

Center for American Progress



Health Care, the Budget and Morality: A Discussion of National Priorities

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Background

Public Health: Grounded in Values. Americans believe in the common good and equal and unbounded opportunity for all. Access to affordable, quality health care is therefore a crucial policy priority and moral challenge. By ensuring that the benefits of modern medicine are available to all, we can prevent people from dying prematurely, delaying needed care, and being forced to choose between basic necessities like rent and health care.¹ Covering all Americans would also protect individuals from the economic hardships that can result from illness, lead to substantial gains in productivity and improve our businesses' competitiveness. But beyond these health and economic gains, for most people, ensuring access to affordable, quality health care is a simple matter of right and wrong. Most value systems, including major faiths, ethical perspectives, and human rights doctrines, offer moral support for fair and just access to health care. The belief that every person deserves quality health care is embedded in our core values, and our vision of health care over the next generation must honor that conviction.

Record of Neglect. Unfortunately, we are falling short in meeting our national and global commitments on health care. In America and throughout the world, people in need are increasingly unable to access affordable, quality health care. Since 2000, the number of uninsured rose by 5 million, to 45 million, or about one in six Americans.² Americans are also struggling with skyrocketing health costs. In 2004, the cost of employer-based health benefits increased at a rate five times higher than that of wages; since 2000, the family share of such coverage increased by over 60 percent.³ These twin pressures of less coverage and rising costs are squeezing families and forcing Americans to go without care. Compared to people in Australia, Canada, New Zealand, and the United Kingdom, Americans report higher out-of-pocket spending and are most likely to say they did not see a doctor when sick, did not get recommended tests or follow-up care, or went without prescription medicines because of cost in the past year.⁴ At the same time – and not unrelated – America continues to have worse than expected health according to a number of health care indicators. The U.S. has lower life expectancy than 20 other nations,⁵ near-epidemics of preventable conditions,⁶ and its infant mortality rate actually rose in 2002 for the first time in 40 years.⁷

The United States also shares in the global struggle against epidemics such as AIDS, tuberculosis, and malaria that are wiping away entire portions of the populations of developing countries. In addition to the devastating toll of HIV/AIDS, nearly 2 million people die of tuberculosis each year, despite the availability of effective and inexpensive treatments.⁸ Malaria causes at least one million deaths per year and an additional 300 to 500 million clinical cases, the majority of which occur in the world's poorest countries.⁹

Matter of Priorities. American policies can make a difference in overcoming these national and global health challenges. Our nation, the most prosperous and powerful nation in the world, has the means to ensure that none of our neighbors is unjustly denied life-saving treatments due to their income, their race, or any other reason. We have the capacity to invest in public health efforts that can prevent illness and prolong lives. We have the ability to secure a safe, effective, and affordable medicinal arsenal. With resolute leadership and realigned priorities, our nation can readily meet all of these goals.

However, rather than embracing these challenges, in recent years political decisions have moved our country farther from achieving our health care goals. The past couple of years have brought an unprecedented reversal in the nation's fiscal health, moving from record surpluses in 2001 to a \$413 billion deficit in 2004.¹⁰ This reversal is largely the result of President Bush's tax changes, the benefits of which overwhelmingly flowed to Americans earning the highest incomes – 73 percent of the cuts went to the top 20 percent of income earners.¹¹ Rather than spending money to fix the health care crisis in this country, or the myriad of other social problems, President Bush and Congress chose to enact tax cuts for the wealthy. Now, to fill the hole created by the tax cuts, President Bush proposes to limit spending on programs such as Social Security, Medicare, and Medicaid – programs that disproportionately benefit poor, disabled, and elderly Americans.¹² Such spending limits represent a significant retreat from the commitments our nation has already made to some of the most vulnerable among us. Additional proposed tax changes that would benefit the relatively wealthy among us would further prevent any progress from being made on the important national and global health challenges we confront.

Potential Problems in the Forthcoming Budget. Since the federal budget is the most tangible embodiment of our nation's priorities and values, it should express our commitment to ensuring fair and just access to affordable, quality health care for all. At a minimum, it should do no harm. Listed below are examples of potential budget policies that may indicate a retreat from the values at the core of our country and could exacerbate health threats that Americans and people around the world face.

Reducing Health Coverage for the Most Vulnerable

- **Capping and Cutting Medicaid:** Medicaid pays for health and long-term care services for over 50 million low-income and disabled individuals.¹³ Because of its flexible financing, Medicaid expanded during the recent economic downturn, covering 6 million more vulnerable Americans and preventing an even sharper rise in the uninsured.¹⁴ However, press reports suggest that Medicaid funding could be capped and cut in the president's budget.¹⁵ This would move health policy in the wrong direction, reducing critical assistance to those who need it most. In the words of Governor Huckabee (R-AR), "But people need to remember that to balance the federal budget off the backs of the poorest people in the country is simply unacceptable. You don't pull feeding tubes from people. You don't pull the wheelchair out from under the child with muscular dystrophy."¹⁶
- **Eroding Drug Benefits for Low-Income Seniors:** In less than a year, Medicare will take over the drug benefit for nearly 7 million vulnerable Medicare beneficiaries who now get their medications through Medicaid. However, the law allows for no overlap in coverage during the transition: Medicaid cannot pay for any drug for any "dual eligible" as of the first day of the Medicare drug benefit's implementation. The law also provides no extra support for states in helping to make this transition and immediately requires states to pay back the vast majority of the savings from this change in responsibility.¹⁷ The president's budget should include funding and policies to ensure that no vulnerable senior falls through the cracks and loses access to needed medicines during the drug benefit implementation.



- **Rationing Lifesaving Drugs for People with HIV/AIDS:** The HIV/AIDS epidemic is clearly a major humanitarian and security threat worldwide, but has not been adequately addressed in the U.S. The public health system fills in gaps in our health financing system through the Ryan White CARE Act, and its AIDS Drug Assistance Program. Ryan White funding has not kept pace with the growing number of people living with HIV/AIDS, increased complexity in drug therapy, and rising drug prices. States have had to literally ration lifesaving drugs, which cost on average \$10,000 to \$15,000 per year, through limits on eligibility, amount of drugs per person and waiting lists.¹⁸ Although the president allocated \$20 million in 2004 to eliminate waiting lists, such lists were only reduced, and the funding was not included in the 2005 budget. The president's budget should reflect his own words: "When we see this kind of preventable suffering, when we see a plague leaving graves and orphans across a continent, we must act. When we see the wounded traveler on the road to Jericho, we will not, America will not pass to the other side of the road."¹⁹

Neglecting Critical Public and Global Health Priorities

- **Tolerating Racial Disparities in Health:** In the United States, large and unjustifiable differences in health and access to health care exist between different racial groups, even controlling for income and insurance status. African-Americans are twice as likely to have diabetes, 9.5 times more likely to contract HIV, and more likely to die from cancer, heart disease, and stroke. Hispanic children are more than twice as likely to not use needed asthma medication as white children. And nearly one in ten Native American women receive no or late prenatal care.²⁰ Rather than trying to address these problems, the administration has tried to minimize them.²¹ The president's budget should significantly increase funding for programs to study disparities, train minority health providers, and tackle health problems more likely to occur among racial and ethnic minorities.
- **Undervaluing Immunizations Against Common, Preventable Diseases:** A fundamental responsibility of the U.S. government is to prevent the spread of disease. A critical tool in public health is immunization and prevention. Yet not only are there cracks in the influenza vaccine supply chain, but misplaced priorities in funding and distribution.²² Federal funding for immunizations for vulnerable populations was reduced to address the flu vaccine shortage in late 2004; Congress did not replace these funds in the 2005 budget.²³ And no major policy initiative has been launched to develop protections against the spread of avian flu or pandemic flu.²⁴ In addition, funding for basic prevention activities has declined. The president's budget should invest in immunizations and prevention, and invest in the long-term infrastructure to protect against pandemic disease.
- **Underfunding Basic Global Health Problems:** Although the U.S. has increased its funding for combating the global AIDS crisis, millions of children die in poor nations of malnutrition, inadequate vaccination against preventable illness, and diseases like malaria, tuberculosis and diarrhea. In 2005, the U.S. is expected to spend less than \$1 billion on funding for non-HIV/AIDS global health priorities. The president's budget should include a significant increase for global health programs. As well, he should ensure that funding for the South Asian relief effort is additional, and is not at the expense of other development spending.

Selected Health Programs' Funding History
(Fiscal Years, Dollars in Millions)
(Percent Increase from Previous Year: Note: Based on Unrounded Funding)

	2001	2002	2003	2004	2005*
Domestic HIV/AIDS					
HRSA Ryan White CARE Act	1,808	1,910 6%	2,018 6%	2,045 1%	2,073 1%
AIDS Drug Assistance Program (part of Ryan White)	589	639 9%	714 12%	749 5%	788 5%
Racial Disparities					
HHS Office of Minority Health	49	50 0.2%	56 14%	55 -2%	51 -8%
NIH National Center for Minority Health Disparities	130	158 21%	186 18%	191 3%	198 3%
HRSA Health Training / Disparities	109	115 5%	119 4%	119 -1%	119 0%
HHS Office of Civil Rights	22	28 27%	33 18%	34 3%	35 4%
HHS Minority HIV/AIDS Initiative	50	50 0%	50 -1%	50 0%	53 7%
SAMHSA's Mental Health Protection and Advocacy	30	33 8%	34 4%	35 3%	35 0%
HRSA Healthy Start Infant Mortality Reduction Program	90	99 10%	98 -1%	98 -1%	103 6%
Indian Health Service Program Level	3,273	3,393 4%	3,541 4%	3,670 4%	3,744 2%
Immunization and Prevention					
CDC Immunization Programs	556	627 13%	643 3%	643 0%	657 2%
CDC Preventive Health Block Grant	135	135 0%	134 -1%	132 -2%	132 0%
Global Disease**					
UNICEF	110	120 9%	120 0%	120 0%	125 4%
USAID Infectious Disease	125	165 32%	156 -6%	185 19%	200 8%
USAID Child Survival and Maternal Health	295	315 7%	324 3%	330 2%	345 4.5%
USAID Vulnerable Children	30	25 -17%	27 8%	28 4%	30 7%

* Note: the 2005 levels for most programs (except Indian Health Service and Ryan White) do not reflect the government-wide 0.8% rescission. In addition, the USAID funding does not reflect rescissions or adjustments. Sources: <http://www.hhs.gov/budget/>, <http://appropriations.house.gov/files/2005LHHSConfTable>, legislative language and agency web sites.

Notes:

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- ⁴ C. Schoen et al., "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs*, October 28, 2004. Available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.487>
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- ¹³ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance* (Washington DC: Kaiser Family Foundation, January 2004).
- ¹⁴ J. Holahan and A. Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003* (September 2004). Available at www.kff.org/uninsured/upload/46827_1.pdf
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- ¹⁶ Pam Belluck, "Governors Working Together to Preserve Medicaid Allotments," *The New York Times*, December 26, 2004.
- ¹⁷ Kaiser Commission on Medicaid and the Uninsured, *Implications of the New Medicare Prescription Drug Benefit for State Medicaid Budgets* (Washington DC: Kaiser Family Foundation).
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- ¹⁹ President George W. Bush, Remarks by the President on the Global HIV/AIDS Initiative (Washington, DC: The White House, April 29, 2003). Transcript available at <http://www.whitehouse.gov/news/releases/2003/04/20030429-5.html>
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