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Introductory Remarks

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INTRODUCTION

INTRODUCTORY REMARKS

Marshall Breger and Riccardo Pozzo**

The difference between the German and the American approach to health care is grounded in each nation's concept of state responsibility. Germany has provided its citizens universal access since the late nineteenth century, while the United States, until recently, has relied on individual initiative and voluntary assistance. The conference on "The Ethics of Health Care: An Assessment in Germany and the United States," that took place on October 4, 2001 at the Columbus School of Law on the Catholic University Campus in Washington, D.C., explored how philosophical and legal traditions in each country affect current health care issues. The conference covered topics such as universal access and the practical challenge of providing some form of health care to the unemployed, patient's bill of rights, emerging technologies of DNA manipulation, soaring costs of hospitals and physicians, and various resource-driven allocation issues. By highlighting the ethical principles that underlie each issue, the conference was a forum for open discussion of life-related values in our health care system.

This interdisciplinary project profited from an enthusiastic synergy at Catholic University among the Deans of the Columbus School of Law, Robert Destro and subsequently Douglas Kmiec, the Dean of the School of Nursing, Ann Marie Brooks, and the Dean of the School of Philosophy, Kurt Pritzl, O.P. The German Embassy co-sponsored the program and their counselors for the social and labor policy section, Günther Horzetzky, and for the scientific section, Karl Wolin, made the setting up of a truly comparative approach between the American and the German health care systems possible. Bayer Inc., USA and Bayer Aktiengesellschaft, Germany generously supported the conference financially from both sides of the Atlantic each with a matching grant. Moreover, we wish to thank Jude Dougherty, Dean Emeritus of the School of Philosophy for his conceptual guidance and Ursula Weide, a

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graduate of the Columbus School of Law, for her insights and initial organizational planning.¹ Finally, our special thanks go to the Honorable Thomas Scully of the United States Department of Health and Human Services for the engaging keynote address he gave during lunch on October 4, 2001. To the above named, and to the speakers that accepted our invitation, we wish to express our heartfelt thanks.

Without any pretence of completeness, we planned the conference around five panels. The first of which, obviously, was to be focused on the leading principle of the German approach, namely universal access to health care, the second on the ethical implications of emerging technologies, the third on a comparative view of health care economics in Germany and the United States, the fourth on the wide spectrum of allocation ethics, while the fifth, conclusive, panel should have provided an assessment involving legal, philosophical, and theological points of view.

The first panel was opened by the Honorable Rainer Schlegel, Justice at the Federal Social Court in Kassel, who outlined the basic structure of the German statutory health insurance, which by and large has been retained unchanged since its introduction by Chancellor Bismarck in 1883 as the first of three social epoch-making insurance laws. In 1884, followed the law about workmen's compensation (statutory occupational accident insurance) and, in 1889, the law on invalidity insurance and on retirement insurance. In 1927, as a reaction to several economic crises, unemployment insurance was added. Eventually, the statutory long-term care insurance of 1994, introduced by Chancellor Kohl, proffered the last act in the German system of social insurance, as we presently understand it. Justice Schlegel stressed that the German system is based on the "in-kind and service principle," that states that the health insurance funds are meant to provide all citizens with the necessary services and in-kind benefits. To this end, the health insurance funds conclude contracts for citizens with associations of doctors, dentists and pharmacists and with hospital owners and other service organizations, so that the doctors, hospitals, pharmacists etc. do not receive payment directly from the citizens, but rather, payments are made by the health insurance funds to doctors' associations, which redistribute the money received from health insurance funds to their

1. The editors of the Journal would like to join Professor Breger and Professor Pozzo in thanking Dr. Weide, a graduate of the Catholic University of America School of Law, whose insights and initial organizational planning advanced the success of the conference on Ethics of Health Care: An Assessment in Germany and the United States held at the CUA Law School on October 4, 2001.

members. The citizens do not pay the doctor directly. They do not even know how much their treatment has cost.

M. Gregg Bloche, of Georgetown University's Law Center, noted that in both the United States and Germany there are different policies of egalitarian departure in different social policy areas. What are the appropriate ethic and policy responses, asked Bloche, to growing evidence of racial and ethnic disparities in the health care that American and Europeans receive? And what are the ethics of spending on health care versus education, environmental and other social policy areas that appear to affect health and human welfare to a much greater extent than does health care?

Tim Jost of Washington and Lee University's Law School observed that the most important health policy issue facing the United States today is how to comply with the German principle, namely, how to provide universal access to health care for all Americans? The German social health insurance program has for well over a century provided a model of how a nation can achieve universal access to health care. It is, however, impossible to provide universal access to health care without having rationing of its availability. Even the Germans faced with continuing increases in their national health budget are being forced to address this issue.

In the United States, health care is rationed increasingly through managed care. The practical ramification of this, however, is that even those who are fully covered by health insurance sometimes cannot get the care they need. The two managed care patients' rights bills currently pending in the United States Congress address the concern of how to control this rationing.

The panel on the ethical implications of emerging technologies was opened by Edmund Pellegrino of Georgetown University's Center of Clinical Bioethics, who spoke on stem cell research as a paradigm case for balancing science, ethics and politics. Given the challenge of biotechnology, how do we use, asked Pellegrino, our technological prowess humanely, wisely and generously without being so overshadowed by its powers that we become its slaves? How, in essence, can we place biotechnology within ethical constraints without losing its therapeutic potential? How do we do so in a democratic, morally and pluralistically divided society, driven by market forces and a yearning for immortality through technology? Pellegrino envisaged three fundamental questions. First, what are the scientific facts and how secure are they? Second, what fundamental ethical issues are at stake? Third, what are the implications of questions one and two for politico-economic policy? It is clear that ethical

considerations should guide both the use of science and the economic and political uses of that science. The various ideological positions about stem cell research, to which we are currently exposed, make it clear that haste, overselling of results and political pressure can lead to more rather than less conflict. The moral weight on legislators is consequently heavy and inescapable.

Gerald Schatz of the Graduate School of the Foundation for Advanced Education in the Sciences raised questions pertaining to health records privacy and confidentiality. Does the right to privacy, he asked, refer to the right of the person to be left alone in ordinary circumstances, to be free from arbitrary intrusion into one's affairs by government and by other persons? Privacy may be a constitutional or statutory protection. In the United States, to the extent that privacy protections exist, they are enforceable in the courts in civil litigation and due process claims. Confidentiality refers to safeguarding privacy, so that records may be subject to varying degrees of confidentiality, to protect the privacy of the persons who are the subjects of those records.

From the panel on comparative health care economics we are pleased to print the paper by Robert Moffit of the Heritage Foundation in Washington, D.C. Moffit pointed out that the core of the discussion is how to deal with rationing within the frame work of the health care delivery system currently in the United States, keeping in mind the most important questions about right, wrong, good, bad, virtue and vice. This issue is central for health care, because personal decision-making is deeply rooted and has an impact on the overall quality of our society. The United States has developed a unique system of health care financing and delivery, quite unlike most other systems in the world. It has created, through the powerful instrument of incentives in the Internal Revenue Code, an employer-based health care system, which allows unlimited tax relief for the purchase of health insurance on one and only one condition, namely that one obtains one's health insurance through one's employer. The most important thing is that the decision to give unlimited tax relief for the purchase of health insurance through the employer has nothing to do with health care policy. Moffit argued that there are no compelling floor speeches on the House or the Senate that Americans should henceforth and forever more have a monopoly of employer-based health insurance exclusively favored by unlimited federal tax breaks.

The section on allocation ethics was opened by Alfred Miller of The George Washington University's School of Public Health and of The Catholic University of America's School of Philosophy. He remarked that in public health issues, uncritical extrapolation of approaches appropriate

for individual ethical behavior to problems of social justice clouds the issues at stake, hides the true nature of the problem and hinders developing realistic solutions. Achieving social justice depends instead on the historical development of an entire society and requires both long-term strategies and concerted, collective action to redress inequities. Allocation and its control have to be understood in terms of the overall system that provides the services and how it developed under the influence of political and other collective actions and social changes. For this reason, concluded Miller, a comparison of the United States and German health care systems and the ways in which they provide and allocate services constitute a case in point of how subtle but powerful differences in the structure of the systems as a whole profoundly influence the outcome in terms of availability and cost.

Heidi Nadolski of the National Association of Statutory Health Physicians in Cologne spoke on budgeting and rationing in the German health care system. Due to the rapidly rising health care expenditure in Germany a number of cost-containment efforts have been made since 1977. The aim of all German health care reform bills is to bring the growth of expenditure in line with the growth of wages and salaries of the sickness fund members. Since the German health care system is mostly financed by employers and employees in the form of payroll deductions, a rise in the monthly contribution rate leads to higher wage costs that harm the competitiveness of the German economy. One important element of the last German Health Care Reform was the introduction of a fixed budget that limits the amount of money that comes into the system. Until now, physicians were collectively held liable for budget excesses pertaining to drugs and remedies. This led to compulsory savings and very cautious prescription behavior. Nadolski's thesis is that in Germany rationing is mainly hidden as a result of the government's budgeting policy. This raises several ethical problems, and Nadolski pointed out many examples of hidden rationing in Germany.

The final panel was opened by Anton Rauscher, the chairman of the Catholic Social Sciences Center in Mönchengladbach, who contributed remarks on the family as health care provider. The agrarian society was based on the model of an "extended family," in which several generations lived and worked together, functioning as a natural institution of social security for its members. Urban industrial workers, however, have no such social security network. As workers left farms and villages for the cities, old family ties dwindled and eventually disappeared. In recent years, economists have proposed an additional private insurance system for the family, similar to that in the United States. Germany certainly needs

reforms to sustain the system and preserve the quality of care it offers, but it must also preserve the substance of its social health insurance system for the family in order to stabilize it in a rapidly changing industrial world.

Roberto Dell'Oro of Georgetown University's Center of Clinical Bioethics spoke on the market ethos and the integrity of health care. He explored the so-called "integrity and compliance programs," that have proliferated in today's health care environment. For those who do not distinguish the delivery of health care from ordinary commerce, integrity and compliance are complementary. The organization that behaves so as to achieve its commercial purpose, i.e., that behaves efficiently, productively, profitably, has integrity. With relation to the health care industry, the promise of the market is to increase competition and to rationalize the system without necessarily altering the fundamentally moral nature of the clinical exchange or undermining the professional standards entailed. Many questions remain both in relation to the ability of the market to deliver what it promises and in relation to its willingness to save the intrinsic morality of medicine. However, several schools of thought make us aware of the social tendencies inherent in the absolutization of the market: the tendency to neutralize non-economic values such as compassion, empathy, care, concern for the common good, to reduce interpersonal relations to mechanistic exchange, and to replace the experience of gratuitousness and esthetic appreciation with the concern for the production of material goods. "Economists," concluded Dell'Oro, "are becoming increasingly sensitive to both anthropological presuppositions and broad social consequences of the market."

Daniel Maher of Catholic University's School of Philosophy raised questions about the traditional understanding of the fiduciary responsibility physicians have to their patients. Such a relation implies that human beings are not exclusively self-interested and are in fact capable of rising above self-interest. The fact that managed care appeals to the self-interest of physicians does not deny that physicians are capable of generous actions. Physicians themselves have for centuries relied upon a complex understanding of human nature. Managed care, on the other hand, appears to replace the concern for patient welfare with the concern for fiscal welfare. It is probably more accurate to say that managed care holds both these concerns in tension but reverses the hierarchy.

The last word was given by William Wagner of Catholic University's Columbus School of Law, who contributed to the relation between constitutional values and health care issues. "A variety of economic, social and political causes," said Wagner, "have introduced a new era in health care." The pressure of market forces and of changes in the economic

forms of organizing the delivery of health care services is calling for the renewed formulation and promulgation of the most basic ethical principles and assumptions. Rapid integration in medical technologies makes necessary specific and detailed answers to concrete moral dilemmas. The litigation of disputes in the area of health care alone will force our courts to adjudicate the role of constitutional values as a basis for the ethics of health care. Gradually, an ethics of health care sanctioned by law will emerge, whether for good or ill. In the process, a new interpretation of our constitutional values will also take shape for better or worse. In the constitutional order of the United States we have a fundamental problem in confronting this challenge. By contrast, the German system assumes that the social state provides for its members participation and a minimal standard of living including health care, and society as a whole has a responsibility for distributing so that all can participate. Germany has something very close to universal health care. If the United States aspires to it, we should note that this is not as a requirement of justice but rather is a socially useful aspiration akin to the benefits offered under Franklin Delano Roosevelt's New Deal. We should tend to pursue it on that basis.

The ongoing debate about the American approach to health insurance has brought fundamental issues of justice and of economic efficiency to the forefront. It is no wonder that both scholars and practitioners have sought out insights of other industrialized nations to ascertain the problems and promises of their "national" approach to health care. This conference is stated to be seen as part of that broader effort that we hope will serve to illuminate the policy debate.

