.

This approach recognizes that even when resources must be unequally distributed, the process can still show equal respect for all parties affected.

Methods for Egalitarian Resource Allocation

Egalitarian approaches employ several methods to achieve fair distribution of healthcare resources:

18. **Lottery Systems**

Random allocation through lotteries represents one of the purest expressions of egalitarianism, giving each eligible person an equal statistical chance of receiving scarce resources regardless of social advantages or ability to game the system. Lotteries have been used for:

- Allocating scarce experimental drugs
- Selecting participants for limited-enrollment clinical trials
- Distributing organs when medical criteria cannot distinguish between candidates

For example, during COVID-19 vaccine trials, some programs used lotteries to select participants from pools of eligible volunteers. Similarly, when demand for new hepatitis C treatments initially exceeded supply, some systems used random selection among clinically similar patients.

While maximally fair in a procedural sense, lotteries sacrifice efficiency by ignoring factors that might predict better outcomes for some recipients. They also face practical challenges in defining the eligible pool and ensuring truly random selection.

19. **First-Come, First-Served**

This approach allocates resources based on the order in which patients present or join waiting lists. Examples include:

- Emergency department triage for non-critical cases
- Waitlists for elective procedures
- Medication distribution during shortages

While seemingly fair, first-come-first-served approaches often disadvantage those with transportation challenges, inflexible work schedules, lower health literacy, or less ability to advocate for themselves. These individuals may present later despite equal or greater need.

To address these concerns, some systems modify first-come approaches with active outreach to vulnerable populations or adjustments for those facing access barriers.

20. **Needs-Based Allocation**

This approach prioritizes those with the greatest healthcare needs, often defined by severity of illness, functional limitation, or threat to life. Examples include:

- Emergency department triage protocols that prioritize the most severely ill
- Transplant allocation systems that consider medical urgency
- Home care allocation based on functional limitations

The UK's National Health Service uses needs-based allocation for many services, prioritizing patients with more severe or acute conditions. Similarly, most organ allocation systems incorporate medical urgency alongside other factors.

Challenges include defining "need" (Is it current suffering? Threat to life? Functional limitation?), measuring need consistently across different conditions, and determining how much priority greater need should receive.

21. **Proportional Allocation**

When resources must be rationed across a population, proportional allocation distributes them according to the size or need of different groups. Examples include:

- Budget allocations to healthcare facilities based on population served
- Vaccine distribution to regions proportional to population
- Research funding distributed across disease categories based on prevalence or burden

For instance, the UK allocates NHS funding to regions using formulas that account for population size, age distribution, deprivation indices, and other need indicators. Similarly, many countries distributed COVID-19 vaccines to regions proportionately to their populations.

This approach promotes geographic equity but may need adjustment for variations in need, existing infrastructure, and implementation costs across different areas.

22. **Universal But Unequal Allocation**

This approach provides some care to everyone but varies the quantity or quality based on need, prognosis, or other factors. Examples include:

- Tiered benefit packages that cover basic services for all but specialized services for those who meet clinical criteria
- Stepped care models that provide simple interventions to all patients but reserve intensive interventions for those who don't respond
- Priority setting frameworks that fund high-priority services for everyone before funding lower-priority services for anyone

Oregon’s Medicaid prioritization list exemplifies this approach—covering a defined set of high-priority services for all eligible residents rather than comprehensive services for some and none for others. Similarly, the UK’s NICE guidance ensures basic treatments are universally available while restricting access to less cost-effective interventions.

This approach embodies the egalitarian commitment to providing some care to everyone while acknowledging resource constraints that make uniform comprehensive care impossible.

Procedural Justice in Healthcare Rationing

Many egalitarian approaches emphasize not only distributive justice (fair outcomes) but also procedural justice (fair processes). Philosophers Norman Daniels and James Sabin proposed the “accountability for reasonableness” framework, which requires that resource allocation decisions:

1. **Be transparent**: The reasoning behind decisions must be publicly accessible
2. **Appeal to relevant reasons**: Decisions must be based on evidence and principles that fair-minded people would accept
3. **Be revisable**: Mechanisms must exist to challenge and revise decisions in light of new evidence or arguments
4. **Include enforcement**: There must be voluntary or regulatory enforcement of the above conditions

Countries including New Zealand, Norway, and the UK have implemented elements of this framework in their healthcare priority-setting bodies. For example, NICE in the UK publishes its methods, evidence, and reasoning, allows stakeholder input, and has an appeals process for its coverage decisions.

Procedural justice approaches recognize that reasonable people may disagree about substantive allocation principles but can often agree on fair decision-making processes. They shift focus from finding the perfectly just distribution to ensuring decisions are made through legitimate, respectful processes.

Special Considerations in Egalitarian Approaches

Egalitarian frameworks must address several special cases and considerations:

23. Pre-existing Health Disparities

Pure equality in resource allocation may perpetuate or exacerbate existing health disparities. To address this, many egalitarian approaches incorporate elements of equity, which may require unequal resource distribution to achieve fair outcomes.

For example, the US Indian Health Service provides additional resources to Native American communities to address historical injustices and resulting health disparities. Similarly, the UK’s health inequalities strategy directs extra funding to areas with the poorest health indicators.

These approaches recognize that treating unequally situated people identically can be as unfair as treating equally situated people differently.

24. **Personal Responsibility and Lifestyle Factors**

Egalitarian approaches must decide whether and how to account for health conditions influenced by personal choices. Potential positions include:

- Strict equality: Treat all patients with equal needs equally, regardless of how their condition developed
- Responsibility-sensitive: Consider personal responsibility in allocation decisions, with lower priority for conditions resulting from "voluntary" choices
- Middle ground: Focus on forward-looking factors like treatment adherence rather than backward-looking judgments about causation

Germany's healthcare system exemplifies the middle approach, offering incentives for preventive behaviors without denying care based on past choices. By contrast, some transplant programs consider alcohol abstinence in liver allocation, representing a more responsibility-sensitive approach.

The challenge lies in distinguishing truly voluntary choices from behaviors shaped by addiction, mental health, socioeconomic constraints, or limited health literacy—and in applying such distinctions consistently across different lifestyle factors.

25. **Age-Based Considerations**

Age represents a particularly challenging factor for egalitarian approaches. Potential positions include:

- Age-neutrality: Ignore age entirely in allocation decisions
- Fair innings: Give some priority to younger patients who haven't had their "fair share" of life
- Prudential lifespan account: Allocate resources across life stages as rational individuals would choose for themselves over a complete life

The UK's NICE has generally taken an age-neutral approach in its evaluations, though it has occasionally made exceptions for end-of-life treatments and pediatric care. Norway's national priority-setting guidelines explicitly reject age as a criterion except where it directly affects clinical benefit.

The challenge lies in distinguishing unjust age discrimination from morally relevant considerations about potential benefit and life course completion.

Strengths of the Egalitarian Approach

Egalitarian approaches to healthcare rationing offer several advantages:

1. **Moral intuition**: They align with widely held intuitions about fairness and equal human worth that cross cultural and philosophical divides.
2. **Social cohesion**: Equal access systems foster social solidarity and reduce divisiveness compared to multi-tier systems that separate populations.
3. **Dignity and respect**: By treating each person's needs as equally worthy of consideration, egalitarian approaches affirm human dignity.
4. **Democratic values**: Equal consideration in healthcare reflects broader democratic commitments to equality before the law and equal citizenship.
5. **Reduced exploitation**: Egalitarian systems reduce the risk that vulnerable groups will bear disproportionate burdens of rationing.

Criticisms and Limitations of the Egalitarian Approach

Despite their intuitive appeal, egalitarian approaches face several important criticisms:

1. **Efficiency concerns**: Strictly equal distribution may sacrifice overall health gains by diverting resources from where they would produce the most benefit.
2. **Leveling down**: Some egalitarian approaches might seem to recommend reducing benefits to some without helping others if doing so increases equality.
3. **Vagueness**: "Equality" and "fairness" can be interpreted in multiple ways, leading to conflicting recommendations about specific allocation decisions.
4. **Practical challenges**: Truly equal consideration may be difficult to achieve given implicit biases, information asymmetries, and power imbalances in healthcare systems.
5. **Resource intensiveness**: Procedural justice requirements like transparency, participation, and appeals mechanisms consume resources that could otherwise provide direct care.

Case Study: Kidney Allocation in the United States

The evolution of kidney allocation policy in the United States illustrates the application of egalitarian principles to a scarce resource. The initial system, implemented in 1987, primarily used waiting time to allocate kidneys, with some consideration of tissue matching. This first-come-first-served approach aimed for procedural fairness but resulted in disparities, as certain groups (particularly African Americans) had lower chances of receiving compatible organs.

In 2014, the system was reformed to incorporate both egalitarian and utilitarian considerations. The new system:

- Gave greater weight to waiting time, enhancing equality of opportunity
- Reduced emphasis on exact tissue matching, which had disadvantaged minority patients
- Considered expected post-transplant survival, introducing utilitarian elements
- Gave priority to patients with the highest "calculated panel reactive antibodies," addressing the needs of the hardest-to-match patients
- Awarded priority to prior living donors, recognizing their contribution

This hybrid approach demonstrates how contemporary allocation systems often combine egalitarian principles with other ethical considerations to address multiple dimensions of fairness while acknowledging efficiency concerns.

Contemporary Applications: COVID-19 Vaccine Distribution

COVID-19 vaccine allocation highlighted tensions between different egalitarian approaches. Initial scarcity required prioritization, with countries employing various frameworks:

- Some emphasized equal access within priority groups (healthcare workers, elderly), using lotteries or first-come-first-served approaches within these categories
- Others focused on geographic equity, distributing vaccines proportionally to population across regions
- Many addressed outcome equality by prioritizing disadvantaged communities with higher infection rates and more limited healthcare access
- Most employed transparent allocation frameworks developed through inclusive processes, embodying procedural justice

The COVID-19 experience demonstrated both the appeal of egalitarian principles in crisis rationing and the inevitable tensions between different conceptions of equality when resources are insufficient to meet all needs simultaneously.

Prioritarianism: Giving Priority to the Worst Off

Prioritarianism represents a middle ground between pure utilitarianism and strict egalitarianism. While it shares utilitarianism’s concern with improving well-being, prioritarianism gives greater weight to benefits provided to those who are worse off. The core principle is that improvements in well-being matter more morally when they occur at lower absolute levels.

Philosophical Foundations of Prioritarianism

Developed by philosophers including Derek Parfit, prioritarianism responds to the “leveling down” objection against egalitarianism. While egalitarians might value equality for its own sake (potentially endorsing making everyone worse off if it increases equality), prioritarians value helping the worst off because their needs are more urgent, not because inequality itself is intrinsically bad.

Prioritarianism is often expressed mathematically by applying a concave function to individual well-being before summing across individuals. This gives diminishing moral weight to improvements as absolute well-being increases, formally capturing the intuition that helping someone in dire need matters more than providing an equivalent benefit to someone already well-off.

Applications in Healthcare Rationing

In healthcare contexts, prioritarian approaches direct resources toward:

26. **Individuals with Severe Illnesses**

Prioritarianism suggests giving precedence to treating severe conditions over milder ones, even if the health gains might be smaller. This aligns with common moral intuitions that helping those suffering severely takes precedence over providing equivalent benefits to those with minor ailments.

For example, Norway's priority-setting guidelines explicitly incorporate severity as a criterion alongside health benefits and resource use. Treatments for more severe conditions receive priority even if they are somewhat less cost-effective than treatments for milder conditions.

27. **Disadvantaged Populations**

Prioritarian approaches often direct extra resources toward populations experiencing health disparities or multiple disadvantages. This might include racial and ethnic minorities, low-income communities, rural populations, or groups facing discrimination.

The UK's health inequalities strategy exemplifies this approach, directing additional resources to areas with the poorest health indicators. Similarly, the US Indian Health Service provides targeted resources to address the health needs of Native American communities that have historically experienced both poor health outcomes and social disadvantage.

28. **Rare and Catastrophic Illnesses**

Many healthcare systems make exceptions to standard cost-effectiveness thresholds for treatments targeting rare, severe conditions. This "rule of rescue" for catastrophic illnesses reflects prioritarian intuitions about the special moral urgency of helping those facing dire circumstances.

For instance, many countries have special funding mechanisms for orphan drugs treating rare diseases, even when these treatments would not meet standard cost-effectiveness criteria. The UK's Cancer Drugs Fund similarly provides access to cancer treatments that exceed normal cost-effectiveness thresholds, reflecting the prioritarian view that helping patients with life-threatening conditions carries special weight.

Strengths of the Prioritarian Approach

Prioritarianism offers several advantages as a framework for healthcare rationing:

1. **Intuitive appeal**: It captures widely shared moral intuitions about the special urgency of helping those who are suffering most.
2. **Avoids leveling down**: Unlike some egalitarian approaches, prioritarianism never recommends making some worse off without helping others.

3. **Balances concerns**: It navigates between pure utilitarianism's potential neglect of the worst-off and strict egalitarianism's potential sacrifice of efficiency.
4. **Addresses disadvantage**: It provides a framework for tackling health disparities without requiring equal outcomes for all.

Criticisms and Limitations of Prioritarianism

Despite its appeal, prioritarianism faces several challenges:

1. **Measurement difficulties**: Determining who is "worst off" in healthcare contexts is complex—is it those with the most severe symptoms, shortest life expectancy, lowest quality of life, or most social disadvantage?
2. **Threshold questions**: How much extra weight should benefits to the worst off receive, and at what point does someone cease to be "badly off" enough to merit special consideration?
3. **Aggregation problems**: Prioritarianism still allows small benefits to many better-off individuals to outweigh larger benefits to a few worse-off individuals if the numbers are sufficiently large.
4. **Practical implementation**: Translating prioritarian principles into operational allocation criteria that can be applied consistently presents significant challenges.

The Health Insurance Broker: Ethical Position and Responsibilities

The Unique Ethical Position of the Health Insurance Broker

Health insurance brokers occupy a distinctive ethical position in the healthcare ecosystem, characterized by multiple relationships and competing obligations:

1. **Dual Agency**: Brokers serve as intermediaries between clients (individuals or employers) and insurance carriers, creating potential conflicts between the interests of these parties.
2. **Fiduciary Responsibilities**: In many jurisdictions, brokers have fiduciary duties to their clients, obligating them to act in the client's best interest above their own financial interests.
3. **Market Knowledge Asymmetry**: Brokers possess specialized knowledge about insurance products, policies, and processes that their clients typically lack, creating an information imbalance that demands ethical management.
4. **Economic Incentives**: Brokers are usually compensated through commissions from carriers or fees from clients, potentially creating incentives that do not align perfectly with client welfare.
5. **Ongoing Relationship**: Unlike agents who may sell a policy and move on, brokers typically maintain long-term relationships with clients, providing service throughout the policy period and at renewal.
6. **Professional Standards**: Brokers operate under professional licensing requirements, industry standards, and codes of ethics that establish baseline expectations for conduct.

This complex positioning creates a unique ethical landscape for brokers navigating treatment rejections. They stand at the intersection of clinical recommendations, insurance policy limitations, regulatory requirements, financial considerations, and above all, the healthcare needs of their clients.

Ethical Frameworks Applicable to Broker Responsibilities

Several ethical frameworks can inform how brokers should respond to treatment rejections:

1. **Principle-Based Ethics**: Considering principles such as:
    - Beneficence (promoting client welfare)
    - Non-maleficence (avoiding harm)
    - Autonomy (respecting client choices)
    - Justice (ensuring fair treatment)
    - Fidelity (keeping promises and maintaining trustworthiness)
2. **Care Ethics**: Emphasizing relationships, empathy, and responsiveness to clients' expressed needs and circumstances.
3. **Virtue Ethics**: Focusing on developing and exercising professional virtues like integrity, diligence, honesty, and compassion.
4. **Contractarian Ethics**: Honoring explicit and implicit agreements made with clients about the broker's role and responsibilities.
5. **Consequentialist Ethics**: Evaluating actions based on their outcomes for client health, financial security, and overall wellbeing.

Different ethical frameworks may suggest different courses of action in specific cases, requiring brokers to engage in thoughtful moral reasoning rather than following simple algorithms.

Core Ethical Responsibilities When Facing Treatment Rejections

When a client's treatment plan is rejected by an insurance carrier, health insurance brokers face several core ethical responsibilities:

29. Responsibility of Competence and Knowledge

Ethical Duty: Brokers have an obligation to possess thorough knowledge of the products they sell, the coverage limitations, the appeals processes, and the regulatory environment.

Practical Application:

- Maintaining comprehensive understanding of policy details, particularly exclusions, limitations, and medical necessity criteria
- Staying current on changing carrier requirements, clinical guidelines, and emerging treatments
- Understanding the legal framework including state insurance regulations and federal laws like the Affordable Care Act, ERISA, and mental health parity requirements

- Developing expertise in alternative coverage options and community resources for uncovered services

Ethical Implications: Without this knowledge foundation, brokers cannot effectively advocate for clients or provide informed guidance. Competence is therefore a prerequisite for fulfilling all other ethical duties. When treatment is rejected, the broker must be able to quickly determine whether the rejection appears consistent with policy terms or represents a potential error or improper denial.

Case Example: A patient with a rare autoimmune disorder receives a denial for an off-label medication. An ethically competent broker would understand: (1) the policy's specific language regarding off-label usage; (2) whether the plan is fully-insured or self-funded, determining which regulations apply; (3) the carrier's exception process for rare conditions; and (4) the state's external review requirements for such denials.

30. Responsibility of Transparency and Education

Ethical Duty: Brokers must provide clear, honest, and comprehensive information to clients both before purchase and when treatment rejections occur.

Practical Application:

- Explaining coverage limitations and exclusions proactively during the sales process
- Educating clients about how medical necessity determinations are made
- Clarifying the distinction between a provider's recommendations and an insurer's coverage decisions
- Providing unvarnished assessment of appeal chances and coverage limitations

Ethical Implications: Transparency builds trust and enables informed decision-making. When treatment is rejected, clients need honest explanations about why the rejection occurred and realistic assessments of options. False hope can lead to delayed care decisions or financial hardship, while overly pessimistic assessments may discourage legitimate appeals.

Case Example: A client's specialized physical therapy regime is denied continuation after initial approval. An ethical broker would transparently explain: (1) the carrier's specific reason for denial; (2) the policy's visit limitations or medical necessity criteria being applied; (3) the full range of options including appeal, alternative coverage approaches, and out-of-pocket arrangements; and (4) realistic assessment of likely outcomes for each approach.

31. Responsibility of Informed Advocacy

Ethical Duty: When treatment denials occur, brokers have an obligation to advocate for clients within the bounds of policy terms, using their system knowledge and relationships to navigate complex appeals processes.

Practical Application:

- Helping clients understand the specific reason for denial
- Assisting in gathering appropriate documentation for appeals
- Leveraging relationships with carrier representatives to expedite reviews
- Advising on the most effective language and framing for appeals
- Escalating to higher levels when front-line responses are inadequate

Ethical Implications: Effective advocacy requires balancing zealous representation with honest assessment. Brokers must navigate between under-advocacy (simply accepting all denials) and over-advocacy (pursuing hopeless appeals or making misrepresentations). The advocacy role does not mean guaranteed success but rather ensuring the client receives full and fair consideration under the policy terms.

Case Example: A patient with treatment-resistant depression receives denial for transcranial magnetic stimulation (TMS) therapy. Ethical advocacy would involve: (1) reviewing denial specifics and policy language; (2) working with the provider to document failed conventional treatments; (3) finding specific clinical guidelines supporting TMS for similar cases; (4) preparing a comprehensive appeal that addresses the carrier's stated reason for denial; and (5) knowing when to escalate to supervisory review or external appeal.

32. **Responsibility of Emotional Support and Care**

Ethical Duty: Beyond technical assistance, brokers have a responsibility to acknowledge the emotional impact of treatment denials and provide empathetic support throughout the process.

Practical Application:

- Listening attentively to client concerns and frustrations
- Acknowledging the stress and fear that treatment denials can cause
- Maintaining consistent communication during lengthy appeal processes
- Treating clients with dignity and respect regardless of policy limitations

Ethical Implications: The psychological impact of treatment denials is significant. Patients already coping with illness must navigate bureaucratic barriers to recommended care. Brokers who recognize and address this emotional dimension fulfill ethical obligations of care while also building trust and strengthening the professional relationship.

Case Example: A cancer patient whose oncologist-recommended treatment is denied experiences anxiety about delayed treatment and uncertainty about next steps. An ethically attentive broker would: (1) create space for the client to express concerns; (2) validate the difficulty of the situation; (3) provide clear, non-technical explanations of options; and (4) commit to regular updates during the appeal process to reduce uncertainty.

33. **Responsibility of Confidentiality and Privacy**

Ethical Duty: Brokers must handle sensitive medical information with appropriate confidentiality while still gathering necessary details to advocate effectively.

Practical Application:

- Obtaining appropriate authorization before discussing medical details with carriers or providers
- Maintaining secure systems for handling protected health information
- Discussing sensitive medical information only when necessary and in appropriate settings
- Following HIPAA and other privacy regulations scrupulously

Ethical Implications: Treatment denials inevitably involve detailed medical information. Brokers must balance the need for specific information to advocate effectively against privacy concerns. Breaches of confidentiality not only violate regulations but can damage trust and cause emotional harm.

Case Example: When helping a client appeal denial for a behavioral health treatment, an ethical broker would: (1) obtain specific authorization before discussing mental health details; (2) minimize documentation to what's necessary for the appeal; (3) use secure methods to transmit sensitive information; and (4) discuss the case only with those with legitimate need to know.

34. **Responsibility of Impartiality and Conflict Management**

Ethical Duty: Brokers must manage conflicts between their own financial interests, carrier relationships, and client needs, prioritizing fiduciary responsibilities to clients when conflicts arise.

Practical Application:

- Disclosing commission structures and financial relationships with carriers
- Advocating for clients even when it might strain carrier relationships
- Providing guidance based on client needs rather than ease of processing
- Recommending external appeals or regulatory complaints when appropriate

Ethical Implications: The triangle of relationships between broker, client, and carrier creates inherent conflicts. Ethical brokers recognize these tensions and establish clear decision frameworks that prioritize fiduciary duties to clients while maintaining professional relationships with carriers.

Case Example: A self-funded employer client has a pattern of treatment denials for certain conditions. An ethical broker would: (1) analyze whether the denials align with plan documents; (2) present unbiased data on impacts to affected employees; (3) recommend plan modifications if systematic issues exist; and (4) advocate for individual employees within the bounds of the broker's relationship with the employer client.

Navigating Specific Ethical Challenges in Treatment Rejections

Beyond general responsibilities, brokers face specific ethical dilemmas when handling treatment rejections:

35. When Policy Limitations Create Harm

Perhaps the most challenging ethical situation occurs when a treatment denial appears technically correct under policy terms but creates potential harm for the client. Brokers must navigate between honoring contractual limitations and preventing harm.

Ethical Approaches:

- Exploring alternative benefits within the policy that might cover the treatment under different coding or categorization
- Identifying external programs or patient assistance options
- Advocating for exceptions based on unique circumstances
- Transparently discussing policy limitations while actively seeking alternatives

Case Scenario: A client with a rare genetic disorder requires a specialized treatment excluded under their policy's experimental/investigational provision. Though the denial aligns with policy language, the treatment has shown efficacy for similar cases and no alternatives exist. An ethical broker might:

- Work with the provider to determine if recategorization is possible
- Explore whether the carrier offers single-case agreements for rare situations
- Investigate manufacturer patient assistance programs
- Connect the client with patient advocacy organizations for additional support
- Consider whether an external regulatory complaint is warranted based on potential broader coverage requirements

36. Balancing Truth-Telling with Hope

When treatment denials occur for services unlikely to be covered through appeal, brokers must balance honest assessment with maintaining appropriate hope and identifying alternatives.

Ethical Approaches:

- Providing realistic assessment of appeal prospects without unnecessarily eliminating hope

- Separating factual policy analysis from personal opinions about coverage worthiness
- Shifting focus to constructive alternatives when appeals are unlikely to succeed
- Acknowledging emotional responses while guiding toward practical next steps

Case Scenario: A client seeks coverage for an innovative treatment available only overseas and clearly excluded under their policy. An ethical broker would:

- Honestly explain the specific exclusion and low likelihood of successful appeal
- Validate the client's disappointment and frustration
- Explore whether any domestic alternatives might be covered
- Discuss financial planning options or community fundraising approaches
- Connect with patient groups for others who have navigated similar situations

37. Systemic Advocacy vs. Individual Solutions

Brokers often recognize patterns of denials that suggest systemic issues rather than individual case problems. This creates tension between addressing immediate client needs and advocating for systemic change.

Ethical Approaches:

- Documenting patterns of denials to identify potential systemic issues
- Bringing legitimate concerns to carrier leadership while maintaining client confidentiality
- Advocating for policy modifications at renewal to address recurring issues
- Supporting appropriate regulatory complaints when patterns suggest improper practices

Case Scenario: A broker notices multiple clients experiencing denials for specific mental health services despite mental health parity laws. An ethical approach would involve:

- Addressing individual appeals with appropriate documentation
- Analyzing whether the pattern suggests a potential parity violation
- Presenting de-identified data to the carrier suggesting a potential compliance issue
- Considering whether to recommend regulatory complaints if the pattern persists
- Proposing policy modifications for employer clients to explicitly cover these services

38. When Client Expectations Exceed Policy Coverage

Clients often expect insurance to cover all medically recommended treatments, creating ethical challenges when broker knowledge indicates certain recommendations will likely be denied.

Ethical Approaches:

- Proactively educating about coverage limitations before issues arise
- Distinguishing between medical recommendations and insurance coverage determinations
- Helping clients understand the concept of medical necessity as defined by insurers
- Exploring supplemental coverage options for anticipated needs

Case Scenario: A client with chronic pain is pursuing various alternative therapies recommended by their provider, most of which fall outside traditional coverage. An ethical broker would:

- Clearly explain which therapies are likely covered versus excluded
- Explore whether any treatments might qualify under specific benefits
- Discuss supplemental policies that might offer broader coverage
- Work with the provider on documentation that aligns with carrier requirements
- Suggest staged approaches prioritizing covered services before exploring alternatives

39. **Professional Boundaries and Scope of Practice**

Treatment rejections create pressure for brokers to provide guidance that may push the boundaries of their professional scope, particularly regarding medical alternatives or legal advice.

Ethical Approaches:

- Maintaining clear boundaries between insurance expertise and clinical guidance
- Making appropriate referrals to legal resources for complex regulatory issues
- Collaborating with clinical providers rather than second-guessing their recommendations
- Focusing on coverage navigation while respecting other professionals' domains

Case Scenario: A client asks whether a denied treatment is truly medically necessary or if alternative treatments would be equally effective and covered. An ethical broker would:

- Clarify that medical necessity determinations require clinical expertise
- Focus on explaining the carrier's specific definition of medical necessity
- Encourage dialogue between the client and their provider about alternatives
- Offer to help investigate coverage for specific alternatives the provider recommends
- Avoid making comparative clinical judgments about treatment options

Ethical Decision Framework for Treatment Rejection Scenarios

When confronting treatment rejections, brokers can apply a structured ethical decision framework:

40. **Assessment Phase**

- **Policy Analysis**: Thoroughly review policy language, exclusions, and limitations
- **Denial Evaluation**: Examine the specific rationale given for denial
- **Client Impact Assessment**: Consider the potential consequences of the denial for the client's health and financial situation
- **Stakeholder Identification**: Identify all parties with interests in the decision (client, provider, carrier, employer if group coverage)
- **Options Inventory**: Catalog all potential responses (appeal, external review, alternative coverage approaches, etc.)

41. **Ethical Analysis Phase**

- **Principles Application**: Consider how key ethical principles (beneficence, autonomy, justice, fidelity) apply to the specific case
- **Conflicts Identification**: Recognize any conflicts between different ethical obligations
- **Prioritization**: Determine which ethical principles should take precedence in this specific situation
- **Professional Standards Review**: Consider relevant professional codes and standards
- **Consultation**: When appropriate, seek colleague input on challenging cases

42. **Action Phase**

- **Transparent Communication**: Clearly explain options and recommendations to the client
- **Informed Consent**: Ensure the client understands and agrees to the proposed approach
- **Documentation**: Maintain records of decisions, rationales, and actions taken
- **Implementation**: Execute the chosen strategy with diligence and follow-through
- **Evaluation**: Monitor outcomes and adjust approach as needed

4. **Reflection Phase**

- **Case Review**: Analyze what worked, what didn't, and why
- **Process Improvement**: Identify system changes that might prevent similar issues
- **Knowledge Integration**: Update practices based on lessons learned
- **Professional Development**: Identify areas where additional education or resources would be beneficial

This framework provides a systematic approach to ethically complex treatment rejection scenarios, helping brokers navigate the gray area between medical recommendations and insurance limitations.

Institutional Supports for Ethical Broker Conduct

Individual brokers operate within broader systems that can either support or hinder ethical responses to treatment rejections:

5. Professional Standards and Codes of Ethics

Industry associations like the National Association of Health Underwriters (NAHU) and the National Association of Insurance and Financial Advisors (NAIFA) provide ethical codes for health insurance professionals. These typically include commitments to:

- Place client interests first
- Maintain appropriate expertise
- Provide honest and accurate information
- Protect confidential information
- Avoid conflicts of interest

These standards provide valuable guidance, though they often require interpretation when applied to complex treatment rejection scenarios.

6. Regulatory Frameworks

Federal and state regulations establish minimum standards for broker conduct, including:

- Licensing requirements establishing basic competency
- Disclosure obligations regarding compensation and relationships
- Market conduct standards prohibiting misrepresentation
- Privacy requirements under HIPAA and state laws
- Fiduciary standards in certain contexts

Regulatory frameworks create a baseline for ethical conduct but typically don’t address the nuanced ethical challenges brokers face with treatment rejections.

7. Brokerage Firm Practices

Organizational policies and culture significantly influence how individual brokers respond to ethical challenges:

- Internal escalation protocols for complex cases
- Peer consultation processes for difficult situations
- Documentation standards for treatment denial assistance
- Compensation structures that may incentivize or disincentivize advocacy
- Training programs addressing ethical dimensions of broker work

Firms with robust ethics infrastructures better position their brokers to navigate treatment rejection challenges ethically.

8. Education and Professional Development

Ongoing education specifically addressing ethical dimensions of broker work is essential:

- Case-based learning exploring nuanced rejection scenarios
- Cross-disciplinary training incorporating healthcare ethics concepts
- Communication skills development for difficult conversations
- Updates on evolving regulatory standards and appeals processes

Without specific attention to ethics education, brokers may default to purely technical approaches to treatment rejections, missing important moral dimensions.

Evolving Ethical Considerations in Treatment Rejection Navigation

The ethical landscape for brokers navigating treatment rejections continues to evolve with changes in healthcare delivery, policy, and expectations:

9. Transparency Movement

Increasing emphasis on transparency in healthcare creates both opportunities and obligations:

- Greater access to coverage determination criteria allows more informed advocacy
- Price transparency tools enable better financial counseling when treatments are denied
- Public quality metrics help identify alternative providers when network limitations drive denials
- Disclosure requirements about broker compensation highlight potential conflicts

Ethical brokers can leverage transparency to better serve clients while also accepting greater accountability for their own roles and relationships.

10. Patient Advocacy Professionalization

The emergence of professional patient advocates creates new collaborative possibilities:

- Specialized advocates may offer deeper expertise in clinical appeals
- Brokers can develop referral relationships with advocates for complex cases
- Collaborative approaches may better serve clients with particularly difficult denials
- Clearer role differentiation may help manage scope of practice concerns

Ethical brokers recognize when client needs exceed their expertise and collaborate appropriately with specialized advocates.

11. **Value-Based Insurance Design**

The shift toward value-based insurance creates new complexities in coverage determinations:

- Treatment value may be assessed differently for different patient populations
- Coverage may become more personalized based on individual patient characteristics
- Outcomes-based coverage creates new types of denials and appeals
- Clinical evidence importance increases in coverage determinations

Brokers must develop new ethical approaches to navigating these more complex coverage landscapes.

12. **Digital Transformation**

Technology is transforming how treatment approvals and denials occur:

- Algorithmic determination of coverage creates new transparency challenges
- Digital records enable more comprehensive documentation for appeals
- Telehealth coverage determinations may differ from in-person care standards
- Online appeals processes create new advocacy opportunities and challenges

Ethical brokers must adapt to these technological changes while maintaining human-centered approaches to client advocacy.

Conclusion: The Broker as Ethical Navigator

Health insurance brokers serve not merely as salespeople or technical experts but as ethical navigators helping clients traverse the complex and often fraught terrain between medical recommendations and insurance coverage. When treatment rejections occur, brokers face the challenging task of balancing multiple obligations: fidelity to clients, honesty about policy limitations, advocacy within appropriate boundaries, and maintenance of sustainable carrier relationships.

The most ethically sound approach recognizes that broker responsibilities extend beyond narrow contractual obligations to encompass broader duties of care. This means not simply explaining why a treatment was denied but actively engaging in informed advocacy, exploring alternatives, providing emotional support, maintaining appropriate boundaries, and continually developing the knowledge needed to navigate increasingly complex healthcare systems.

In the gray area between medical recommendations and insurance approvals, the ethical broker serves as guide, advocate, educator, and sometimes, creative problem-solver. While they cannot guarantee coverage for every recommended treatment, they can ensure that clients receive the full benefit of their expertise, advocacy, and care during what is often a vulnerable and frightening time. This ethical commitment to client welfare, balanced with honest recognition of policy limitations, defines the broker's unique and vital role in the healthcare ecosystem.

Rights-Based Approaches to Healthcare Rationing

Rights-based approaches frame healthcare allocation in terms of claims that individuals can make against healthcare systems or society. These approaches emphasize that certain healthcare needs create obligations that cannot be overridden by utilitarian calculations or majority preferences.

Philosophical Foundations of Rights-Based Approaches

Rights-based approaches draw on several philosophical traditions:

1. **Natural Rights Theory**: Some argue that healthcare rights derive from fundamental natural rights to life and bodily integrity.
2. **Social Contract Theory**: Others ground healthcare rights in hypothetical agreements that rational individuals would make when establishing a society.
3. **Human Rights Frameworks**: International declarations like the Universal Declaration of Human Rights recognize "the right to a standard of living adequate for health and well-being, including medical care."
4. **Capabilities Approach**: Martha Nussbaum includes bodily health among the central human capabilities that societies are obligated to secure for all citizens.

Rights-based approaches vary in whether they frame healthcare as a negative right (freedom from interference in obtaining healthcare) or a positive right (entitlement to certain healthcare services), with significant implications for rationing.

Types of Healthcare Rights Claims

Several kinds of rights claims influence healthcare rationing:

13. Right to a Decent Minimum

This approach holds that everyone has a right to a basic package of healthcare services that meets essential needs, even if comprehensive care must be rationed. Society is obligated to ensure no one falls below this threshold,

Case Study:
Utilitarian Ethics and Medicare for all

This section comes largely from Claude, AI, downloaded March 25, 2024

Medicare for all

Medicare for all is a catch phrase loosely meaning ‘a national single payer healthcare program’ that may or may not closely resemble our current Medicare program. See page 7 above for a brief overview of Medicare and Medicaid.

Utilitarian Ethical Overview

Utilitarianism is a moral philosophy that holds that the most ethical choice is the one that maximizes overall utility or well-being for the greatest number of people. The origins of this idea can be traced back to ancient philosophers like Aristotle, Epicurus, and the Buddhist tradition. However, the classical utilitarianism doctrine was developed and popularized in the 18th and 19th centuries by thinkers like Jeremy Bentham, John Stuart Mill, and Henry Sidgwick.

Core Principles of Utilitarianism

The foundational principle of utilitarian theory is that actions, policies, and practices should be evaluated by analyzing their consequences and outcomes. Specifically, decisions should be made based on maximizing happiness, well-being or pleasure while minimizing suffering, pain or unhappiness for the greatest portion of the population possible.

Utilitarians define utility or well-being in terms of the experiences of pleasure, satisfaction, happiness versus pain, suffering, or unhappiness. They believe these positive and negative subjective experiences can be measured, quantified, compared interpersonally, and ultimately maximized across a population.

In essence, utilitarianism is a consequentialist moral theory, meaning the ends can justify the means if the net outcome results in more utility or well-being overall. This contrasts with deontological ethics focused on absolute moral rules like honesty or rights.

The Greatest Happiness Principle

Jeremy Bentham, the founder of modern utilitarianism, articulated the core philosophy through his "greatest happiness principle." He wrote:

> "Nature has placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do...By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question."

Bentham believed all ethics and public policies should be judged by this utility calculus – do they increase or reduce overall happiness and well-being? He took a quantitative approach, arguing we should engage in "felicific calculus" by estimating the degrees of pleasure versus pain produced by an action across intensity, duration, certainty, nearness, and number of people affected.

John Stuart Mill on Higher and Lower Pleasures

Bentham's protege John Stuart Mill expanded on and refined the theory of utilitarianism in his seminal 1863 work Utilitarianism. Mill agreed that increasing happiness and minimizing suffering was the ultimate goal of ethical behavior. However, he rejected the idea of simply equating utility with raw pleasure or hedonistic satisfaction.

Mill made an influential distinction between **higher and lower pleasures**. Lower pleasures were base, rudimentary gratifications like physical appetites or sensory inputs. Higher pleasures involved more refined satisfactions of the mind and emotional/moral sentiments. Mill argued these higher pleasures of the intellect should be more highly valued than baser delights when making ethical calculations.

Mill also placed more emphasis than Bentham on evaluating actions by their tendency to promote **enduring happiness or well-being, rather than just fleeting pleasures**. He spoke of seeking a "balanced whole" of gratifications, intellectual pursuits, personal dignity, and social relationships & virtues.

This set the foundation for modern applications defining well-being more holistically beyond just pleasure. For Mill, quality of experience mattered more than just raw quantity. Yet the goal remained to maximize the sum of overall human well-being defined in these richer terms.

Peter Singer and Expanding the Moral Circle

In the 20th century, the Australian philosopher Peter Singer revived and expanded upon utilitarian thinking through works like Practical Ethics. Singer was one of the first to extend utilitarian calculations of pleasure/pain to consider the wellbeing of non-human animals as well.

Singer argues that there is no moral justification to limit utilitarian consideration to just humans if other sentient creatures can experience suffering. He believes each being's interests should be weighed based on their ability to subjectively experience wellbeing or suffer. Therefore factory farming, animal testing, and other practices causing animal suffering should be rejected as unethical from a utilitarian view.

Moreover, Singer argues the moral circle of ethical consideration should be expanded even further to encompass all future generations. The consequences of climate change, environmental destruction, and unsustainable policies negatively impact long-term utility across vast swaths of future humans and life itself. Thus, assessing actions by measuring and totaling all stakeholders affected, including future ones, is essential.

Singer's work reignited discussion around utilitarian priorities and how to operationalize interpersonal utility comparisons and tradeoffs across time. This reinvigorated utilitarian arguments in domains like global health, environmentalism, and animal ethics.

Practical Applications of Utilitarianism

On a practical level, utilitarianism provides a framework for analyzing difficult moral dilemmas or public policy choices where there are competing benefits and costs. It pushes evaluating issues by:

1) Identifying and estimating all the sources of happiness, suffering, or impacts on wellbeing resulting from a potential decision for all stakeholders.

2) Quantifying or scoring those positive/negative utilities to the degree possible.

3) Weighing and summing the total positive and negative utilities across the population affected.

4) Enacting the choice or policy that maximizes net positive utility and overall societal wellbeing.

Critics argue this is an oversimplification that ignores other vital considerations like individual rights, social contracts, moral rules, or virtue-based ethics. Proponents counter that the utilitarian approach at least provides a systematic framework to analyze consequences in an impartial, empirical way for the greater good.

Some examples where utilitarianism may shape analysis:

- Public health policies like mandatory lockdowns or vaccine drives may restrict individual liberty but could be justified if promoting greater societal health and minimizing premature deaths.

- Laws and regulations limiting corporate pollution and environmental damage could reduce some economic utilities but be deemed ethical based on avoiding far greater ecological suffering and existential risks.

- Government welfare, healthcare, and economic policies may be judged based on how effectively they reduce societal poverty, preventable disease, pain and achieve broad financial security & life satisfaction.

- Animal welfare regulations might mandate more humane farming and slaughtering practices based on avoiding suffering despite higher consumer costs.

- Principles of effective altruism and global aid prioritization weighed by greatest good per dollar.

In this way, utilitarianism attempts to serve as a general moral guidepost for policies, laws, and personal choices by focusing on outcomes and consequences to maximize overall positive wellbeing and flourishing.

Of course, measuring and precisely weighing all utilities is incredibly complex and fraught with challenges. Defining what qualifies as positive/negative experiences, interpersonally comparing them, and projecting long-term impacts is an imperfect science at best.

As such, while utilitarianism can provide a framework, it generates difficult philosophical questions and tradeoffs. Is minimizing suffering more important than promoting happiness? How does mere potential for future experience get weighted? How does one balance personal vs societal interests? These dilemmas have sparked critique and refinement of the theories over centuries.

At its core though, utilitarianism represents a consequentialist approach attempting to empirically calculate the greatest good and guide choices to improve overall human (and perhaps sentient) welfare and flourishing for the long-term. It provides a way of systematically thinking through costs and benefits beyond just individual impacts. This analysis can be a helpful tool when combined with other moral, ethical, and pragmatic considerations.

The Utilitarian case for single payer healthcare

Here is a summary of the key utilitarian arguments in favor of a single-payer universal healthcare system like Medicare for All:

2. Maximizing Overall Wellbeing and Happiness. The core tenet of utilitarianism is to pursue the policies and actions that produce the greatest good and well-being for the greatest number of people. A universal healthcare system increases overall societal welfare by:

   - Providing comprehensive health coverage to all citizens, drastically reducing the suffering, pain, and diminished quality of life that stems from lack of insurance and access to care.

- Offering financial risk protection by eliminating out-of-pocket costs and bankruptcies due to medical bills, reducing a major source of anxiety and hardship.

- Improving population health outcomes and longevity through better preventative care and disease management, increasing healthy life years.

- The increased economic productivity, job retention, and financial security that comes with a healthy workforce.

8. Harm Reduction Principle. Utilitarians place negative value on actions that cause pain, suffering, or a diminished quality of life. Lack of health insurance is directly linked to foregoing needed care, worse health outcomes, higher mortality rates, and financial ruin. A universal system minimizes these negative utilities.

9. Maximizing Overall Social Welfare. Utilitarians aim to promote policies yielding the highest net benefits across a population. Economic studies show current U.S. healthcare spending is inefficient, with high administrative costs crowding out better health outcomes. A single-payer system could cover everyone with similar or lower total costs, increasing utility.

10. Relief of Healthcare Burdens. Having health concerns is already an area of disutility. But the current private insurance system layers on additional hassles, paperwork, billing issues, and coverage denials that create extra psychological burdens and opportunity costs. A streamlined system removes these negative utilities.

11. Equal Consideration of Interests. A key utilitarian principle is considering everyone's interests equally. The current multi-payer system unevenly distributes healthcare access and financial risks. Universal coverage promotes equitable consideration of each citizen's ability to have good health.

12. Societal Investment and Stability. Following utilitarian logic of maximizing good consequences longterm, a healthier population increases overall economic productivity, social stability, and human flourishing. Universal healthcare represents an investment in developing human potential.

13. Expanding the Moral Circle. As philosopher Peter Singer argues, modern utilitarianism expands moral consideration beyond just humans to all sentient beings capable of experiencing welfare or suffering. Healthcare policies preventing pain and premature death could be viewed as an ethical obligation in this light.

While utilitarians must consider potential economic disincentives or wait times, most analyses show these negative utilities are heavily outweighed by the large-scale benefits to public health, financial security, and societal wellbeing that a well-designed single-payer system could provide.

For utilitarians focused on maximizing the greatest good across society, universal healthcare represents one of the most powerful levers for improving quality of life measures and reducing suffering. This makes a strong ethical case from a utilitarian perspective despite the complexities involved.

The utilitarian ethical framework applied to analyzing and evaluating Medicare for All

From a utilitarian perspective, the primary consideration is whether implementing a Medicare for All (M4A) system would increase overall societal welfare and well-being compared to the current U.S. healthcare system.

Potential Sources of Increased Utility/Well-Being:

- Providing comprehensive health coverage for all Americans would reduce the suffering, pain, and diminished quality of life that results from lack of insurance and access to care.
- Financial risk protection by eliminating out-of-pocket costs and potential bankruptcies from medical bills.
- Improved population health outcomes and longevity by incentivizing preventative care.
- Economic productivity gains by reducing missed workdays and maintaining a healthier workforce.
- The psychological wellbeing and sense of security that comes with universal health coverage.

Potential Sources of Decreased Utility:

- Paying higher taxes required to fund the system could reduce economic consumption.
- Wait times, delays, or potential rationing of some services could cause temporary disutility.
- Disruptions and adjustment costs of transitioning from current healthcare system.
- Potential disincentives for medical innovation or pharmaceutical development.

Weighing the Tradeoffs:

To evaluate from a utilitarian view, we must attempt to quantify and compare the positive utilities of improved health access/outcomes against the negative utilities of economic/freedom disruptions as much as possible.

Numerous studies have estimated the potential cost savings, productivity gains, and financial security benefits of M4A could be over $1 trillion/year compared to the current system’s expenditures. This financial upside contributes to economic welfare.

Health economists also analyze metrics like QALYs – quality-adjusted life years – to quantify the utility gains in length and quality of life from a universal system preventing premature deaths and managing chronic conditions more proactively.

Moral philosophies like that of John Stuart Mill would suggest these substantive physical and mental health improvements constitute “higher pleasures” deserving of being weighted more heavily than temporary disruptions or limits on economic choice/consumption.

There are concerns a single-payer system could negatively impact medical innovation or wait times for care. However, other countries with universal coverage do not appear to substantively lag at developing new drugs/technologies. And the uninsured often face extraordinarily high wait times for basic needs currently.

From a utilitarian view, if the system is well-designed and adequately funded, the potential reductions in mental/physical suffering, enhanced financial security, and productivity gains could massively outweigh the economic transition costs and temporary inconveniences based on quantitative modeling.

Broadening the Scope:

Taking the utilitarian view even further, one could consider the benefits of a healthier population in advancing a more productive society and expanding the overall “utility” of human knowledge and capabilities going forward. A universal healthcare system could be seen as an investment in improving the quality of life not just for current stakeholders, but future generations.

Critics argue utilitarianism places too much focus on aggregate societal welfare over individual liberty and rights. There are legitimate concerns that single-payer could limit care choices or medical privacy for some individuals.

However, a utilitarian framework allows weighing these individual disutilities against the potentially much larger benefits to the collective. If a relatively small sacrifice provides outsized positive impacts to the broader public welfare, it could be ethically justified from a utilitarian consequentialist position.

In summary, while the utilitarian calculation is complex, most analyses suggest a well-implemented Medicare for All system would likely substantially increase overall societal wellbeing across financial risk protection, health outcomes, economic productivity, psychological factors, and other positive utilities. This could outweigh the adjustments or limits on consumption/innovation according to the greatest good principle. Of course, other moral frameworks must also be brought to bear, but the utilitarian lens provides a systematic approach to thinking through costs and benefits.

The Broker’s Ethical Responsibilities

Next, we’ll examine at least one aspect of the broker’s ethical responsibilities in a Utilitarian ethical construct. We’ll focus on types of information ethical brokers should disclose when presenting policy options to their clients. How can a broker practice ‘the greatest good for the greatest number’ ethics? More specifically, what disclosure responsibilities do health insurance brokers have both legally and ethically when they present a policy to clients?

- First, brokers must honestly explain policy terms.
- Second, they cannot leave out important information.
- Third, they must quote the price.

But do they also have a fourth ethical requirement – to disclose policy implications, such as likely medical outcomes and medical risks? Should the broker provide clients with information about likely impacts of using their health insurance policies? Should they present clients with data about treatment practices and medical outcomes?

In other words, should the broker explain how insurance policies are often misused by poorly informed patients and how this may cause them harm? Or how the various incentives in our healthcare system combine often to provide more care than many people need, or indeed that is good for their health?

The well informed broker knows that patients sometimes overuse our medical system, meaning get excessive and unnecessary care. Some insurance programs may actually increase the likelihood of this. High deductible plans, for example, may inhibit overuse until the deductible is met, then *dis*inhibit the same behavior after. Subscribers may think ‘care is now free to me – or almost free – so I might as well get as much as possible to save money next year.’ Rather than generating benefit, this excessive care can only harm the subscriber / patient in two separate and distinct ways.

First in no particular order, excessive care can harm the patient, the employer group and the healthcare system *financially* through both direct and indirect additional costs. The direct costs come from copayments and other out-of-pocket spending like parking, transportation, missed work, hiring childcare and the like. The indirect costs come from increasing your company’s utilization experience – or your community’s – thus impacting premium cost trends over time.

Unnecessary care, in other words, increases the costs of funding our healthcare system.

Second, unnecessary and excessive care can harm the patient *medically* through error or side effects for example. This by definition. 'Unnecessary care' means care you don't need, that won't make you healthier, from which you won't benefit. But all medical care contains some element of risk, some chance of harm. The patient who receives unnecessary care cannot benefit from it – by definition – but may be harmed by it.

As a general rule, patients should avoid unnecessary care, if only for this 'potential medical harm' reason.

Many people underestimate medical risks or consider that 'low risk' or 'essentially risk free' means 'no risk'. Hmmm…

Consider the sad case of Samantha Reckis, a 7 year old girl living on Cape Cod in 2003.[29] Samantha ran a fever over Thanksgiving and her parents gave her Children's Motrin, about as safe and benign a medication as exists. Unknown to anyone at the time, Samantha suffered from an uncommon skin disorder called Stevens-Johnson syndrome that makes your skin feel hot, more or less like a bad sunburn. That's what her parents felt apparently when they touched her skin.

The Stevens-Johnson condition can be exacerbated by exposure to ibuprofen, an ingredient in Motrin. When Samantha's parents gave her Children's Motrin to reduce her 'fever', she had a bad reaction – so bad, in fact that it developed into a condition known as Toxic Epidermal Necrolysis, an extremely rare and painful skin condition. Over the next 9 years, poor Samantha endured multiple hospitalizations and surgeries, lost nearly all of her skin, suffered permanent lung and liver damage and became legally blind.

In February 2013, a Plymouth County jury found that Johnson and Johnson, the makers of Motrin, was at fault for causing Samantha's condition because the company had failed adequately to warn patients of this potential adverse effect. Such a notice, the jury decided, could have alerted Samantha's parents or physicians to stop using the drug and thus reduce the harms caused to Samantha. The jury awarded Samantha $50 million and each of her parents $6.5 million, all to be paid by Johnson and Johnson.

This is an extreme example of harms from a standard and safe medical intervention. If Children's Motrin can cause all these harms to a little girl, imagine the potential downsides and potential harms from more invasive and risky interventions.

- Vioxx for example, a drug 'as good as aspirin but with fewer stomach bleeds' led to 12,000 deaths according to a court settlement.

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[29] Family Awarded $63 Million in Motrin Case, Wallack and Lazar, Boston Globe, Feb 3, 2013

- Menaflex, a bovine based knee cartilage replacement, caused adverse reactions in 42% of patients in pre-approval FDA studies.

- Estimates of the harms caused by medical devices range from a low of 16,000 Americans to a high of 160,000.[30] (We have only this wide estimate of device harms due to the lousy data on device harms. But even the low estimate seems pretty high to me.)

Should brokers inform their subscribers of these types of risks? Should brokers tell patients how to protect themselves from harms? Or should brokers adopt the 'let the buyer beware' ethical standard and limit their own responsibilities to selling insurance policy packages?

Research has demonstrated that above a certain level of care, generally defined as the Medicare norm in low cost regions, the excess doesn't generate patient benefit. As Jonathan Skinner, a Dartmouth Institute of Healthcare researcher summarizes

> There is just no evidence that doing more helps. At best you do the same and in some cases you actually do worse [due to infections, errors, sides effects, etc.] [31]

Other researchers have discovered that patients who receive excessive and unnecessary care actually have slightly higher mortality rates. As Elliott Fisher, Director of the Dartmouth Institute for Health Policy and Clinical Practice learned in his huge early-2000s research study on treatment variation, hospitals that spent the most on patient care and did the most tests and procedures experienced a 2 – 6% higher patient mortality rate. [32] The reason, according to Fisher, is quite simply that

> The additional medicine patients get in the high-cost regions leads to the harm. [33]

Fisher in his studies noted that for every 10% increase in regional medical spending per capita over the Medicare minimum, the risk of death went up. Slightly admittedly but statistically significantly. Somewhere in the ballpark of children's Motrin risk. (Samantha Reckis' story haunts me.)

More care, in other words, is worse for you than less care. Once Fisher and his cohort discovered this, an entire industry of researchers descended on healthcare statistics to determine which

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[30] Jeanne Lenzer, The Danger Within Us for many more examples and details.

[31] Jonathan Skinner, John E. Wennberg, How Much is Enough", NBER Working Paper 6513, 1998

[32] Brownlee, Overtreated, page 50

[33] Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

interventions generate the best benefits, which the most harms and, perhaps most importantly, how to determine those outcomes.

One result of this years-long effort is that researchers have learned that patients generally have 2 or more treatment options that generate roughly similar outcomes but that may pose very different risks. Not to mention different costs.

Another is that researchers determined that only a relatively small proportion of medical interventions have been tested to see how well they actually work - how effective they are, in other words.

A third is that researchers have definitively learned that more medical care isn't always better than less.

Fisher actually summarized all this research in a brief Letter to the Editor of the Boston Globe on March 2, 2018 entitled 'Check Your Assumptions at the Door.' Patients should, he recommends

> Question widely held assumptions:
>
> That current treatments – including drugs – all have been proven safe and effective (safe, maybe; effective, no) …
>
> That physicians can tell you what's best for you (they can, but only if they know what is important to you);
>
> Or that more medical care is always better (it's not).
>
> The system is ripe for disruption and new thinking. But it will take a fearless commitment to keeping patients at the center.

Should the broker – the 'benefits advisor' – participate in this 'fearless commitment to keeping patients at the center'… in other words, a client educational process? Or should the broker ignore current research and stick with spreadsheeting and compliance?

Should the broker teach clients how best to use their benefits and specifically their health insurance policies? Or does the broker's ethical responsibility end with arranging medical care financing?

Should the broker stick with a narrow definition of professional responsibility and let the policy buyer beware? Or should the broker adopt a more expansive definition of professional ethics?

What ethical disclosure responsibilities does the broker have?

Why Health Insurance Brokers Need Ethical Disclosure Standards

The only effective, sustainable way to control your client's healthcare expenses is to teach them how to avoid unnecessary, ineffective, excessive and low quality medical care. That's my opening position.

Any other attempts to control healthcare expenses - financial engineering, clever insurance plan designs or ancillary programs – fail to reduce healthcare inflation. Here’s the depressing historical summary: Over the past 60 years, we’ve tried

- Cost sharing or ‘major medical’ in the 1960s. These programs were inflationary so they were replaced by

- First dollar coverage or HMOS in the 1979s through 90s, the opposite of cost sharing. People complained about the restrictions so they were replaced by

- High deductible plans, the opposite of first dollar coverage post 2000. People complained about the deductible size.

We’ve tried

- wide hospital networks figuring that more competition would lower costs, and
- narrow hospital networks, figuring that more carrier control would lower costs;
- defined benefit plans to allow employers more design latitude and
- defined contribution plans to allow employees wider choice,
- individually underwritten plans to reward healthy people and
- community wide rates to avoid penalizing sick people and
- virtually everything in between.

Some companies have adopted ancillary programs to reduce spending like

- Wellness programs to reduce demand for medical services, but these show disappointing returns on investment if any returns at all, and

- Price transparency programs to help employees spend less for specific medical services, but these have little, if any impact outside of a few commodity services like X-rays and MRIs that are probably way overused anyway. What’s the point in getting a less expensive unnecessary scan?

These programs all fail for the same reason: Patients will always find a way to access a medical service that they believe will improve their health. In other words, if patients – i.e. your subscribers – believe they need it, they'll get it.

Even if that belief is false. And there's nothing you can do about it.

The only thing we've never tried: teaching employees how to avoid unnecessary and poor quality care. That's a really promising approach.

And that's what ethical brokers should introduce.

Disclosing data on medical care quality: some ethical issues

This text will introduce medical care quality metrics. It's designed to give brokers and patients – ordinary people not trained in medicine, statistics or econometrics, not professional researchers and not nerds - the tools necessary to choose high quality, beneficial medical care and avoid low quality, ineffective or harmful care.

Once you, as a broker, understand these metrics, you'll be in a position to decide whether or not to teach them to your clients. Anecdotal evidence suggests that the better brokers understand these topics, the more likely they are to teach them to clients.

And the more ethical it makes them.

The wise patient today knows that more care doesn't mean better care. But do most of your subscribers and patients have the skills to differentiate high from low quality care, and better from poorer outcomes? I suspect not. That can put you in an uncomfortable ethical position.

Consider this evidence from the US Department of Health and Human Services. 88% of Americans, they find, are medically illiterate, meaning lack the skills necessary to assess likely treatment benefits and harms [34] though I suspect the real number – the percentage of people who understand and use the tools described later in this text – is actually much lower.

Interestingly, however, virtually everyone I meet either professionally in classes or socially claims to be medically literate and generally sees themselves not only as medically literate but also very well informed about medical care. I think that underscores the problem!

Health and Human Services also claims that medically illiterate patients have higher hospitalization rates and medical costs, and poorer health outcomes, the exact opposite of broker's goals.

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[34] https://health.gov/communication/literacy/quickguide/factsbasic.htm

Knowing this, can you, as a broker, simply develop plans that raise deductibles without including a complementary education program that helps your subscribers spend their deductibles wisely? Is that really ethical? Would you want someone to do that to you?

‘Do unto others as you would have them do unto you.’

How a medically literate consumer thinks

Here’s a simple overview of how a medically literate person makes a medical care decision. Ask yourself as you go through this list – how many of your clients follow this protocol? And, if you don’t teach it to your clients, who will?

- **First determine how well the medical intervention works** and decide if it works well enough for you. You’ll need to understand what a comparative study is, and understand how to interpret the study results. I’ll show you how. Different patients can make different decisions based on the same set of facts.

- **Second consider your treatment options.** You have them about 85% of the time. Learn to explore them. Again, I’ll show you how.

- **Third determine which providers – practitioners and hospitals – generate the best outcomes for your preferred intervention**. I’ll show you a simple and useful way to choose. It’s better than looking up lots of outdated statistical indicators on lots of hard-to-navigate-and-understand websites.

- **Fourth, evaluate your insurance policy** to see which providers are in-network, which treatments are covered, what your copayments are and how to access the care you want.

I submit that an ethical broker will teach subscribers to follow this process, with the likely result that they’ll tend to generate better outcomes with less risk and at lower costs.

But deviate and watch spending and risk increase and benefits potentially decline.

The Goldilocks principle

Good, proper and appropriate medical care fits the Goldilocks principle: not too little, not too much, but just right.

- Too little medical care leads to *undertreated* patients and poorer-than-optimal outcomes. Undertreated patients are harmed by their diseases.

- Too much medical care leads to *overtreated* patients and higher-than-necessary costs and medical risks. Overtreated patients are harmed by their care, not their diseases.

- Inappropriate medical care leads to suboptimal outcomes, excessive costs, patient dissatisfaction and sometimes lawsuits.

Overtreatment, and inappropriate care represent about 40% of medical interventions. I'll explain in the 'Slippage' chapter below. Attacking slippage, in other words, becomes a prime focus of ethical broker activities.

The best medical decisions

The best medical decisions come from wise, well informed patients working together with thoughtful, caring clinicians.

- **Patients** know their own hopes and fears and the benefit / risk tradeoffs they are prepared to make. Different patients, when faced with the same set of facts, can reasonably make different care decisions and all be right.
- **Clinicians** have extensive knowledge and experience that can aid a patient.
    - Wise patients avail themselves of this knowledge, experience and counsel.
    - Unwise patients ignore it or delegate decision making to their clinician.

Ignoring clinician counsel deprives patients of potentially valuable insights. That's the 'art' of medical care.

Delegating decision making forces your treaters to assume or guess the benefit / risk tradeoffs you're willing to make. Studies suggest that clinicians often get this wrong.[35]

The Slippage Problem in US Healthcare

I got this term from David Cordiani, CEO of Cigna, a huge national health insurer, who introduced it in his keynote talk at Yale's annual Healthcare Conference in April, 2015. 'Slippage' is to healthcare what 'breakage' is to shipping and 'spoilage' is to food service – stuff that goes wrong, the inevitable problems at afflict any industry.

We can estimate the amount of slippage in our healthcare system from expenditure data since we so often assign dollar values to medical interventions. Read the expenditure data below as indicators of slippage volume: when I suggest that 40% of *expenditures* are ineffective or inappropriate, I imply that about 40% of *interventions* are ineffective or inappropriate. Not an exact equality but good enough for government work.

Cordani somewhat conservatively pegged slippage at 'at least 25%' of all US healthcare spending but added that the real figure is probably much higher. Consider 25% a low estimate.

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[35] Mulley et al, Patient Preferences Matter

That approaches $800 billion dollars nationally per year or about $2500 per health insurance policy.

Using a different approach, PLOS arrived at a roughly similar conclusion by surveying physicians about the unnecessary care they provide to their own patients in 2017. [36] In other words, this survey asked physicians about their own behavior and the behavior they observed in their colleagues.

The overall estimates for unnecessary care from this group of 2100 physicians:

- 20% of medical care was unnecessary,
- 22% of prescription medications were unnecessary,
- 25% of tests were unnecessary, and
- 11% of procedures were unnecessary.

Among the specific findings:

- 27% of respondents (physicians) believed that at least 30 – 45% of overall medical care was unnecessary,
- 30% believed that at least 30 – 45% of prescriptions was unnecessary,
- 38% believed that at least 30 – 45% of tests were unnecessary,
- 16% believed that at least 30 – 45% of procedures were unnecessary.

This strikes me as a big deal.

In 2018 a Washington State survey used yet another approach to put some meat on this slippage / unnecessary care bone. The Washington Health Alliance analyzed utilization and billing data from 2.4 million commercially insured patients who used 47 oft-overused services, and found that 45% of services delivered were wasteful accounting for 36% of medical spending.

Cordani's 'at least 25%' waste estimate might be low.

The Washington study is noteworthy for a couple of reasons. First the Washington Health Alliance, the group responsible for this study, consists of virtually all the hospitals, insurance carriers and large benefits agencies in the state. This report was cowritten by the Washington

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[36] Overtreatment in the United States, Lyu et. al. September 6, 2017 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970

State Medical Association and the Washington State Hospital Association, essentially the medical establishment in Washington.

Second, the group identified overuse from the Choosing Wisely list. Choosing Wisely is a creative and very useful medical decision making tool that far too few patients know or use.

Choosing Wisely

Choosing Wisely is funded by the American Board of Internal Medicine Foundation that basically asked lots of specialty medical associations to submit a list of service that their members do but that don't generally benefit patients. Among the 70+ organizations that submitted a list: the American Academy of Allergy, Asthma and Immunology, the American Academy of Family Physicians, the American Academy of Dermatology, the American College of Cardiology and many more.

Each partner organization submitted at least 5 services that 'physicians and patients should question' because of the low level of benefit provided (if any benefit at all) and / or high level of patient risk.

Choosing Wisely is a useful, albeit low bar for poor quality care.

The Washington State folks identified 'appropriate' care as care that is

- Supported by evidence
- Truly necessary
- Not duplicative of other tests or procedures already received and
- As free from harm as possible.

They used Choosing Wisely's list as the basis for determining low quality care and waste, defining low quality care as

- Likely wasteful, meaning there are serious questions about the appropriateness of the service, or
- Wasteful, meaning the service was very likely unnecessary and should not have occurred.

Remember that 'likely wasteful' and 'wasteful' care is, while clearly subjective, defined both by Choosing Wisely – i.e. the various medical specialty organizations - and the state hospital and medical establishment. Again, a pretty conservative bar.

Third, the Washington State report focused on 47 commonly overused services of which just 11 common tests, procedures and treatments represented 93% of the overuse. That list includes preoperative tests and lab studies prior to low-risk surgery, too frequent cancer screenings, eye imaging tests for people without significant eye disease, annual EKG tests or cardiac screening for people with low risk of heart disease, and imaging for uncomplicated conditions such as low back pain.

In other words, the Cordani and PLOS systemic slippage estimates are supported by the Washington State details indicating that (a) slippage is a huge financial problem and (b) it comes from a relatively limited number of services.

Brokers thus can focus their educational efforts fairly narrowly and have a potentially great impact on their client's health and finances. Our question: is it ethical to do so? And should they?

Five kinds of slippage

Let's expand on the Washington State definition of low quality care to identify 5 types of medical interventions that can generate patient harm and financial waste:

- **Care that doesn't work** or works so badly that you don't want it
- **Care that works on some people** but likely not on you for reasons like age, sex, overall health and, surprisingly, socio-economic status
- **Care that works in tests but is overused in real life** so quite possibly won't benefit *you*
- **Care that you don't want** when you learn of your treatment alternatives
- **Care from low quality providers** (clinicians and hospitals) when higher quality providers are available.

I'll discuss all these in more detail below.

How to avoid slippage

Identifying slippage is Step 1. Avoiding it is Step 2.

My suggested slippage avoidance process: teach your clients *to ask the right questions of their doctors*. I'll discuss those questions later in this text.

I developed this process for two main reasons:

First, extensive research shows that most patients trust their doctors and value the patient doctor relationship. Attempts to undermine or go around it seemed doomed to failure.

Patashnik, Gerber and Dowling argue in their excellent book Unhealthy Politics that physicians are the most credible source of patient information, far more than ‘studies’ or ‘guidelines’. [37] Any attempt to undermine physician credibility, in their and my opinion, will simply fail.

My questions therefore enhance the doctor-patient discussion process. Remember that doctors are all highly trained, have access to all the relevant literature, are experienced you and generally welcome patients sharing their hopes, fears and concerns. At least, that’s what physicians report.

Second, very few patients are ‘medically literate’ and able to understand, evaluate and critic medical studies and reports.

This doesn’t mean people are stupid!

Rather, it means they haven’t had the necessary training. Medically illiterate folks – even if they’re otherwise very well educated – need guidance when googling to understand complex information about medical technology and science.

I don’t see the utility of showering medically illiterate folks with data and study conclusions. You end up with ‘This study shows surgery benefits but that study shows medication benefits. I’m confused so I’ll ask my doctor’ and you go to my first reason above.

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My questions and the discussions they prompt can overcome those problems. These questions allow your subscriber’s physician – their most trusted medical advisor - to interpret complex information and apply it to them.

But who in our complex healthcare system, teaches your subscribers how to talk with their doctors? There’s clearly a need as demonstrated by the waste data presented above. Seems to me we as a healthcare system, and brokers as a profession, have dropped the ball on this.

Why Brokers?
The problem of advice bias and three types of care

Who advises people NOT to receive medical care or to question routine medical advice and care? In our healthcare financing system, physicians are paid to treat. They have a financial incentive to intervene for they generally do not get paid unless they do something to the patient. Many studies have shown that surgeons tend to recommend surgery far more than non-surgeons do, and sometimes more than patients need.

But physicians, as Patashnik, Gerber and Dowling argued above, are patient’s most trusted advisors.

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[37] Patashnik, Unhealthy Politics, chapter 3

Thus we see a biased medical advice system. Practitioners generally only make money by providing medical care. No one in our healthcare system is paid to advise patients against medical care. No one, in other words, balances the economic intervention interests of clinicians.

'But my doctor suggested that I not have this procedure' goes the superficial but true counter argument. Put this into a tri-partied context.

- Some care is clearly necessary, meaning that virtually all physicians evaluating the same patient would recommend it.
- Some care is clearly unnecessary, meaning that virtually no physicians evaluating the same patient would recommend it.
- And some care is in the gray area, meaning that some physicians might recommend it while others might not.

The 'my doctor recommended against this procedure' statement probably falls into category 2 above, though possibly category 3 too.

The advice bias problem arises only in category 3, the gray area. Research suggests that this is perhaps the largest of the 3 categories.

How large is each category? In other words, what percentage of medical care falls into each? John Wennberg, founder of the Dartmouth Institute, answers this in his book Tracking Medicine. [38] He calls our category 1 'effective care' defined as services that, on the basis of reasonably sound medical evidence, are known to work better than any alternative. This group of treatments accounts, based on his research, for only about 15% of all medical care.

Wennberg calls our category 3 above, the gray area, 'preference sensitive' care meaning care for which there is more than one option and in which different people can make difference decisions and all be correct. Preference sensitive care requires judgment and individuality to evaluate the risk-benefit tradeoffs.

Consider torn or injured rotator cuffs, for example. A surgeon will likely examine the patient, identify a rotator cuff tear and recommend surgery. But a physical therapist, reviewing the same data on the same patient, might well suggest physical therapy, at least to start. Is one right and another wrong?

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[38] Wennberg, Tracking Medicine, pages 8 – 10, then Parts II and III

That situation arose for a student of mine, a licensed health insurance broker in his 60s who managed to tear his right rotator cuff. ‘It was so weak and sore’ he told me, ‘that I couldn’t shift the gears on my pick up.’ It apparently had a gear shift next to the steering wheel.

He went on to tell me that he visited an orthopedic surgeon who took an MRI, identified the cuff tear, and recommended surgery. ‘I would have agreed to surgery’ he went on to say, ‘prior to hearing your lectures and reading your books.’ (See – there actually is some value to continuing education classes!)

‘But I asked the surgeon if all physicians would agree with that analysis and recommendation. He answered with a snort that some might suggest physical therapy but that would be a waste of time and that I’d be back in his office shortly thereafter.’

My former student decided to try PT and reported when next I saw him that his shoulder was pain free and that he had regained 99%+ range of motion – it might have been 100% but he wanted to be conservative - in the same time as surgical recovery but without the costs and risks of surgery. ‘Thanks’ he smiled as he relayed the story.

Wennberg estimates that preference sensitive care represents about 25% of medical spending, making our category 3 larger than category 1, the clearly beneficial group of treatments.

Wennberg goes on to describe supply sensitive care, or the 60% of medical spending that is about the frequency with which patients get treatments. Physician decisions, he claims, are strongly influenced by the capacity of the local medical market. Areas that have more surgeons experience more surgery; areas with more Neo Natal Intensive Care Units have more babies admitted to NICUs; areas with more cardiac catheterization beds have more cardiac catheterizations, etc.

How often should a physician see patient in pain, suffering from a chronic condition or desiring to feel better? Once a month? Once a quarter? Semi-annually? The answer, according to Wennberg:

The doctor will sort it out based on how sick an individual patient is and how many opening he has in his schedule. Specialists tend to fill their appointment books to capacity. [39]

Thus a physician might say to a patient ‘I’d like to see you again in 3 weeks’, but the office booking clerk, seeing that the doctor is booked for the next 6 weeks, asks the doctor if waiting 6 weeks is OK. ‘Fine’ the doctor replies, raising the question of why he or she originally wanted to see the patient in 3 weeks.

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[39] This discussion comes from Maggie Mahar, Money Driven Medicine, page 172, including Wennberg’s quote.

This is sometimes called Roemer's Law, named after a healthcare economist named Milton Roemer who discovered that if more hospital beds exist in a region, there are more hospitalizations.

And it's sometimes called 'supply induced demand.' A hospital buys a new MRI machine and suddenly lots of patients need MRIs. Or when a new dermatology practice opened near my house, I tried to get an appointment only to learn that they were fully booked for the next 3 months. How was that possible for a new practice? According to Wennberg, they simply saw patients more frequently to fill up their calendars. (I don't know if that was the reason but it certainly seemed likely.)

Wennberg's estimate that 25% of medical spending goes to preference sensitive care and 60% falls into the supply sensitive category highlights the problem of advisor bias. And our current fee-for-service physician payment system exacerbates it. Your physician might consciously think 'I'd like to see this patient again in 3 weeks' and subconsciously 'and I'll get paid to see her.'

Or 'this procedure will probably help the patient' and subconsciously 'and I'll get paid to perform it.'

Does this actually happen? Let me quote conclusions from 3 recent studies on the impact of fee for service payments on physician recommendations:

- On average a 2 percent increase in payment rates leads to a 3 percent increase in care provision, with elective procedures responding most strongly to pricing incentives.[40] In other words, when physicians get paid more to do something, they do it more frequently.

- When specialists are paid through a fee-for-service scheme rather than on a capitation basis, surgery rates increase 78%. [41] Again, the more specialists are paid, the more they tend to do.

- Patients seeing fee-for-service ophthalmologists were twice as likely to have cataract surgery as patients seeing doctors in capitated systems. Interestingly the number of cataract surgeries dropped by 45% within 6 months after a studied ophthalmology group of physicians switched to a capitated payment contract. [42] Or, in the vernacular, physicians respond to financial incentives.

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[40] Do Physician's Financial Incentives Affect Medical Treatments? Clemens et al, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2101251

[41] Shafrin, Operating on Commission: analyzing how physician financial incentives affect surgery rates, Health Economics http://onlinelibrary.wiley.com/doi/10.1002/hec.1495/abstract

[42] Effect of Physician Reimbursement Methodology on the Rate and Cost of Cataract Surgery, Shrank, 2005 https://www.ncbi.nlm.nih.gov/pubmed/16344447

Thus we see a systemic bias in favor or patients receiving more medical care based on the advice – potentially biased - that they're likely to get. This makes medical service different from, for example, legal services.

In court the prosecution and defense attorneys argue different interpretations of the same facts, more or less, in John Wennberg's terms, different preference sensitive interpretations. The judge or jury then decides who is right.

But in medical care, patients only have one interpretation, that of their own physician. Patients generally rely on one interpretation and rarely have the skills to question it. (Yes, patients sometimes get second opinions and these can be incredibly useful. But only if they're used in specific ways. I'll get to that.)

We lack in medicine the 'alternative interpretation' feature that opposing attorneys offer in legal services. Where do patients learn how and when to question tests and procedures, especially common ones – things like the eye imaging tests, cancer screenings and annual EKGs that the Washington State report highlighted as waste?

Carriers might play that role – but the managed care experience of the 1990s has turned popular opinion against trusting carriers too much.

Second opinions are too cumbersome. Who wants to get a second opinion when the doctor says 'let's run this test to rule out' something or other? Or when your doctor says 'it's time for your annual mammogram'? Or even 'your cholesterol level is getting high. The guidelines recommend that I put you on medication to lower it.' 'High' to your doctor may be 'moderate' for the patient, assuming, of course, that the patient is medically literate, an assumption that is incorrect 88% of the time according to HHS.

Even if patients get a second opinion, it may be from another doctor in the same practice who may have an informal – perhaps even unconscious – motivation to support his/her colleague.

That leaves the broker. Should the broker advise clients of potential risks of easy availability of medical care? How much should the broker inform clients about systemic abuses? In sum…

What ethical disclosure responsibilities does the broker have to protect his/her client from unnecessary / excess treatments and the related potential medical harm?

Overview of Disclosure Ethics

The Biblical View of Business Ethics: 'Do not do unto others as you would not like done to yourself' and 'Love thy neighbor as yourself' are two fundamental ethical dictates of Judeo-

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Christian religions. We – Americans coming from Judeo-Christian traditions and teaching – believe that we have responsibilities to treat others as we would want them to treat us.

The Business Ethics Center of Jerusalem defines business ethics as 'the value structure that guides individuals in the decision making process when they are faced with a dilemma of how to behave within their business or professional lives.'[43]

Ethical business considerations fall into two separate categories.[44] First, business ethics regulates conduct in direct contact situations, such as with employees, clients or suppliers. These commonly fall into standard categories including employee relations, honest representation and truth in advertising.

These types of ethical issues have an immediacy or personal effect: lying to a customer may induce that person to buy the wrong product. Shading the truth may persuade a client to purchase a policy that benefits the broker inappropriately. In both cases, the only party harmed is the party in direct contact with the unethical broker.

Second, business ethics involves social responsibility. These ethical issues consider how much all of us must take responsibility for society as a whole. Ethical social behavior, for example, includes protecting our natural resources, caring for the poor and providing equal educational opportunities to all.

This course will deal primarily with the first type of ethical business considerations – the direct contact situations – though we will make some social responsibility types of ethical observations also.

Unequal Knowledge about our Healthcare System

What does 'unequal knowledge about the healthcare system' mean?

Brokers typically know a great deal more about our healthcare system than do their clients. Among the areas of broker expertise:

Underwriting guidelines

Regulations

Provider cost data (at least rough and crude measures)

Outcome data (again, rough and crude measures)

Treatment complication data (assuming a well informed broker)

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[43] See www.besr.org/DCPage.aspx?PageID=198

[44] This discussion comes from www.besr.org/DCPage.aspx?PageID=199

And several similar categories.

We will explore the broker's ethical responsibilities to share all available information with their clients.

In developing our overall position on the ethics of disclosure, we will rely primarily on the Torah. Why?

The Torah also known as the beginning of the Old Testament or Five Books of Moses, has served as the moral and ethical foundation of our Judeo-Christian western civilization for thousands of years.

Virtually all the great historical ethicists and philosophers had a deep understanding of the Torah's teachings. These permeate our shared views of right and wrong, morals and ethics, and have done so for a very long time.

Some Judeo – Christian Business Ethical Positions on Disclosure: Start with Abraham's purchase of a burial plot for his wife Sarah

In the first commercial transaction in the Torah or Old Testament, Abraham laid down the 'full disclosure' commercial principle.[45]

The story of Abraham purchasing a burial plot for his wife Sarah is instructive from our ethical viewpoint. The haggling over land takes five steps in Genesis 23: 3 - 20:

Step 1: Abraham explains what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot;

Step 2: The sellers offer 'the choicest of our burial places';

Step 3: Abraham considers this (perhaps even goes on a guided tour of choice burial places) then asks for 'the cave of Machpelah…which is at the end of [the sellers] field', and offers to pay 'full price';

Step 4: The sellers confirm that they have exactly what Abraham wants 'the field and cave that is in it';

Step 5: The buyer and seller ultimately agree on the land and price and transact the purchase in public 'in the presence of the sons of Heth, before all who went in at the gate of his city'.

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[45] This interpretation is entirely my own and not entirely in line with typical or traditional religious commentaries. The genesis of this interpretation comes from www.torah.org Business Ethics: The Challenge of Wealth and various commentaries including *Parchas Chayei, Parchas Sarah, Parchas Metzora, Parshas Shoftim* and *Responsa-Vayigash.*

Note the similarity with health insurance policy sales:

Step 1: the Buyer explains what he/she needs in vague terms – a policy to cover my employee's medical needs, perhaps with some specific issues in mind;

Step 2: the Broker says 'we have many quality plans available' and explains them;

Step 3: the Buyer considers several options, then stipulates what he/she wants;

Step 4: the Broker confirms that a specified policy contains the desired benefits;

Step 5: the Buyer enrolls by signing a contract.

It was clear from Abraham's negotiations that he had the opportunity to view the land and cave prior to purchasing. The seller had helped him learn about the land, pointing out the choicest burial place. Indeed, the seller may even have warranted the land: 'none of us will withhold from you his burial place', thereby confirming that this was, in fact, burial property.

The seller apparently understood that Abraham – 'a foreigner and a visitor' – did not know all details about local burial plots. The seller therefore helped Abraham learn everything that he needed to know so he could make a wise, informed purchase.

There was no ambiguity about the land, the location or the use. No confusion about exactly what Abraham bought…because the seller provided such a thorough and detailed education.

Caveat emptor 'Let the Buyer Beware' is Unethical

The lesson about this transaction? That in the Torah there is no concept of 'let the buyer beware'. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc. This was clearly not true for Abraham, the 'foreigner and visitor'. The seller could have taken advantage of his lack of knowledge to swindle him – but did not. The seller educated the buyer. This is the ethical business lesson of Genesis 23: 3 – 20.

'Let the buyer beware' also assumes that all parties have not only equal information and equal access to information but also equal abilities to understand the information available. In the Biblical case, Abraham was only able to understand the intricacies of burial plots after being educated by the seller. Is this concept still valid today? Can 'let the buyer beware' serve as a valid basis for commercial transactions?

The answer is no. Traditional Torah ethics remain valid today for two main reasons.

First, sellers and buyers rarely have exactly the same information. The seller virtually always knows his / her products far better than the buyer. The simple reason is that the seller deals in this market – for this product – far more frequently than does the typical buyer.

Today's health insurance broker, for example, spends his or her entire professional life dealing with health insurance policies. The broker constantly hears customer and market feedback – 'I thought the policy covered this but my claim was rejected' or 'The specialist my doctor recommended wasn't in network' or 'This carrier answered all my questions completely and handled my claim quickly' for example.

The buyer, on the other hand, probably only deals with health insurance issues once or a very few times per year. This puts the buyer at an information disadvantage. He or she simply can't know as much about the products, carriers, markets and nuances as the pro who deals with these issues daily.

This was clearly the case for Abraham, whose expertise did not include detailed knowledge of local burial plots. That's why he relied on the seller's representations and information – he had no other option.

Second, in the real world, sellers can understand their product information far better than the buyer can. This is primarily because the health insurance broker has studied healthcare issues in far greater depth than the typical buyer. Even if the buyer has access to information, he / she often lacks the background and context in which to place that information.

Again, this is similar to Abraham's situation. He was a merchant, with expertise in his own arena – not in burial plots. He was not in a strong position to understand burial plot issues without additional education.

Our clients are similar to Abraham. They are accountants, schoolteachers, fishermen or others, with expertise in their own fields, not healthcare. Lacking the broker's healthcare education and background, they are less able to understand healthcare details and issues than the broker.

How many of your clients know and understand the systemic information presented earlier in this text?

Thus for these two reasons – that the broker has both *better access to product information* and a *better ability to understand that information* – today's health insurance salesperson has an ethical responsibility to educate the client. Just like Abraham's burial plot seller.

***Mekach Tau* or fraudulent sale**

According to traditional Talmudic law, it is forbidden to sell an item—whether moveable items or real estate—if the item is defective. If this is done without informing the buyer of the defect before he completes the purchase, the seller is perpetrating a fraud. [46]

The prohibition is not necessarily or only a function of price, i.e. charging full price for a defective product. Instead, it is an issue of the seller misleading the buyer either intentionally or unintentionally. (Sema 228:7)

Sometimes defining faulty products is simple. Selling a broken watch, for example, is clear: if the watch doesn't tell time, then it is faulty. Two issues here. First intent. Did the seller intend to deceive the buyer? If so, then various compensation modes become relevant. Second quality. Even if the seller did not intend to defraud the buyer, then the doctrine of *mekach tau* still holds.

But selling a product designed to maintain your health becomes dicey. What do commentators say about a product that buyers use as designed but that makes buyers less healthy, something like insurance payments for Aduhelm, the Alzheimer's product we discussed earlier in this course? Is the broker who sold the coverage that funded Aduhelm committing an ethical transgression?

Or can the broker claim *caveat emptor*, let the buyer beware, and hide behind the argument 'I only arrange healthcare financing. Not my job to ensure that my client spends the money wisely.'

Do Your Fellow A Favor

The Torah and various commentaries clearly provides the answer. According to this doctrine of *mekach tau*, the seller is obligated to make full disclosure of any defect in the goods or services sold. We have already discussed this.

Rabbi Dr. Meir Tamari, an expert on business ethics, states this clearly and strongly, 'there is no Jewish basis for the "let the buyer beware" concept'.[47] He continues:

Such philosophy presupposes that all the players in the market possess the same access to information regarding price, quality and comparative markets. They are able and are required to ascertain the truth of the state of the playing field, and if they do not, that is their problem.

The problem, of course, is that no such market exists or can exist. The seller virtually always knows more about the product, the applications - and the misapplications - than the buyer as we discussed above.

Tamari continues 'if there is a flaw in the goods [or services] one is obliged to reveal it to the buyer' otherwise 'the sale is cancelled [the buyer cannot be forced to accept a discount in lieu of

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[46] This discussion comes from Mind the Blemish: Principles of Mekach Ta'us https://dinonline.org/2016/03/04/mind-the-blemish-principles-of-mekach-taus/

[47] Tamari, Honesty in Business Dealings, https://www.besr.org/library/honesty.html

the defect] … there does not need to be any intent to defraud; even if sold in good faith, the seller still bears responsibility and the sale may be cancelled'.[48]

Thus, the health insurance broker who claims 'I didn't know that the policy contained that' has no ethical defense: Jewish law makes the seller responsible to understand fully all the implications of each health insurance policy.

What about the broker who claims 'not my job to watch how people use their health insurance'?

Rabbi Tamari addresses this in the Business Ethics Guide, Economic Justice in a Jewish Perspective. [49] He quotes the Rabbis that 'he who does not *do his fellow a favor*, is not of the sons of Abraham' for 'we force one to act contrary to the selfishness of Sodom'.

This answers our questions above. The seller must first educate the buyer and make full disclosure about the policy's coverage. But second and equally important, the seller must *do his fellow a favor* and highlight problems with the health insurance policy that *may* occur. In other words, highlight ways that people use their health insurance in ways harmful to their health.

Why would Jewish law --- which later became Judeo-Christian ethics – place such a burden on sellers?

There appears some thinking that these burdens ultimately work to the advantage of the seller. If all sellers act ethically as described above, then it becomes very easy to sell products to buyers. The reason: buyers would have a very high degree of confidence in the seller's representations.

Business Ethics = Business Efficiency

In doing this, the Torah advises us to *put business long term financial interests ahead of short term profit goals.*

If everyone followed the Torah's teachings, in other words, we would have a very well functioning business economy. The Torah can be seen as a manual for how to prosper in business. We'll read its various ethical teachings in this light.

Ethical sellers – i.e. those who follow the Torah's teachings - would not have to prove their honesty or credibility. They could concentrate, instead, on selling products. This is very efficient: sellers could focus on their income generating activities (i.e. sales) rather than spending time explaining or justifying their personal ethical standards, or establishing personal credibility. They would thus generate higher incomes.

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[48] Tamari, Honesty in Business Dealings, https://www.besr.org/library/honesty.html

[49] http://www.besr.org/library/responsa/economic.html

Abraham's burial plot sellers, apparently, had this credibility, as there is no mention of Abe searching for other plot sellers. He did not shop around for a 'better deal'. He was – apparently – satisfied with his seller's ethical positions and chose to do business with him.

The religious laws outlined above ultimately work to the seller's advantage.

Efficiency and Health Insurance Sales

Let's apply this standard to health insurance brokers. If we all *do our clients a favor* and warn them about risks of healthcare systemic abuse and excess, then we may help control healthcare inflation. By *doing our clients a favor*, we may serve the interests of our entire economy by reducing healthcare costs.

In short, we do well for our clients and do well for our country by doing our clients a favor. We also, according to the Torah, do well for ourselves as brokers by adhering to this ethical standard.

Whose Interests Should the Broker Protect?

This ethical disclosure standard seems to require brokers to act against physician and hospital financial interests by educating clients about medical risks, waste and low quality care – teaching them, in other words, how to make wise medical care decisions. Providers, under our fee-for-service financing arrangements, have an economic incentive to treat, and often to overtreat, up to about 40% of the time according to the data presented earlier. Brokers, under this standard, have the burden of countering these physician economic incentives.

Seen in this light, the Torah's teachings may set up a conflict in our healthcare economy. Let's look at the gray area, in which a subscriber may or may not need treatment, and discuss the economic incentives facing each party. (Ethical discussions always focus on gray areas, as these are the difficult cases. There's no ethical dilemma in an easy or obvious case.)

Providers – physicians and hospitals – have an economic interest in treating and make the most money by providing the most treatment. The lens through which they view the patient may – consciously or unconsciously – include their own financial self interest. 'Patients of this type', they may think, 'often improve with treatment.'

Upton Sinclair, and American writer in the early 1900s, summarized this problem succinctly while campaigning for governor of Illinois:

It is difficult to get a man to understand something when his salary depends on him not understanding it.

When in doubt, our economic system tends to motivate providers to treat.

Patients with health insurance generally have little or no *economic* incentive to avoid treatment. They purchased insurance exactly for this situation. They generally have minimal out of pocket costs, depending on their policy type and deductible situation. Even a $1000 or $3000 out of pocket payment pales in comparison to a potentially life saving treatment or to treatment that eliminates a chronic pain.

In addition, patients who are sick or in pain are often scared and want to trust someone who offers relief. The reassuring physician who counsels ‘I have treated many patients like you successfully’ provides exactly the advice that the patient wants to hear.

Thus, our systematic incentives may induce unnecessary treatment for patients in the gray area. The providers gain, but the patient doesn’t pay.

Who Wins and Who Loses in the Gray Area?

This seems, at first cut, a win-win situation. The provider wins – gets paid. The patient wins – gets better. Even if the patient doesn’t improve much, he/she didn’t pay much. No harm, no foul.

Except for two problems. First, in the US, a great deal of care generates little to no patient benefit, as discussed earlier. But the provider always gets paid. Our ‘win-win’ becomes ‘providers win, patients get nothing’ around 30% of the time.

Those odds might be attractive to patients if medical treatments were risk-free - if we never had treatment complications, then reasonable and rational patients might decide that a 70% chance of improvement is good enough. They might discount the ‘no benefit’ risk and agree with their physician’s advice to receive treatment.

Unfortunately, however, medical treatments are never risk-free. This is the second problem. There are always complication risks. Remember Samantha Reckis from earlier in this course? She’s the little girl on Cape Cod who went blind from taking children’s Motrin. Expanding on this, consider these data points from a large Johns Hopkins study published in 2016:[50]

- 250,000 Americans die from medical errors annually,
- 10% of US deaths are due to medical error
- Medical errors are the 3rd leading cause of death in the US.

In addition, according to a 2018 survey of 6700 physicians, 691 or slightly over 10% reported that they themselves had made a medical error in the previous 3 months. [51]

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[50] Johns Hopkins study released May 3, 2016 https://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us

[51] Physician Burnout, Well-being and Work Unit Safety Grades, Tawfik et. al, Nov 1, 2018 https://www.mayoclinicproceedings.org/article/S0025-6196(18)30372-0/fulltext

This is not the business efficiency envisioned in the Torah's ethical discussions. This is very inefficient and unethical: one group in our society (providers) wins with every transaction while another (patients) loses fairly regularly.

They sometimes lose big time.

The Broker's Education Responsibility

What group in our society can counter the providers? Who can give warnings to patients about risk? Who can give unbiased advice to patients about when to trust providers and when not to? Who can act – in Biblical terms – like Abraham's burial plot seller?

I suggest that the broker has these responsibilities. This is a wider definition of broker duties than is currently common in our industry. But it is the definition that follows from the ethical standards discussed in the Torah.

Is it enough simply to describe the health insurance policy in detail?

Such a description would include a discussion of copayments and deductibles, pre-existing condition exclusions if any, available providers, prescription drug coverage, price etc and then show alternative products and describe them.

Though this may satisfy some customers, it does not satisfy the Torah's ethical requirement.

The broker also has an ethical responsibility to describe policy implications – the likelihood of benefit and harm from using the health insurance policy.

And the broker has an ethical responsibility under the 'do your fellow a favor' principle to teach clients how to identify and avoid wasteful and / or harmful medical care.

How Much Should Brokers Disclose?

The question posed by Rabbi Tamari in Parchas Shoftim above, in the discussion of *do the fellow a favor* remains: How much should a seller disclose about a product to a customer?

Tamari starts with the religious doctrine of Mekach Taut or faulty sale, discussed above. That's the doctrine requiring full disclosure of any defect in the goods or services sold, and a cancellation of the sale due to product defects *even if the seller was ignorant of the flaw at the time of sale*.

It is unclear from Genesis 23 exactly how much information Abraham's burial plot seller provided. He apparently provided a great deal and probably all that was necessary in that circumstance. But we get into a gray area when applying the lessons of Genesis to more complicated transactions, like health insurance policy sales.

Is it a 'product defect', for example, if someone goes to a less expensive and also lower quality in-network hospital and picks up an infection? Or if someone opts for surgery and has a complication, only to learn later that physical therapy might have been a wiser choice? Or if someone takes a heart attack prevention medication, later has a heart attack and subsequently learns that the medication was proven ineffective in comparative studies?

That's why the Rabbis expanded their discussion to include *do the fellow a favor.* Now we have the ethical tools to address this question.

Review Questions
Answers on next page

1. What does 'let the buyer beware' mean?

    a. That the buyer should beware that the seller is probably lying when he/she represents something

    b. That the buyer should beware that the seller is probably taping the transaction to protect him/her self in the event of a fraud accusation

    c. That the buyer should beware that the product probably contains hidden defects that the seller is not under any legal or ethical obligation to disclose

    d. That they buyer must do his/her own product research because the seller feels him/her self under no ethical obligation to disclose product details

2. What does 'let the buyer beware' assume?

    a. That the buyer understands that the seller is probably lying when he/she represents something

    b. That all parties to the transaction have equal abilities to understand the product information available

    c. That buyers have a certain minimum level of intelligence

    d. That sellers have less than a certain minimum level of intelligence

3. Is 'let the buyer beware' an ethical or unethical standard?

    a. This is an ethical standard

    b. This is not an ethical standard. In fact, it is unethical

    c. It is only an ethical standard for service type products like health insurance

d. It is generally an ethical standard but is inappropriate for service type products like health insurance

4. What does ‘do your fellow a favor’ mean?

a. That buyers should help sellers whenever possible

b. That sellers should try to put themselves in the buyer’s position, and should educate buyers as they would like to be educated themselves if they were the buyer

c. That sellers should embrace ‘the selfishness of Sodom’ thus creating a more competitive market

d. That buyers should embrace ‘the selfishness of Sodom’ thus putting more demands on the seller

5. Is ‘do your fellow a favor’ an ethical standard?

a. No

b. Yes

c. Only when the buyer figures that the ‘favor’ is worth less than the product in question

d. Only when the buyer figures that the ‘favor’ is worth more than the product in question

Review Questions
Correct answers in **bold**

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Some Concrete Ways for Health Insurance Brokers to ‘Do Your Fellow a Favor’ and to Avoid ‘Letting the Buyer Beware’

We discussed the low quality and wasteful care problems earlier in this text. Let’s drill down on the issue here as a brief summary.

Our fee-for-service healthcare financing system is weak at generating outcome data - we have fewer follow-up studies than we should. Many argue that this is due to our billing system: providers get paid based on inputs – procedures performed – rather than on outcomes. This can create a disincentive to study care effectiveness. Studies showing that treatments generate poor outcomes may hurt them economically.

Ditto for drug manufacturers, device manufacturers, hospital and other participants in the healthcare system. All exhibit a reluctance to engage in outcome studies.

As a result, medicine today is less scientific than we would like to believe. Here’s Shannon Brownlee, author of *Overtreated*, articulating the treatment outcome problem over the past few decades and continuing until today:

Much of what doctors were doing was based more on hunches than good research. There were gaping holes in medical knowledge even when it came to something as seemingly mundane as a tonsillectomy. [52]

And here’s Harvard Business School Professor Michael Porter on the issue of choosing the ‘best’ physician or hospital:

Physicians generally lack information on results, or their efficiency in achieving results, that is essential for knowing if they are doing their job well…most physicians lack any objective evidence of whether their results are average, above average or below average. [53]

As a result, medical practitioners rely on guidelines or norms. Not always a good idea. Yale Medical School Professor Dr. Sherwin Nuland explains the problems using routine standards or current ‘care norms’ as decision making justification:

Better watch out or the pendulum swing of medical dogma will bash your head in. It swings back and forth far more often than most people realize and with greater velocity.

Thirty years ago patients with inflammation of … the colon were routinely treated with a diet low in roughage. There was no uncertainty about this course of action…and yet, a few years

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[52] Brownlee, op cit, page 27

[53] Porter and Teisberg, Redefining Health Care, page 54

later, medical opinion reversed: decreased roughage was found not to be a panacea but a cause of the disease.

This new medical discovery was announced in the same assuredness and supported by just as much evidence as had been used for precisely the opposite viewpoint. [54]

This is sometimes called Medical Reversal, today's in-vogue term to describe how we embrace a treatment for a while only to reject it years later when it's shown to be non-beneficial or harmful. Nuland summarizes one such incidence above. Vinay Prasad in his brilliant book Ending Medical Reversal lists dozens more including

Estrogen replacement therapy for postmenopausal women to reduce heart attacks, a treatment he claims 'was of no benefit to the heart…. Doctors stopped recommending it not because we discovered something better, but because we never should have used it in the first place.' [55]

Coronary stent insertion to prevent heart attacks in asymptomatic patients until the COURAGE study showed that stents did not help patients live longer. [56]

Vertebroplasty or insertion of medical grade cement into brittle vertebra to strengthen the bones and take pressure off the nerves. This became a billion dollar a year business in 2012 even though two 2009 studies showed that patient pain reduction was the same in the placebo and treatment groups. Patients, companies – your clients – spend a billion dollar a year on a treatment works no better than a sham!

And over 140 more in his book's Appendix.

Prasad argues that much of what doctors do is unfounded in science and is, simply, wrong. This can help us focus on the broker's ethical disclosure issue. Should the broker, armed with a company's claims experience and recognizing that some employees have preventive stents or vertebroplasty, inform the client of these issues?

Clearly brokers cannot give medical advice. They're not qualified or licensed to do so and should avoid doing it, despite the fact that I regularly hear about brokers giving medical advice. One, for example, told me in class that clients often ask her how to choose a primary care physician. Her shocking answer, shocking to me at least: look for a PCP with specific training in your issues of concern.

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[54] Sherwin B. Nuland, 'Medical Fad: Brain, Midwives and Leeches' New York Times, June 25, 1995, section 4, page 16.

[55] Prasad, Ending Medical Reversal, pages 2 – 3

[56] Ibid, page 27

‘If you have gastro-intestinal problems, for example, look for a PCP who is trained in internal medicine. If you have orthopedic problems, ask your potential PCPs if they have any advanced training in orthopedics.’

I say ‘shocking’ because I know of no studies showing that those kinds of PCPs generate better patient outcomes than a control group and neither did this broker. (See why a basic knowledge of comparative studies is useful?)

But I see a potential lawsuit on the horizon. (I’m not a lawyer.) What happens to a client who follows this broker’s advice, chooses a PCP and has a bad medical outcome? Might the client sue the broker for poor advice? (I’m still not a lawyer and have no idea is this is realistic or not. But why would a broker open herself to such potential problems?)

I will argue instead that brokers should teach clients how to identify and avoid unnecessary, ineffective and wasteful medical care. Two reasons for this. First, the company hires the broker to help control healthcare costs, to save money on healthcare in other words. Part of this professional responsibility includes helping the company avoid wasting money on ineffective care.

That seems to me part of the broker’s fiduciary responsibility, and a core part at that.

Second, under the ‘do your fellow a favor’ ethical standard, the ethical broker should preemptively educate clients before they waste money on ineffective care. What would Abraham have said if he bought a cemetery plot for his wife and only later learned that the seller knew Abe was purchasing non-cemetery land but didn’t say anything in advance? The Rabbis would label that unethical and so, I suspect, would most reasonable people today.

Today’s broker knows about healthcare waste, low quality care and care harms based on their own studies and professional education if not only from the data presented in this text. You have the knowledge. Is it ethical to withhold it from your clients? We’ve clearly seen, under the ‘do your fellow a favor’ standard, that it is not.

The ethical question has, thus, shifted from ‘*should* the broker disclose information about healthcare system waste to the buyer?’ to ‘*how* should the broker disclose this information?’

The Process of Disclosure in today’s healthcare system

Dr. Prasad echoes many researchers in claiming that clinicians rely on hunches rather than facts far too often. Science gives us facts; hunches give us guesses.

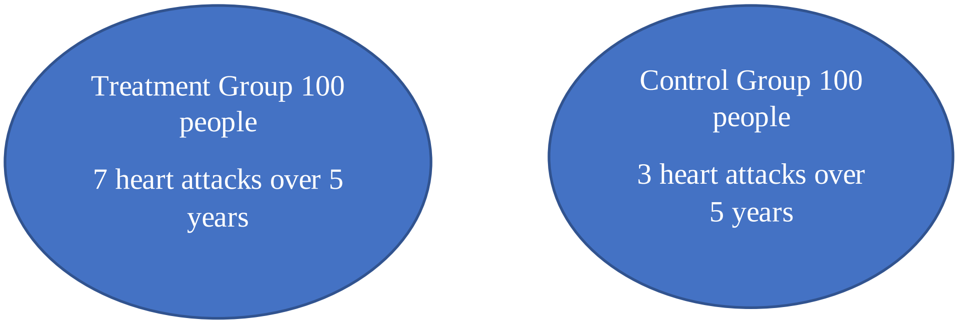
I propose that Step 1 in client disclosure and education starts with explaining how medical science arrives at facts and how to differential facts from hunches. That process – science in other words – relies on comparative testing.

Comparative tests tell us if and how well a medical intervention works in real life, on real people.

When testing, medical researchers typically divide a large group of people in half to make 2 identical smaller groups. They give one group the treatment but not the other. [57]

Then researchers watch both groups for a time period, say 5 years, and note medical differences like the number of heart attacks, deaths or strokes. They attribute any differences to the intervention.

Here's a simple visual representation of a comparative study for a hypothetical heart attack preventive medicine. The Treatment Group gets the medicine while the Control (or Placebo) Group does not. In this case, for simplicity purposes, I've assigned 100 people to each group. Note that this example is not based on any actual medication and is presented only to show what a comparative study looks like.



Can you determine how well the medicine worked to prevent heart attacks? In this example, the medicine prevented 4 heart attacks per 100 people over 5 years.

Simple! Actually not simple at all. Medical research methodology is very complicated and worthy of many texts, each much longer than this. But this example shows the essence of what a comparative study is. In effect, this example shows how the science tells us how well medical care works.

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[57] Research methodology is extremely complicated. If you're interested in learning more, check out Know Your Chances by Woloshin et al. It's an easy to read introduction to medical statistics and research methodology.

Scientifically determined outcomes, ‘facts’ in other words, rely on comparative study data. That’s how researchers determined that vertebroplasty worked no better than a placebo to reduce back pain, that estrogen didn’t protect postmenopausal women from having heart attacks and that stents in stable patients did not prevent heart attacks….among lots of other things.

But what happens if you don’t have 5 years available? Say that a new heart attack prevention medicine just came on the market, looks promising and you, a person with some elevated heart attack risk, have a doctor’s appointment the next day.

Your doctor may say ‘this is the newest generation of heart attack preventive medicine and has been configured to reduce the side effects of the old drug. I suggest you try it and see how you tolerate it.’

In theory the new drug works well. But it hasn’t been tested yet in real life, on real people, for years. So how well does it work?

Dr. Prasad studies that issue. He asks in his research ‘how well do medical interventions work if they haven’t been subjected to comparative tests?’

How well, in other words, does medical theory hold up to subsequent testing?

Prasad and his team conducted a fascinating study summarized in his book Ending Medical Reversal. They reviewed every article in the New England Journal of Medicine between 2001 and 2010 and pulled out those that tested an established medical practice, i.e. subjected an established medical practice to a comparative study. Established medical practices are those commonly used on patients like inserting stents into stable patients and, at least for a time historically, prescribing estrogen to postmenopausal women to prevent heart attacks … interventions that made medical sense and that the medical community embraced.

363 studies qualified.

Prasad then asked ‘Of those 363 studies, how many *affirmed* the practice?’ i.e. found that it benefited patients.

38% affirmed the practice, 40% negated the practice, (found it ineffective or harmful) and 22% were ambiguous.

Dr. Prasad’s research shows that if you base your medical decisions on biology, physiology, anatomy and logic – *but not on test results* – you are wrong about as often as you are right.

We’ll call this Prasad’s Law at restate it clearly here: Medical interventions that haven’t been subjected to comparative testing are ineffective or harmful about half the time. How do we know that they’re ineffective or harmful? We learn this when they’re subsequently tested, potentially many years in the future.

But that’s after patients have used it!

According to Dr. Prasad, rather than focusing on outcomes, patients often

gravitate toward the nuts and bolts — what does it do, how does it work?

But the real question is: Does it work? What evidence is there that it does what you say it does? What trials show that it actually works?

You shouldn't ask *how* does it work, but *whether it works at all*. [58]

He goes on to claim that 'of all those things we're doing currently that lack good evidence, probably about half of them are incorrect.' [59]

Why is this the case?

Our bodies are enormously complicated and our understanding of medical risks, causality and treatment impacts is surprisingly limited. Sometimes (often?) rather than using the most *important* biological or anatomical factors in our medical theories, we use the most *easily accessible and measurable*.

Here's an analogy to illustrate: [60]

Assume that our bodies are controlled by a wizard located in our brain, more or less like the fellow behind the curtain in the Wizard of Oz.

The wizard in our brain has a wall of knobs that control body parts and functions - one controls cholesterol levels, another blood pressure, a third bone density, a fourth eye ball pressure, etc.

If each knob is 1 inch in diameter and 1 inch apart (so the wizard can get his fingers around it) the wall is six and a half feet high and half a mile long!

We simply can't account for all the initial effects, rebound effects, interactions and modifications from turning a knob or two. We don't always know, for example, how turning a knob 2 feet high 100 yards from here affects a level controlled by a knob 3 feet high 300 yards away. And how either of these affects a knob 4 foot high 400 yards away. Or the impact of the last knob change on the first. And so on.

Medicine rarely works in the simplified 'if A causes B, and B causes C, then A causes C' scenario.

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[58] Quotes from Nicholas Bakalar, Medical Procedures May Be Useless, or Worse, New York Times July 26. 2013, italics added

[59] These are quotes from Dr. Prasad's video http://www.mayoclinicproceedings.org/cms/attachment/2007391767/2029532458/mmc3.mp4 . Some minor edits for grammar and syntax

[60] I've adapted this example from David Newman, Hippocrates's Shadow, page 202

Now, as an ethical broker, do you think this is something your clients should know? A meaningful way to 'do your fellow a favor' is to explain what a comparative test is and why using test data as the basis of medical decision making is so important.

Or do you prefer to 'let the buyer beware' and endure the same client decision making mistakes next year as last. And as the year before that.

And then, when your client complains that premiums increases are too high, simply raise deductibles and say 'wellness program' more loudly…just like last year, the year before and the year before that.

Medically well informed patients always ask 'has it been tested for the outcomes that concern me?'

If it *has been* tested, then your doctor can tell you how well it works. All physicians today can access extensive databases of medical studies…in their offices… in real time so they can answer this question.

If answers exist.

Asking this question may motivate your doctor to refresh his or her memory and look for new studies that have been published since the last time he or she checked.

You and your doctor can then decide if the intervention works well enough for you. I'll show you how in the next section.

But you may learn that the intervention *has not been* appropriately tested. In that case, you know your chance of benefit is only 50/50. Prasad's Law tells us that.

And even if it benefits you, it might not benefit you very much.

Examples of medical care that *should* work, but doesn't

Case studies that illustrate the power of ethical disclosure education

I'll present 6 case studies to show the power of asking 'has it been tested for the outcomes that concern me?' and why you need to ask this question about every medical intervention: [61]

- Niaspin, an HDL 'good cholesterol' boosting drug
- Atenolol, a blood pressure lowering drug
- Zetia, a cholesterol lowering drug

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[61] All reference notes for this section appear at the end of this text

- Vertebroplasty, a back surgery technique
- Arthroscopic knee surgery, a knee osteoarthritis remedy
- Rest after heart surgery, an historical example to tie everything together

Niaspin, an extended release niacin drug. Niacin, a B vitamin, has been shown in tests to raise good (HDL) cholesterol. More good cholesterol is associated with a lower heart attack risk, so artificially raising it benefits patients, at least in theory.

Niacin doesn't lower total cholesterol like commonly prescribed statin drugs.

Cardiologists have prescribed various niacin products for years. One, Niaspin manufactured by Abbott Labs, generated about $900 million in 2009 sales from about 8 million prescriptions. [62]

In 2011, the AIM-High trial of niacin effectiveness showed that, while extended release niacin *is* associated with higher HDL levels and lower triglyceride levels, this *does not* translate to a reduction in cardiovascular events like heart attacks and strokes. [63]

In 2013, a second study, this time of Merck's niacin drug Tredaptive found the same thing: no difference in coronary event rates between people taking Tredaptive with a statin, and those just taking the statin. [64]

Dr. Steven Nissen, Chief of Cardiology at the Cleveland Clinic, summarized the Tredaptive study findings: It raised good cholesterol. It lowered bad cholesterol. It didn't improve clinical outcomes. That is a stunning finding. [65]

Two studies on two different niacin based drugs arrived at the same conclusion: niacin doesn't reduce rates of heart attacks or strokes.

This is an example of Prasad's Law: interventions that appear to make biological sense and that are adopted before publication of comparative tests are proven ineffective or harmful about half the time when they finally are tested.

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[62] Armstrong, Abbott Doubled Niaspin US Sales Before Trials Cut Use, Bloomberg, June 10, 2013 https://www.bloomberg.com/news/articles/2013-06-10/abbott-doubled-niaspan-u-s-sales-before-trials-cut-use

[63] This sentence paraphrases the New England Journal of Medicine discussion of the AIM High study http://www.nejm.org/doi/full/10.1056/NEJMoa1107579#t=article .

[64] http://www.reuters.com/article/merck-cholesterol-idUSL1N0BREGB20130227 and For a good summary see CBS News estimate, Study: Heart Drug Tredaptive is Ineffective, Jonathan Lapook, July 29, 2013

[65] CBS News, op cit

Patients who bought and took Niaspin received no heart attack or stroke reduction benefit from it.

They only exposed themselves to side effects like burning, tingling, itching, headaches, stomach upset, intestinal gas, dizziness, and redness of the face, arms, and chest. [66]

Plus the price of Niaspin pills.

Atenolol, a blood pressure lowering drug

High blood pressure is a common condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems such as heart disease. High blood pressure can damage the heart and coronary arteries and lead to heart attacks, strokes and death, among other events.[67]

Lowering blood pressure, therefore, *should* reduce the number of heart attacks, strokes and deaths. So strongly do physicians subscribe to this theory that they write millions of blood pressure lowering medication prescriptions annually, worth billions of dollars, including 36 million prescriptions for atenolol in 2010.

Atenolol recorded $161 million in 2014 sales.[68]

Unfortunately comparative study hard outcomes do not support the theory.

Start in 2003 with publication of the LIFE study on two of the most commonly prescribed blood pressure lowering medications - also called beta blockers - losartan and atenolol. [69] Neither outperformed the placebo.

In an accompanying European Heart Journal editorial, Dr. Franz Messerli, writing for the European Society of Cardiology concluded

the LIFE study should be considered as the final straw that will break the camel’s back and hopefully motivate physicians to no longer expose their elderly hypertensive patients to the cost, inconvenience, adverse effects, and most importantly, to the inefficacy of beta-blockers.

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[66] This list comes from WebMD http://www.webmd.com/vitamins-supplements/ingredientmono-924-niacin%20and%20niacinamide%20vitamin%20b3.aspx?activeingredientid=924&

[67] http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/WhyBloodPressureMatters/Why-Blood-Pressure-Matters_UCM_002051_Article.jsp

[68] http://www.pharmacompass.com/sales-forecast/atenolol

[69] See ‘The LIFE Study: The straw that should break the camel’s back’ by Franz Messerli for a brief summary in the European Heart Journal, March 2, 2003.

That was followed up by a 2004 meta review (a compilation that integrates results from several different studies to develop a single conclusion) in the Lancet entitled ‘Atenolol in hypertension: is it a wise choice?’ [70] Those reviewers found that

there were no outcome differences between atenolol and placebo in the four studies, comprising 6825 patients, who were followed up for a mean of 4.6 years on all-cause mortality, cardiovascular mortality, or myocardial infarction [heart attacks].

The theme was then picked up in the March 15, 2005 issue of The American Family Physician, a publication of the American Association of Family Physicians. Dr. Henry Barry’s article ‘Should Atenolol Be Used for Hypertension?’ concluded that, though atenolol *did* lower blood pressure,

It does not appear to reduce the rates of cardiovascular mortality or morbidity.

Let’s summarize:

- One major, high quality comparative study in **2003** concluded atenolol generates ‘no benefit’
- A large meta study in **2004** concluded ‘no benefit’
- Physicians writing in various highly regarded journals – who reviewed the underlying study data – between **2003 and 2005** recommended *against* prescribing these drugs
- **Six years later**, docs wrote 36 million Atenolol prescriptions and **ten years later** Atenolol achieved $161 million in annual sales.

I hope you’re beginning to understand why you need to ask if it has been subjected to comparative testing about *every* medication.

And find out what those test results are.

Even for medications that have been around for a long time.

Zetia, a cholesterol lowering drug. Zetia (ezetimibe) lowers cholesterol by blocking its absorption in the intestines, unlike statins that block cholesterol absorption in the liver.

Some patients can’t tolerate statins.

Others might not achieve their desired cholesterol reduction goals with statins alone.

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[70] A meta review is a comparison of several tests. Meta reviewers study, for example, the methodology of each individual test to ensure that researchers didn’t goof somewhere along the line.
http://www.ncbi.nlm.nih.gov/pubmed/15530629

Zetia offers benefits to both types of patients: those who can't tolerate statins and those who don't achieve their cholesterol goals from lifestyle changes and statins alone. As Zetia's website, zetia.com, said from about 2011 - 2016 [71]

Adding Zetia to a statin is proven to help reduce cholesterol more than a statin alone.

Zetia's annual sales ranged between about $1 and $4 billion since 2008.

Unfortunately for Zetia users and the people who pay for it, we should also point out the next sentence on zetia.com, the one following 'Adding Zetia to a statin is proven to help reduce cholesterol more than a statin alone', this one written in bold

Unlike some statins, Zetia has not been shown to prevent heart disease or heart attacks.

The New York Times review of Zetia's 2008 clinical trial, concluded it [72]

… failed to show that the drug had any benefits…[and]

… no trial has ever shown that it can reduce heart attacks and strokes

Our old friend Steve Nissen from the Cleveland Clinic (of Atenolol fame above) called these results 'shocking'. [73]

Harlan Krumholz, cardiologist at Yale Medical School went even further, asking 'How can a drug have $4 billion in sales without any evidence of benefit?' [74]

Vertebroplasty to relieve back pain Let's switch focus now from medications to procedures. Consider vertebroplasty, a procedure to inject medical grade cement into fractured vertebra (back bones) to reduce back pain. It's a minimally invasive procedure with a low complication rate, about 1 – 3%.[75] Complications include soft tissue damage, nerve root pain and compression, pulmonary embolism, respiratory and cardiac failure and death.

In 2008, the US market for vertebroplasty was $245 million.

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[71] I had used this example in lectures for several years. When I visited the site in late December 2016, I discovered that it had been replaced with a 'prescribing highlights' pdf in small print.

[72] Drug Has No Benefit In Trial, Makers Say, Berenson, NY Times, January 14, 2008

[73] Ibid.

[74] Another Vytorin Mess for Merck, Herper, Forbes, Nov 15, 2009

[75] Estimate from Johns Hopkins Health Library

Then in 2009 the New England Journal of Medicine published two studies comparing vertebroplasty to a control or placebo group that received lidocaine (a topical skin numbing agent), massage and aromatherapy to reproduce operating room smells.

- The Australian study found ‘no beneficial effect’ of vertebroplasty compared to the control group.
- The Mayo study concluded that patient improvements were similar in the placebo and experimental groups.[76]

Vertebroplasty, in other words, worked as well as, but no better than, the safer and far cheaper placebo.

Dr. Rachelle Buchbinder, lead author of the Australian study, recommended that vertebroplasty not be performed outside of research settings. There are some risks, she reasoned, without any demonstrated patient benefits.

Did any of your own clients have vertebroplasty? If so, are these the clients who demand that you lower their healthcare costs?

See where this goes?

Surgery for Knee Osteoarthritis Knee osteoarthritis is a degenerative disease that causes pain, stiffness and decreased knee function.

Arthroscopic surgery, including lavage (removal of particulate material such as cartilage fragments and calcium crystals) and debridement (surgical smoothing of articular surfaces and osteophytes) was the widely used treatment in the early 2000s despite the fact that, according to the New England Journal of Medicine in 2008 ‘scientific evidence to support its efficacy is lacking’. [77]

Estimates of the number of knee arthroscopies performed annually in the US vary, and not all address osteoarthritis so we’ll have to estimate the size of this problem:

- A 2002 New England Journal of Medicine study estimated 650,000 procedures at $5,000 each, creating a $3.25 billion market. [78]

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[76] For a good summary of those studies, with expanded comments, see Sham-Wow by Walter Eisner in Orthopedics This Week, August 11, 2009, https://ryortho.com/2009/08/sham-wow/

[77] Kirkley et al, A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee, NEJM, September 11, 2008

[78] Moseley et al, A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee, NEJM, July 11, 2002

- A 2014 NEJM study estimated the market at 500,000 knee arthroscopies at about $20,000, generating a $10 billion market. [79]

- Vinay Prasad in his 2015 book Ending Medical Reversal estimated the market at 700,000 patients spending $4 billion.[80]

How poorly does the scientific evidence support the efficacy of arthroscopic surgery to treat knee osteoarthritis?

- A 2008 New England Journal of Medicine published study concluded that they 'failed to show a benefit of arthroscopic surgery for the treatment of osteoarthritis of the knee' [81]

- This followed a 2002 comparative study which concluded 'At no point did [the] arthroscopic-intervention group have greater pain relief than the placebo group'

- In addition, 'objectively measured walking and stair climbing were poorer in the débridement group than in the placebo group at two weeks' (Treatment side effects really matter!)

- The 2002 study concluded 'This study provides strong evidence that arthroscopic lavage with or without debridement is not better than and appears equal to a placebo procedure in improving knee pain and self-reported function.' [82]

Those disagreeing with these study conclusions present the usual 'weak study methodology' case, primarily, I would suggest, to protect their incomes. Even at our lowest market estimate - $3 billion – that's certainly a big incentive for lots of people to protect their turfs.

These studies raise some uncomfortable questions:

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[79] These estimates from Cram, et al, Total Knee Arthroscopy Volume, New England Journal of Medicine, Sept 19, 2014. I was unable to develop a specific number of procedures by year, nor estimate the annual growth rate of knee arthroscopies.

[80] Prasad, Ending Medical Reversal, page 22

[81] Kirkley, op cit

[82] Moseley, op cit

- Why, after the 2002 paper, did doctors continue to prescribe this procedure and patients have it?

- Why after the 2008 study did both parties continue to use it?

This is an extension of Prasad's Law that says treatments adopted absent testing are proven ineffective or harmful about half the time. Here we have treatments used *even after* studies showed no patient benefit, underscoring the need for you to ask this question and insist on a clear answer about *every* medication and procedure.

Asking encourages your doctor to check (again?).

Never hurts but may help.

A lot!

Rest after heart surgery, an historical example to tie all this together. We'll start in the early 1900s with Dr. James Herrick's advice then fast forward to today's protocols.

Herrick was an extraordinarily influential coronary care researcher who received impressive accolades from both the Association of American Physicians and the American Medical Association.

In his major 1912 paper, Herrick wrote that, after having a heart attack or heart surgery 'the importance of absolute rest in bed for several days is clear'. [83]

Herrick's recommendations were adopted by most hospitals according to cardiologist Eugene Braunwald. Over time hospitals extended Herrick's advice of absolute bedrest from several days to a few weeks.

That remained the treatment norm for decades. Indeed, thirty four years after Herrick's paper, Dr. Thomas Lewis published his own coronary care textbook *Diseases of the Heart* and elaborated on Herrick's prescription:

Rest in bed should continue for 4 – 6 weeks to ensure firm cicatrisation of the ventricular wall … Patients have lost their lives … by neglect of these precautions. [84]

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[83] Braunwald, The treatment of acute myocardial infarction, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760555/

[84] Silverman et al, British Cardiology in the Twentieth Century, Chapter 27

Lewis' justification came from pathological studies showing that it can take 6 to 8 weeks for firm scarring of the lesion to occur. Rest for that amount of time was considered necessary to minimize ventricular rupture risks. [85]

Dr. Paul Woods, another coronary care authority, reinforced that message in his textbook *Diseases of the Heart and Circulation* in 1959, 13 years later, recommending 3 – 6 weeks of bedrest or more depending on the severity of the heart attack.[86]

Thus three medical textbooks written between 1912 and 1959 agreed: post heart attack and heart surgery, patients should rest, pretty much for as long as possible.

But by the 1960s medical opinion reversed. Braunwald in an overview of cardiac practices, claims doctors began to realize that

> Prolonged bed rest, which had been routine since Herrick's day, could actually be harmful in some patients by leading to venous thrombosis and fatal pulmonary thromboembolism. In uncomplicated cases, the duration of absolute bed rest was shortened to about five days. [87]

Patients who asked 'what do you recommend doc?' in the ***1940s and 50s*** would have received the long bedrest recommendation.

But patients who asked the same questions in the ***1960s and 70s*** would have received the short bedrest advice.

And today, patients are advised to walk every day during the first 6 – 8 weeks post heart surgery, the exact opposite of Herrick's, Lewis's and Woods' recommendations. [88]

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[85] Julian, Ischemic Heart Disease in Dialogues in Cardiovascular Medicine, 2006 http://www.dialogues-cvm.com/document/DCVM40.pdf

[86] Silverman, op cit.

[87] Braunwald, op cit.

[88] WebMD, Recovering after heart surgery, http://www.webmd.com/heart-disease/guide/heart-disease-recovering-after-heart-surgery#1

1950s

1970s

2000s

How can ‘rest’ and ‘don’t rest’ both be right? They obviously can’t. At least one is wrong. Drs. Herrick, Thomas and Woods offered their *best guesses* backed up with biological justifications. In effect, they said ‘our best guess is that the risk of ventricular rupture exceeds the risk of venous thrombosis and fatal pulmonary thromboembolism’ (if they even knew those risks existed).

Their guesses were really testable propositions which, apparently, weren’t actually tested until relatively recently. When tested, we learned that thrombosis risks exceed ventricular rupture risks. Thrombosis and embolism risks are so high in fact that today’s patients are advised not even to stand in one place for more than 15 minutes! [89] The exact opposite of Herrick’s, Thomas’s and Woods’ advice.

That’s why wise patients don’t research *why* a specific medical recommendation makes sense. Doctors and scientists can justify a wide range of (often conflicting) recommendations, just as we’ve seen here. Prasad’s Law tells us that absent testing for specific outcomes of concern, those recommendations are wrong about half the time.

Instead of relying on theory, wise patients rely on test data, the facts.

The tragedy of this story is that some heart attack recovery patients presumably died in the last century *from following the established protocols and textbook advice*.

They didn’t ask if the recommendations had been tested.

The ethical broker’s next step:
Help clients interpret test results

Let’s return to our simple comparative study example in which 7 people in the placebo group had heart attacks and 3 did in the treatment group. How does a medically literate patient discuss these results?

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[89] WebMD, op cit.

This presents a golden opportunity for brokers to teach clients how to interpret and discuss treatment benefits with their doctors.

The standard, correct **and useless** way to summarize the tests results is ‘this medicine cut the heart attack risk by 57%.’ (The math is quite simple: 7 people in the placebo group had a heart attack. 4 people avoided a heart attack by taking the medicine. 4/7 is 57%.)

Though correct, this is not useful for medical decision making.

57% of what?

- In this case, 57% of 7 per 100. (I’m getting confused by all these numbers and I’m writing this stuff!)
- But here’s another example of a 57% risk reduction. From 3 in 10,000 to 1.29 in 10,000 over 10 years. That’s a 57% reduction.
- Or from 5 in a million to 2.15 in a million over 15 years. That reduction of 2.85 events per million people over 15 years is, again, a 57% reduction.

Preventing 4 heart attacks in 100 people over 5 years may seem like a pretty good benefit.

- But preventing 2.85 heart attacks in a million people over 15 years seems like a pretty small benefit. (If you’re not totally confused by now you should consider yourself brilliant.)

Here’s a general rule of thumb for reporting test results: whenever you hear expressions like ‘57% better than’, or ‘reduces your risk by 57%’, ask ‘57% *of what*?’

- If it’s 5 in a million, then a 57% reduction is a pretty insignificant number.
- But if it’s 7 in 100, then you probably want to pay attention.

Percentage reductions like 57% better than sound more impressive than they really are. I’d even say that whenever someone quotes study results in this way they’re trying to sell you something. That’s why retail vendors – refrigerators, clothes, appliances - tend to quote prices in percentage off. It sounds bigger than it is.

- ‘Prices slashed by 57%’ sounds big.

- ‘Prices slashed by $4.38’ sounds small.

It’s the same in medicine.

A better way

I propose that brokers teach clients to ask these two simple questions to learn the results of comparative tests:

- Out of 100 people like me, how many benefit? and
- Out of 100 people like me, how many are harmed?

Ask ‘**out of 100**’ to get a number for your answer. ‘4’ for example, conveys more information than ‘some’, ‘many’, ‘a few’ or ‘quite a few’.

Some patients may decide that 4 people benefiting is good enough to have the treatment while others say ‘only 4? That’s not very many’. Different people can reasonably interpret the answers differently. That’s the essence of a doctor-patient discussion: apply information to the particular desires of a specific patient.

Ask about ‘**people like me**’ because treatments can have different impacts on different demographic groups. Consider these examples.

Age: The American Academy of Pediatrics recommends against prescribing cough and cold medications for respiratory illnesses in children under 4 saying ‘these products offer little benefit to young children and can have potentially serious side effects’. [90] They’re apparently fine for 6 or 8 year olds - or 30 or 40 year olds – but not for very young children.

… out of 100 people … these medications work, but

… *like me* … not if you’re under 4 years old

Gender: In 2014, the Food and Drug Administration cut the recommended dose of Ambien, a sleep aid, in half for women after determining that men and women metabolize it differently. Women, it turns out, have more of the drug in their bodies the next morning, putting them at higher risk of impaired driving.[91]

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[90] ChoosingWisely, American Academy of Pediatrics, http://www.choosingwisely.org/societies/american-academy-of-pediatrics/

[91] CBS News 60 Minutes, Feb 9, 2014 http://www.cbsnews.com/news/sex-matters-drugs-can-affect-sexes-differently/

… out of 100 people … the medication works, but

… *like me* … not so well for women

Other patient differences exist but we don't always know how frequently. You and your doctor may have to estimate the impact on people like you.

An interesting *like me* category that most people don't consider but that an ethical broker should discuss: social status

I'll define social status ambiguously as a combination of wealth, income and sense of control over your life, analogous to the way former US Supreme Court Justice Potter Stewart defined pornography: you know it when you see it.

The notion that social status impact disease rates and treatment effectiveness was first introduced in the Whitehall studies during the last 1900s. These studies tracked disease and death rates by job and rank in the British civil service and their conclusions have been reproduced in other studies, in other countries.[92]

Whitehall found that low social status folks had higher disease and death rates than high status folks. Surprisingly – and this is the big deal - this was not *only* due to measureable factors like cholesterol, blood pressure, blood sugar, smoking, obesity or exercise rates.

After correcting for those factors, *the lowest status folks were about twice as likely to have heart attacks, develop other diseases and die as the highest status ones*.

Whitehall also found a gradient: the higher you are on the social status scale, the lower your disease and death rates and the reverse, the lower you are on the social scale, the higher your disease and death rates.

Over and above specific disease risk factors, Whitehall concluded, there is something about social status *independently* that impacts people's health. Harvard School of Public Health Professor Nancy Kreiger, whose own work affirms Whitehall's conclusions, put it this way:

An individual's health can't be torn from context and history. We are both social and biological beings—and the social is every bit as "real" as the biological. [93]

A major 2016 study in JAMA, the Journal of the American Medical Association found that the life expectancy gap between the richest 1% of Americans and the poorest was about 12 years on

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[92] See, for example, Isaacs and Schroeder, Class – The Ignored Determinant of the Nation's Health, New England Journal of Medicine, September 9, 2004 http://www.nejm.org/doi/full/10.1056/NEJMsb040329, Drexler, The People's Epidemologists, Harvard Magazine, March-April 2006 http://harvardmagazine.com/2006/03/the-peoples-epidemiologi.html, The Panel Study of Income Dynamics at the University of Michigan https://psidonline.isr.umich.edu/, and Bradley and Taylor, The American Healthcare Paradox

[93] Drexler, The People's Epidemiologists, Harvard Magazine, March-April, 2006

a gradient similar to Whitehall's. In an accompanying editorial, Nobel laureate Angus Deaton emphasized the impact of income and social status on health and castigated traditional medical thinking:

The finding that income predicts mortality has a long history… the mortality gradient by income is found wherever and whenever it is sought…**but the medical mainstream emphasizes biology, genetic factors, specific diseases, individual behavior, health care, and health insurance.** [94]

Consider the medical impacts of your own social status. Let's say that after examining you, your doctor says 'your cholesterol level is slightly higher than I'd like. The guidelines suggest lowering it. I'll prescribe a medication.'

- If you're a *low* status person (facing higher than average heart attack risks according to Whitehall) you may be undermedicated, leaving you exposed to *disease* harms.

- But if you're a *high* status person (facing lower than average heart attack risks according to Whitehall) you may be overmedicated, exposing you unnecessarily to *medication* harms.

Try to include social status factors in your 'like me' discussions with your doctor along with age, gender, general health status, family history etc. One good information source is the 2004 report 'Work, Stress and Health: The Whitehall II Study'. Share it with your doctor. It's surprisingly easy to read and it may change the way you think about medical care.

It did for me.

Define the benefits that matter

Identify the **benefits** of interest to you. If you are taking a heart attack prevention medication ask 'out of 100 people like me, how many avoid a heart attack by taking this medication?'

If you want to reduce your back pain, ask 'out of 100 people like me, how many enjoy less back pain as a result of this procedure?'

Beware of listing 'lower my cholesterol' or 'lower my blood pressure' as the benefit you hope to achieve. These 'test benefits' may or may not correlate closely to 'patient' or 'event' benefits. Focus on the specific benefits you hope to achieve.

And be as specific as possible.

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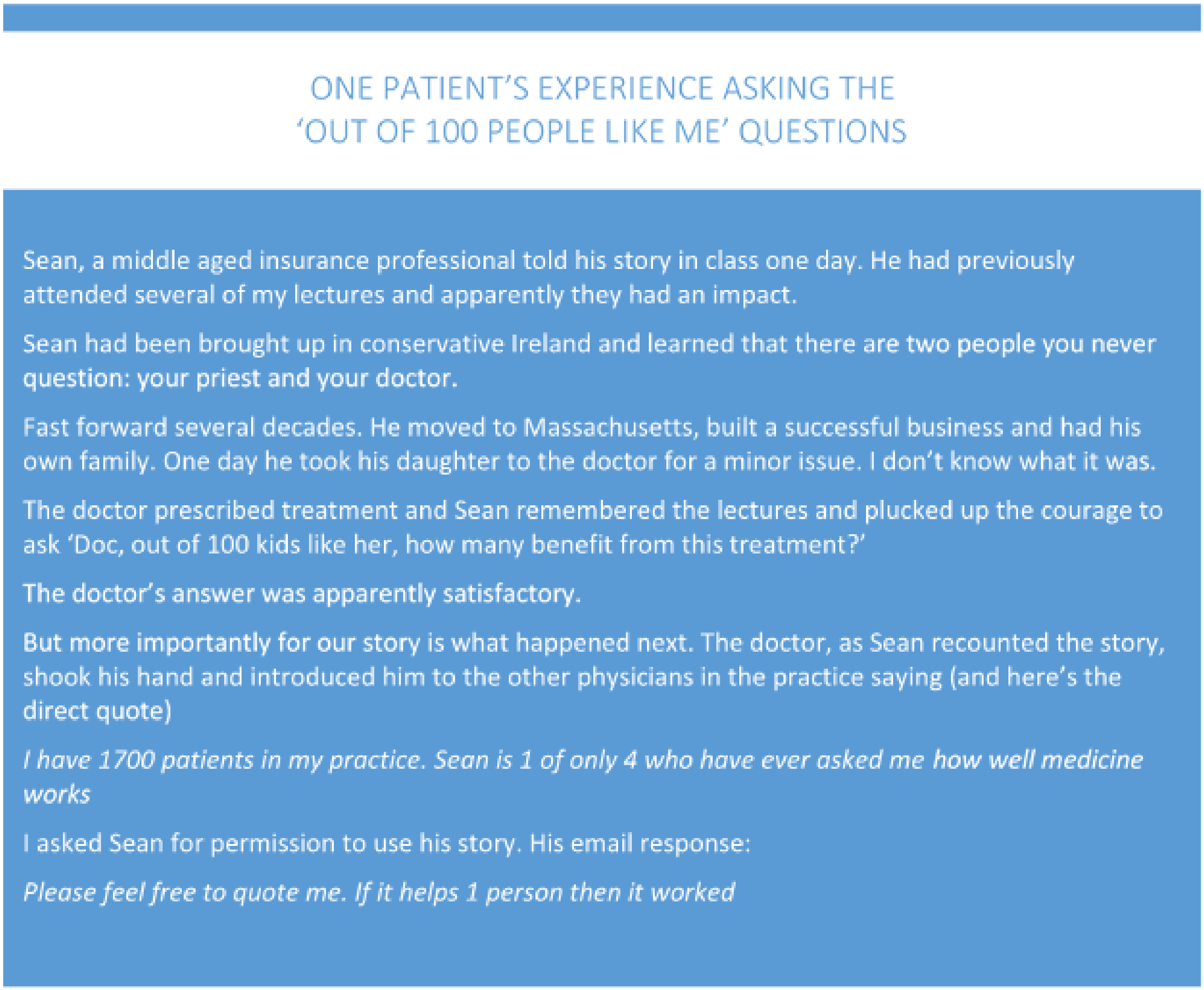
[94] Chetty, The Association Between Income and Life Expectancy in the United States, JAMA, April 26, 2016. See also Deaton's editorial, On Death and Money: History, Facts and Explanations, same issue, slightly paraphrased with emphasis added.



ONE PATIENT’S EXPERIENCE ASKING THE ‘OUT OF 100 PEOPLE LIKE ME’ QUESTIONS

Sean, a middle aged insurance professional told his story in class one day. He had previously attended several of my lectures and apparently they had an impact.

Sean had been brought up in conservative Ireland and learned that there are two people you never question: your priest and your doctor.

Fast forward several decades. He moved to Massachusetts, built a successful business and had his own family. One day he took his daughter to the doctor for a minor issue. I don’t know what it was.

The doctor prescribed treatment and Sean remembered the lectures and plucked up the courage to ask ‘Doc, out of 100 kids like her, how many benefit from this treatment?’

The doctor’s answer was apparently satisfactory.

But more importantly for our story is what happened next. The doctor, as Sean recounted the story, shook his hand and introduced him to the other physicians in the practice saying (and here’s the direct quote)

I have 1700 patients in my practice. Sean is 1 of only 4 who have ever asked me how well medicine works

I asked Sean for permission to use his story. His email response:

Please feel free to quote me. If it helps 1 person then it worked

Some case studies to indicate the power of asking this question
Real life situations that develop from ethical disclosure actions:

Consider antibiotics to treat pediatric ear infections, a quite common childhood problem. Ear infections can be painful for the child and frightening for the parents who, not unreasonably, want to do something to help their child.

Ear aches are sometimes viral and sometimes bacterial. Doctors often prescribe antibiotics.

This intervention – antibiotics to treat pediatric ear aches - has been studied so Prasad’s Law doesn’t apply.

A meta review – that’s a compendium of several individual studies – of 15 studies on 4100 kids concluded that 6 in 100 who took antibiotics reported less ear pain after 2 – 7 days; 94 in 100 did not enjoy less ear pain as a result of the antibiotics. [95] Most had a complete recovery within 2 – 7 days without the medication.

But 11 in 100 who took antibiotics suffered uncomfortable side effects like diarrhea.

- Out of 100 kids who take antibiotics to treat ear infections, how many benefit by enjoying less ear pain in 2 – 7 days? **6**

- Out of 100 kids who take antibiotics to treat ear infections, how many are harmed by diarrhea or other uncomfortable side effects? **11**

Now you have sufficient information to discuss this intervention with your pediatrician. Does it work well enough for your child? Some parents may decide yes, others no.

But in both cases, it's an informed decision made by a parent in light of the facts.

Dozens of similar cases exist. One website www.TheNNT.com lists about a hundred. Choosing Wisely www.ChoosingWisely.org takes a slightly different approach and lists hundred more. Both sites will provide good information for you to discuss with your doctor.

Comparing 'out of 100 people like me…' to 'the guidelines say…'
Case study of hypertension

The American Heart Association recommends that people over 60 years old begin treatment for high blood pressure when their readings exceed 150/90. [96]

But out of 100 people like that, how many benefit by following those guidelines?

Some answers come from a 2009 Cochrane report that summarized 15 trials totaling 25,000 subjects over age 60 with moderate to acute hypertension followed for average 4.5 years. [97]

Out of 100 people over 60 years old with moderate to acute hypertension, how many avoid cardiovascular disease or death over 4.5 years?

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[95] This information comes from Antibiotics for Acute Otitis Media on theNNT.com http://www.thennt.com/nnt/antibiotics-for-otitis-media/. The underlying studies Sanders S, Glasziou PP, DelMar C, Rover sMM. Antibiotics for acute otitis media in children. Cochrane Database of Systematic Reviews 2004, Issue 1. Art. No.: CD000219. DOI: 10.1002/14651858.CD000219.pub2.
Turck D, Bernet JP, Marx J, et al. Incidence and risk factors of oral antibiotic-associated diarrhea in an outpatient pediatric population. J Pediatr Gastroenterol Nutr 2003;37:22-26.

[96] http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/American-Heart-Association-backs-current-BP-treatments_UCM_459129_Article.jsp

[97] Musini, 2009, Pharmacotherapy for hypertension in the elderly

Answer: About 4

Here are Cochran's numbers:

- Risk of cardiovascular death or disease without taking hypertensive medication: 14.9/hundred. This is the control group.
- Risk of cardiovascular death or disease among patients taking hypertensive medications: 10.6/hundred. This is the test group.
- Medication benefit: 4.3 fewer deaths or diseased patients/hundred (4.3%)

I don't know how many, if any, were harmed by the medication.

This case study shows why the ethical broker doesn't simply 'let the buyer beware' and rely on some set of guidelines but instead 'does his fellow a favor' and teaches a better question to ask.

What if your doctor can't answer these questions?

Prasad's Law! If your doctor can't answer these questions, the medical intervention hasn't been studied thoroughly.

It's ineffective or harmful about half the time. [98]

Period.

That's why asking these questions is so important!

An alternative metric that some ethical brokers have introduced

A different version of 'out of 100 people like me, how many benefit and are harmed' has been developed by researchers over the past couple of decades. It's called the Number Needed to Treat (NNT) and Number Needed for Harm (NNH).

The Number Needed to Treat tells us how many people need to take a particular medication, or have a test, for one person to benefit. An NNT of 1 means that if 1 person takes this medication, then 1 person will benefit from it.

But an NNT of 50 means that 50 people need to take a medication for 1 person to benefit. We get NNT data from comparative studies (remember them?)

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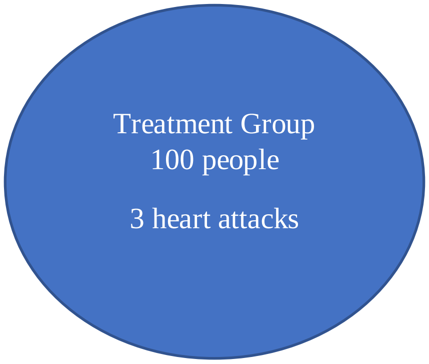
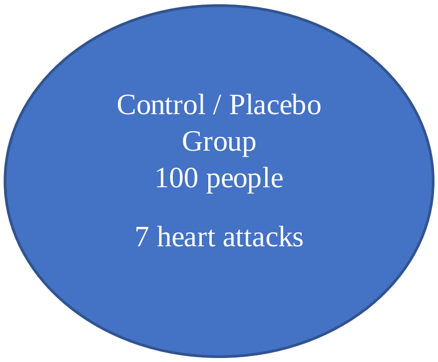
[98] I assume your doctor has internet access and can look up any relevant comparative studies. Though I don't normally give specific advice, I'll make an exception here: if your doctor doesn't use the internet … get another doctor!

Consider this comparative study of the same heart attack prevention medicine we introduced earlier. Can you estimate the number of people who need to take the medicine to prevent 1 heart attack?





In this hypothetical example, the medication prevented 4 heart attacks per 100 people who took it. Therefore 25 people had to take the medicine to prevent 1 heart attack. The Number Needed to Treat or NNT is 25.

Once you know this, you can compare treatment effectiveness. In fact one group of clever researchers has developed an entire website based on NNT calculations called, not surprisingly, TheNNT.com. This site lists the Number Needed to Treat and to Harm for lots of different interventions.

Here’s a sample to show the power of using NNT calculations to choose a heart attack prevention treatment for people without heart disease and who have not had a heart attack.[99]

- The NNT for statins to prevent a non-fatal heart attack is 104.
- The NNT for statins to prevent a stroke is 154.

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[99] The statin calculation comes from http://www.thennt.com/nnt/statins-for-heart-disease-prevention-without-prior-heart-disease-2/. The Mediterranean Diet calculation comes from http://www.thennt.com/nnt/mediterranean-diet-for-heart-disease-prevention-without-known-heart-disease/

Now consider the Number Needed for Harm from statins:

- The NNH for developing diabetes is 50.
- The NNH for muscle damage is 10.

This means that 104 people need to take statins for 5 years to prevent 1 non-fatal heart attack. But 2 of those 104 people will develop diabetes and 10 will experience muscle damage.

This example shows how you can compare benefits and harms from a medical intervention.

Let's now look at how to compare benefit from different medical interventions. This time we'll compare statins to adopting a Mediterranean Diet.

- The NNT of statins to prevent 1 heart attack among people with no heart disease and who have not previously had a heart attack is 104.
- The NNT of people who adopt the Mediterranean Diet is 61.

In addition, some people were harmed by the statins – we discussed that above – while none were harmed by the Diet. (Remember that I don't give medical advice. These are just some research summaries.)

These metrics, the NNT and NNH, give patients a clear way to compare treatments and to decide which works best, just like the 'out of 100 people like me, how many benefit' question discussed above. Both metrics get to the same answers but some people prefer one to the other. I thought it useful to introduce both in this section.

Integrating These Ethical Standards Into a Discussion with a Benefits Administrator

Consider this situation: A Benefits Administrator for a large company puts the company's benefits out to bid. Two brokers respond. Both offer similar plans at similar prices. Both are experienced. Both are professional. Both offer all the standard services – 401(k) administration, FSA administration, wellness programs, etc. Both are impressive.

The Benefits Administrator tries to find some reason to choose one broker over the other. Since they appear to be mirror images of each other, he has little to choose. So he asks both brokers 'why should I choose you?'

Broker A talks about experience: 20 years in the business, a good customer service reputation, intimate knowledge of carriers and plenty of references. Broker A talks about his commitment to clients and interest in helping clients. He even offers to meet with the Benefits Administrator quarterly to provide policy and regulatory updates.

Certainly, thinks the Benefits Administrator, Broker A is fine. There's nothing wrong with him. A solid choice.

Then Broker B comes along. This broker also has years of experience, a good customer service reputation, good relations with the various local insurance carriers and plenty of references. This broker also offers to meet quarterly to discuss policy and regulatory updates. (Both brokers, it seems, value face time with the Benefits Administrator.)

But in addition to all these services, Broker B makes a surprising statement:

My company has a clear business standard that defines our relationship with clients. The ethical standard that we embrace is called 'Do Your Fellow A Favor'. I've studied business ethics and decided that I want my company and my employees to live up to this standard.

Many of my competitors use a different ethical standard. They 'let the buyer beware.'

Intrigued, the Benefits Administrator asks Broker B to continue.

I won't save you any premium money in the short term as compared to Broker A. He's a fine broker who is perfectly capable of running rates and showing alternative policies.

I won't show you any plans that he doesn't. And I offer all the same services as he does.

But in addition to offering everything that he offers, under my 'do your fellow a favor' standard, I'll also educate your employees about how to use our healthcare system.

I'll tell them things about the healthcare system that they probably won't learn from their doctors but that may help them interact with their doctors. I'll help them become wiser consumers of medical care.

The Benefits Administrator starts to yawn as Broker B continues:

Better educated consumers, who shop more wisely, use medical resources more efficiently. In the long run, this may save you money….maybe quite a bit.

The Benefits Administrator suddenly perks up:

> You'll save us money? Explain. Give me an example.

Broker B then summarizes:

I noticed that in the past few years, several of your employees had vertebroposty procedures for their back pain. A few others had arthroscopic knee surgery for knee osteoarthritis. (Broker B apparently really did his homework.)

I also noticed that several take Atenolol and quite a few took Niaspin over the years.

All these treatments have been shown in comparative studies to work no better than a placebo.

That means you may have wasted your company's money on ineffective treatments, and your employees exposed themselves to medical risks without receiving any benefit.

'What?' the Benefits Administrator bursts out, shocked. 'How can you say that?' Broker B continues:

As part of our 'Do Your Fellow a Favor' educational campaign, we teach people how to identify and avoid unnecessary and low quality medical care.

A key part of that educational process involves teaching employees what a comparative study is and how to understand the results.

I'm happy to include you in our seminars, but for now I'll just summarize some studies. Both of those procedures – vertebroplasty and arthroscopic surgery to treat knee osteoarthritis – have been shown to be ineffective in comparative studies. Neither benefited patients more than a sham procedure.

Ditto for Niaspin and Atenolol.

While we don't tell your employees what specific care to get or to avoid – we're not licensed or trained for that - we teach them the skills to evaluate care quality and to discuss this with their doctor. Studies show that employees who have these skills get better medical care, with less risk and at significantly lower costs.

And they tend to avoid ineffective treatments, like the ones I mentioned.

I, of course, don't know which of your employees had these procedures or which took those medications. I only know that it's highly unlikely that they received any benefit from them.

'So,' says the Benefits Administrator, somewhat stunned 'having this information available may reduce my employee's rate of ineffective care. That could affect our Experience Modifier and save us some premium money in the future. Interesting.'

Broker B continues:

The US wastes about a trillion dollars annually on ineffective and unnecessary medical care. Your company alone probably wastes tens of thousands.

Our 'Do Your Fellow a Favor' program aims to reduce that, not by restricting access but by helping your employees make wiser medical care decisions and talk more effectively with their doctors.

It's a new approach in the benefits arena but one that shows great potential.

And it's risk free: people only participate if they want to. But we're finding that lots of employees really want access to this information and pay attention when we present.

‘Interesting,’ comments the Benefits Administrator. ‘I’ve never heard of that approach but it seems to make sense to me. We would probably need a custom approach to our employees since we work 2 shifts and have several people off-site.’

Broker B responds:

Each company is different and we always try to fashion the educational process around the company’s needs. The information content is similar but our approach varies by client.

In the end, the Benefits Administrator considers the two brokers. One who takes the ‘let the buyer beware’ approach about dealing with our healthcare system. The other who ‘does his fellow a favor’.

Which will help my employees the most, he wonders.

In the end, the Benefits Administrator chooses…..*Well, who would you choose?*

How Should an Ethical Broker Proceed?

The British think death is inevitable; Canadians think death is preventable;
Americans think death is optional.[100]

Clearly no broker can keep current on all healthcare literature and advise clients on all healthcare decisions. That’s beyond any human’s capabilities.

But, as we have argued in this course, the ethical broker has a responsibility to advise clients not only on policy details but also on likely treatment outcomes, and to help clients chose policies that improve chances of treatment successes.

We have outlined some issues in this course. Many, many more exist.

Hopefully, we have pointed brokers in the right direction, both for ethical advising and for their own future research.

But in this concluding chapter I’d like to offer some general advice for how best to act ethically. [101]

1. Educate yourself about our healthcare system.

The more you know about our healthcare system, the better you can help your clients.

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[100] I don’t know the origin of this expression. I first heard it from John Kingsdale, Director of the Massachusetts Healthcare Connector, at a speech at the Boston Harvard Club sponsored by the Pioneer Institute of 1/15/09.

[101] Some of this advice comes from the Afterward of Overtreated. See Brownlee, op cit pages 308 - 310

Today’s bookstores are full of insightful and useful books about healthcare. Some that I have found particularly useful include

Overtreated by Shannon Brownlee;

Ending Medical Reversal by Vinay Prasad

Overdiagnosed by by H. Gilbert Welch

An American Sickness by Elisabeth Rosenthal

Know Your Chances, by Steven Woloshin

Doctored by Sandeep Jauhar

How We Do Harm by Otis Brawley

The Quality Cure by David Cutler

Mistreated by Richard Pearl

Typical feedback from brokers who have these books is that they contain fascinating and very useful information. Ethical brokers use that information their normal professional work. folks.

Help your clients understand the importance and utility of their primary care doctor. Help them find primary care doctors with whom they can communicate easily.

2. **Help your clients ask questions. Help them remember that doctors are guides to medicine, not gods to be believed unquestioningly.**

Here are 5 questions I regularly teach people to ask.

- Has the proposed treatment been subjected to comparative tests?
- Out of 100 people like me, how many benefit and are harmed by it in tests?
- Is it overused in real life?
- Would most doctors make the same treatment recommendation or might some suggest something different?
- How many patients like me do you treat annually?

3. **Help your clients use the web appropriately, not excessively. I often encourage people to focus their internet research on 3 sites:**

- ChoosingWisely
- The US Preventive Services Task Force and
- Cochrane

These 3 non-financially-conflicted resources present good analyses of likely medical intervention outcomes.

I tend to stay away from other sites.

Help your clients to have the courage and skills to advocate for themselves, for in the end, all healthcare decisions are ultimately their own.

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We have, in the Judeo-Christian ethical tradition, thousands of years of business experience. Hopefully some of the ideas in this course will help today’s health insurance brokers continue that ethical tradition.