Ethical Insurance Advising II

The Public Health Insurance Arena

HealthInsuranceCE
2025

Table of Contents

Introduction and Overview..... Page 3

Ethical Responses to the Problem of Care Rationing ..... Page 28

Case Study : Utilitarian Ethics and Medicare for All..... Page 60

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.

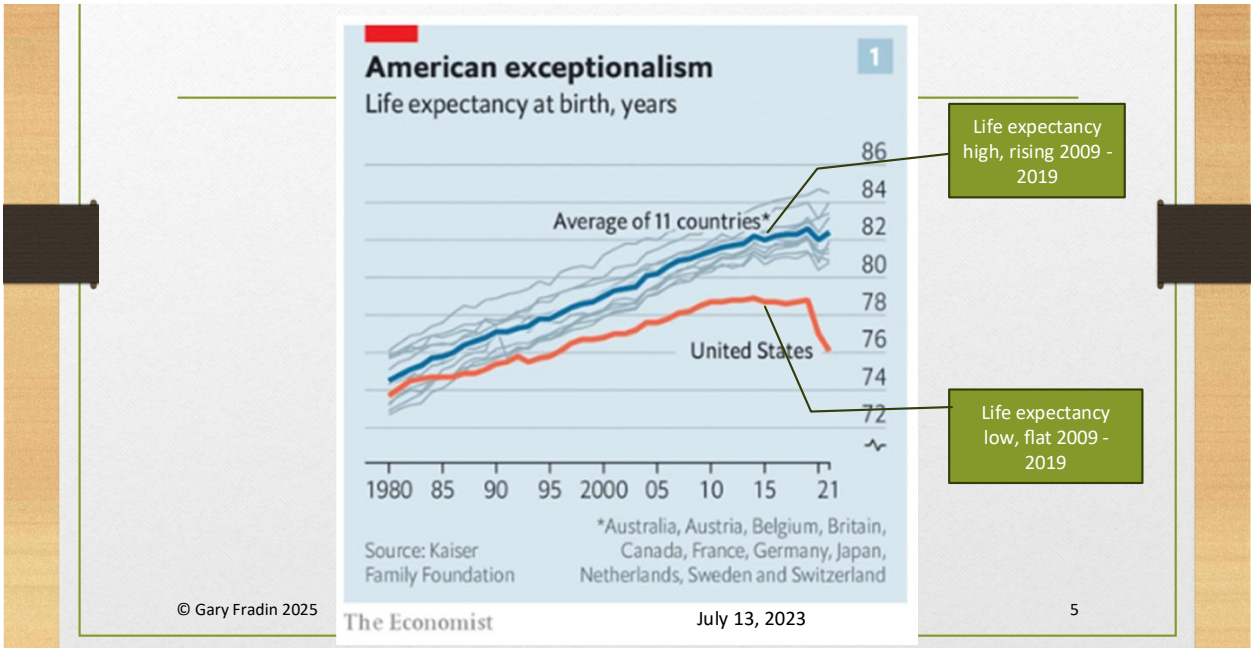
The utilitarian ethical lens thus places particular ethical responsibilities on system participants including brokers. Since everyone pays in, everyone should benefit. A system is unethical, according to utilitarians, if everyone pays in but few, if any, benefit.

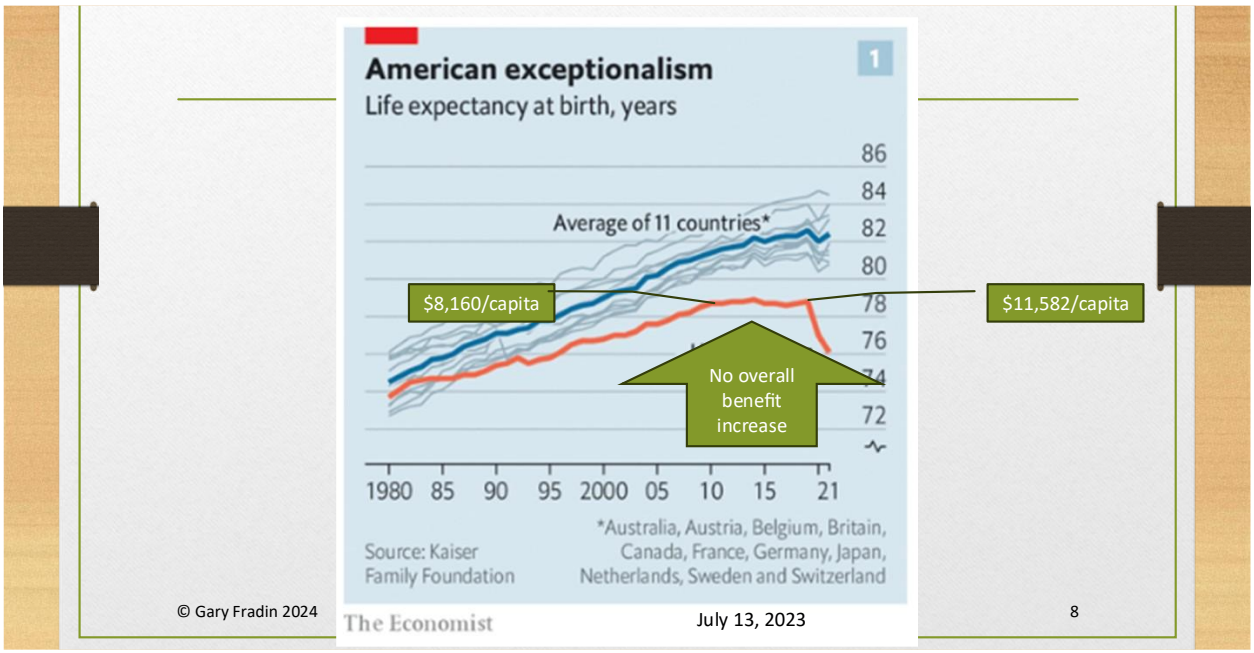
> We can accuse our overall healthcare system as being 'unethical' per this utilitarian metric since it cost more in 2019 per capita than in 2009. (I use 2019 as the cut-off

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.





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.[i]

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: [ii]

> 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.

'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[1]

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

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

to 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.

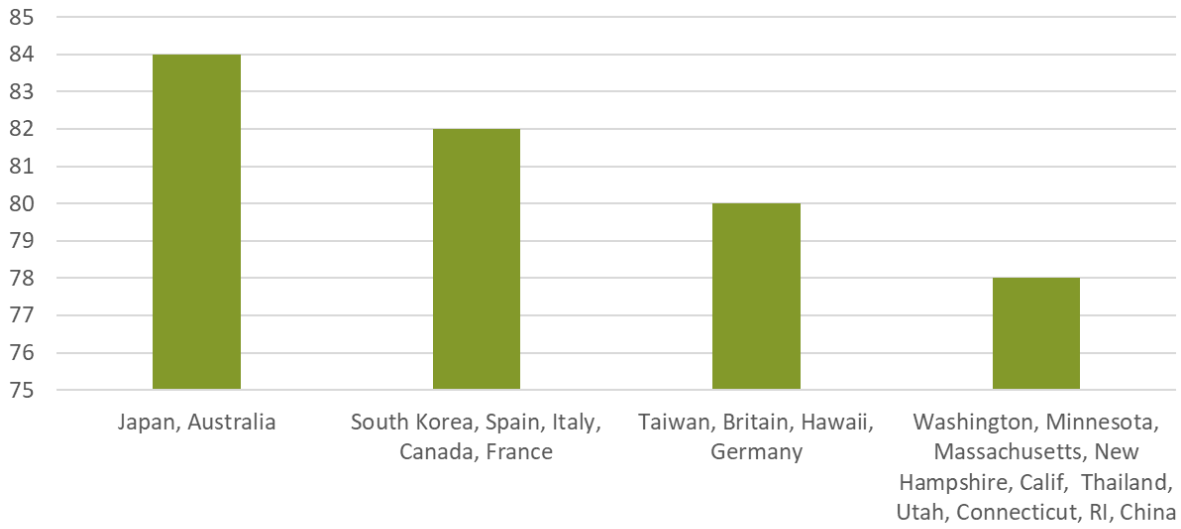
While utilitarians must consider potential economic disincentives or wait times, most analyses show these negative utilities are heavily outweighed by the large-scale benefits to public health, financial security, and societal wellbeing that a well-designed single-payer system could provide.

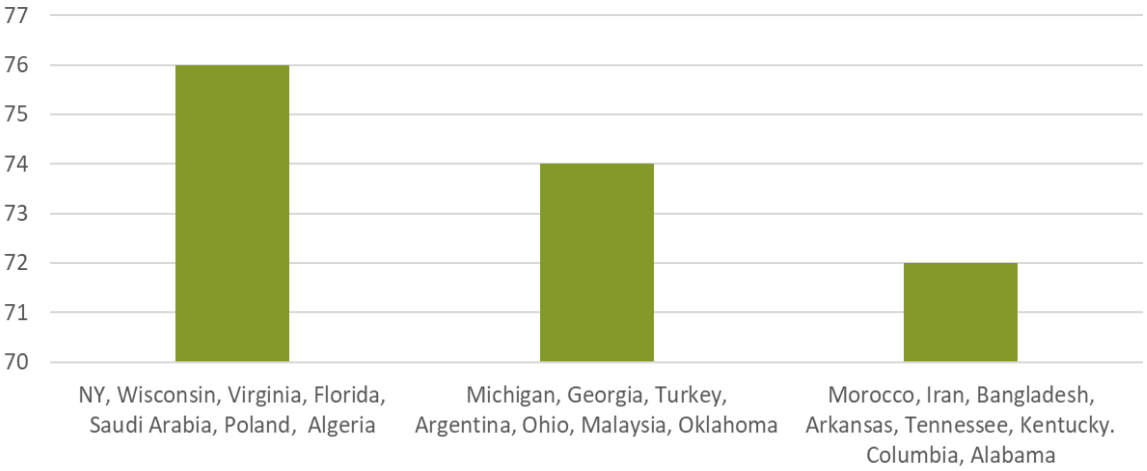
For utilitarians focused on maximizing the greatest good across society, universal healthcare represents one of the most powerful levers for improving quality of life measures and reducing suffering. This makes a strong ethical case from a utilitarian perspective despite the complexities involved.

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[2]. 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.[3]
- Bangladesh spent about $37 per capita according to a 2024 report in Global Health: Science and Practice.[4] 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. [5]

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.[iii] 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.

---

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

[3] 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

[4] 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.

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

'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.

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'.[6] 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

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

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.[iv] They 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.' [v]

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 access by time, say 3 prescription refills per month.[vi] 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 Affordable Care Act, as "terribly complex, blatantly unjust, outrageously expensive, grossly inefficient".[vii] 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:[viii]

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 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.[ix] This report labelled as '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.[x]

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.[xi] 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 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

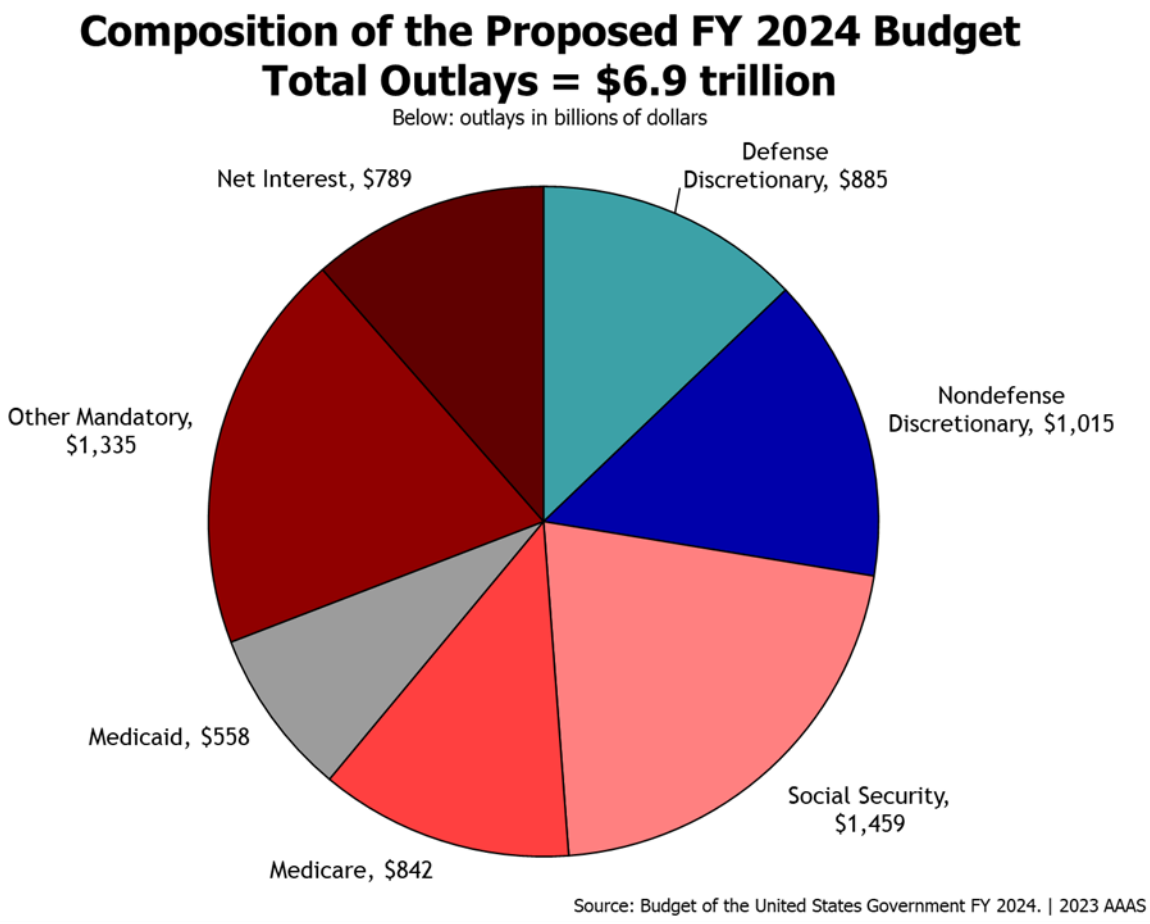
The federal budget shows how we, as a society, allocate our public resources. Our current budget makes us look like a healthcare system with an army financed by foreigners.[xii] See the breakdown below.[7] In round numbers, we allocate

- 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.

[7] This chart was downloaded in July, 2024



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. [xiii]

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

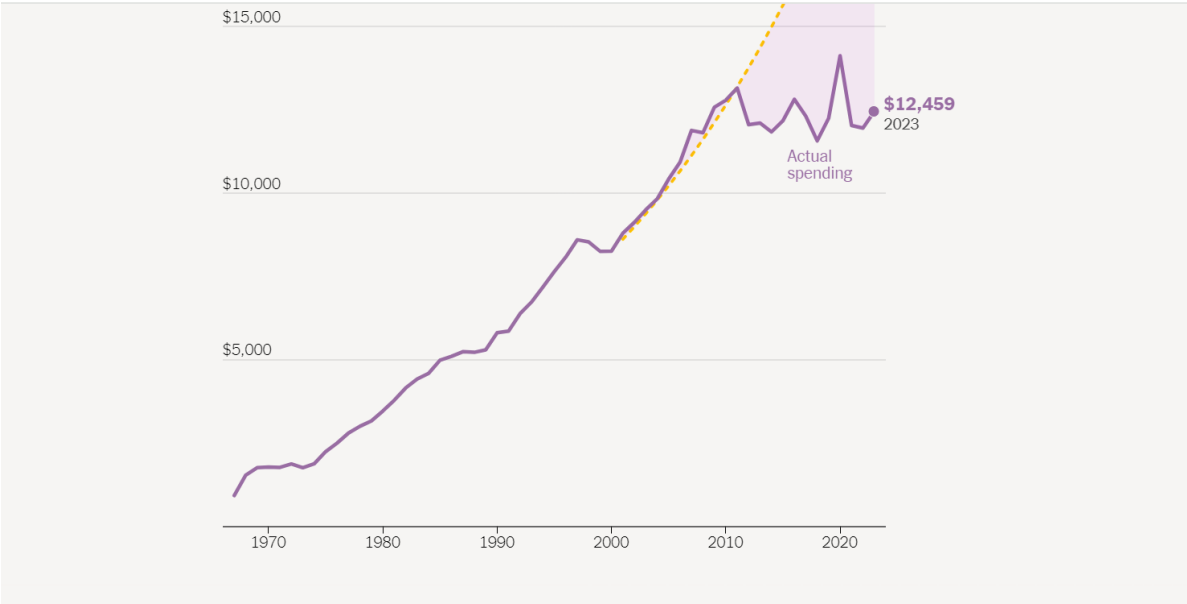
Interestingly, however, Medicare's spending per capita has flattened in the past few years. [8] Might this suggest that Medicare has learned how to control its expenditures so can act as a viable, national healthcare system?

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).[9] The cumulative savings was about $3.9 trillion, an enormous sum.

[8] 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.

[9] 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.[xiv] 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

- 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.[xv]
- 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"[xvi] and will add additional comments of my own.

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.[xvii]

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:

- 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.[xviii] 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?

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.[10] 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

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

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

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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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:

1. 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

2. 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.

3. 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.

4. 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.

5. 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:

1. 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.

2. 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.

3. 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.

4. 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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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:

1. 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.

2. 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.

3. 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:

1. 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.

2. 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.

3. 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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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:

1. 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

2. 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

3. 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

4. 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

5. 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:

1. 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.)

2. 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

3. 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:

1. 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.

2. 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.

3. 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.

4. 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:

1. 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.

2. 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.

3. 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.

4. 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:

1. 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.

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

[ii] 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/

[iii] 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

[iv] 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.

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

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

[vii] '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.

[viii] Much of this section comes from ChatGPT

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

[x] 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

[xi] Parts of this lengthy section come from ChatGPT

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

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

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

[xv] These cost estimates from ChatGPT

[xvi] 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

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

[xviii] 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/