

The Ethics of Asset Stripping

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Asset Stripping" is the popular term for the requirement that the elderly in care at the potential public expense pay full costs until their assets (or wealth) come down to some minimum level.² More technically it is described as "asset testing", that is the patient's degree of contribution is subject to a test based on the level of assets. The wider use of the measure since July 1993 has caused outrage, especially among the elderly. Ironically many of those who in their younger days abused demonstrators for peace, freedom, justice, the environment, or whatever, are demonstrating en masse against asset stripping.

Any policy measure has a myriad of ethical issues. Asset stripping is no exception. This article focuses on only one, but one of the most important, and in doing so raises wider issues of health ethics. However it is useful to deal briefly with some other issues which have been added to the maelstrom, which may or may not have an ethical dimension.

Any economist is loath, for instance, to ignore the issue of efficiency, a characteristic problem in any selective regime, or indeed, in the provision of publicly funded services. It will creep back into the discussion. Here we simply note that inefficiency, properly defined, is unethical, for it reflects a waste of resources that could be used for other purposes.

A widespread concern is that the asset stripping applies only to an older age group. Representations have been made to the Human Rights Commission that this is age discriminatory. We await the Commission's findings, but note that if the Government removed the age barrier that would hardly address the general concern.

It is also common to argue that people should not have to pay for their health care. When it is pointed out that food, clothing, and shelter are necessary for

health, the principle is redefined as people should be entitled to free medical care. That limits but does not resolve the issue. Should aspirins obtained from a chemist be free?

There are also some generalities which hardly stand up to the mildest scrutiny. The claim the elderly have been paying their taxes all their life is a little premature, and in any case the likelihood is that they have received more from the Government than they paid to it, if only for the technical reason that those of their cohort who are dead probably paid more to the state than they received from it - in adulthood anyway. In any case economists would be hesitant to analyse transfer payments through time as easily as the claim makes. The claim appears to be a crude statement of a belief that there was a social contract - between the people and the government - which has been reneged upon. In so far as it is true it applies to

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a much wider range of issues than asset stripping, and to a much wider range of people than a single generation.

This list of grievances could be extended, perhaps indefinitely.³ Instead we need to go to the core of the issue.

The first is that *asset stripping is a user charge*. In some respects it is no different from a standard user charge for medical and related services, except for its intensity. We normally think of user chargers being paid out of income, but it would be equally useful to think of them being paid out of wealth. When one pays a fee to a general practitioner, it initially comes out of income. If there was no charge the sum could be added to the individual's

savings (or reduce their debts) so in effect the user charge depletes such assets.

That asset stripping is a user charge allows the standard analysis which is designed to capture simply the difficulties of making judgements in such cases. Suppose the population can be divided into the rich and the poor, and also into the sick⁴ and the well. That gives four categories, which can be arranged as a four partitioned box thus:

	WELL	SICK
RICH	Rich Well	Rich Sick
POOR	Poor Well	Poor Sick

While the population is in four groups - Rich Well, Rich Sick, Poor Well, and Poor Sick - most of the public debate looks at only two, and often a different couple. Thus those who support asset stripping tend to look at the vertical comparison of Rich Sick and Poor Sick asking "is it not fair that the rich should contribute more to their care than the poor?" Meanwhile those opposed to asset stripping may be comparing horizontally the Rich Well with the Rich Sick asking "is it fair that the sick should be treated differently from the well?" Observe in each case the natural response to each question is "yes", yet they derive two very opposite policy conclusions. Yes to the first suggests "of course the Rich Sick should not pay more than the Poor Sick, for otherwise we are imposing a tax on sickness". How to untangle this paradox?

Note that the horizontal division need not be well and sick. It could be, for instance, those who do not want a BMW, say and those who do want one. The policy answer here is usually very plain. Buy your own BMW if you want it and can afford it. That is the standard policy for most goods and services we desire, although we may

also ensure the poor have enough income - through a benefit or tax credit - to enable them to buy what are deemed to be necessities. What is the difference with health services?

The fundamental difference is that the sick person usually does not have much choice at being sick and needing treatment. They may have little choice, eg to go to a GP or not. Observe that socially we deem that the sick choose to have an aspirin (purchased from the chemist) or not. It is for philosophers to tease out the theory of this degree of choice in all its intricacies. Practically it is the lack of choice which distinguishes many health decisions from most other resource decisions.

In terms of the diagram then, there is no choice where a person is on the horizontal scale. You are either sick or well, in need of the care for the elderly or not.⁵ Allowing that, at least in the medium run, each person does not have a lot of influence over whether they are rich or poor, then the allocation of each person into a quadrant is unique.

Now that has a very important economic implication. People have a choice whether they own a BMW or not. Typically we allow the standard market mechanism to work: they look at their income, assets, and circumstances, and decide whether to purchase the BMW. Economists can show, that in a very useful sense their decision is efficient, and is not a waste of resources (from the perception of the consumer anyway). They can also show that other allocation mechanisms, most notably central planning in which the decision is made by some other agent, are likely to be less efficient. So it makes practical sense, if we can distribute the income fairly, to leave consumers to make their own choices in such circumstances.

But typically, when it comes to medical decisions, the consumer does not make decisions in the same way. First it is made by someone else, usually a doctor or other medical professional. Second the community as a whole often says that if the professional decides the patient is in need of the service (or care) then they should have it. Moreover, while there are questions of efficiency of delivery, they are very much less important than the question of entitlement to the basic service.⁶

Strictly the need for long stay care may not be a "sickness", but the above analysis applies in so far as the individual does not have a choice between being in that state, and generating related needs. Thus residential care for the elderly is an area where the community has expressed a desire that there should be an entitlement. That is evident enough from the practical policy decision that those in need should get the care even if they cannot afford to pay it.

That conclusion does not automatically resolve whether those

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who can afford the care should pay for it, or those who cannot but have sufficient assets should use their wealth to pay for the care until it is depleted to some minimum. The conclusion does not even specify the means of delivery of the service.⁷

Suppose we provide the care to the Poor Sick charging them only their income less some personal spending money. Should we do that to the Rich Sick?

There is no pure economic answer. Economists would point out that the asset stripping involves a very onerous level of taxation on the wealth. For those who do not die quickly enough it is at confiscatory levels. One might note that in the same year as it introduced this asset stripping, the National government abolished estate duty on the dead because it was unfair and inefficient, and wonder why a more excessive levy on the living (if only the sick living) should be considered otherwise. But these efficiency issues, as important as they are, do not adequately deal with the equity issue, and hence the central one.

Suppose user charges are efficient, or more precisely, efficient compared with the best alternative. Should there be a user charge? A useful way of thinking about this issue is that suggested by John Rawls in his seminal *A Theory of Justice*. He conceives of social justice decisions being made behind a veil of ignorance "so that we could be any person in our society".

The standard example is not knowing whether we would be rich or poor in society, we are to decide how they are to be treated. Rawls suggests that in such circumstances a rational person is likely to choose those policies which favour the poor over the rich.

Now there is a sense that when I think about the treatment of the elderly I am behind a veil of ignorance (albeit one modified by my present position). Assuming I make it, I am not sure whether I will be rich or poor in retirement, well or eventually sick enough to require a retirement home.

From my current perspective, then; how do I think the elderly should be treated?

There are numerous issues here, but to confine ourselves to the one involving potential asset stripping of the elderly. First I would expect that there would be adequate residential care for all elderly in need. I might not end up needing it, but I would hope it was available if I do. There appears to be no practical way that this can be entirely funded from private sources. As the American experience shows, where there is a much greater dependence on private provision, there is a need for public involvement in long term care of the elderly.

Second; I accept that if I end up in residential care I should make some contribution to it. It is not unreasonable that if I am poor I should contribute my income less an amount for personal spending. The exact level has to be set, but the relevant level might be to leave the person in the residence with an amount that enables her or him to spend on those activities the care does not supply at a level similar to that of people outside on the same income.

This is a criteria not unlike that set out by the 1972 Royal Commission on Social Security in its famous "participating in and belonging to" objective. It is perhaps less well known that the Royal Commission began its principles which include that objective with:

The community is responsible for giving dependent people a standard of living consistent with human dignity and approaching that enjoyed by the majority, irrespective of the cause of dependency.

This notion of dignity has been a driving force in New Zealand social policy thinking for over 100 years.⁸ The patient is entitled to some discretionary spending (indeed as much as practical) as a part of maintaining their dignity. Moreover the patient adds to her or his dignity by contributing to the cost of a service that he or she is using.

What if one has more income than the poor, and is in need of residential care? If a person has accumulated the means of earning more income before they enter the home it is damned undignified if all the extra income is confiscated by the state. Quite frankly I don't care if the total expropriation is carried out by an authoritarian marxist like Joe Stalin, or by a liberal conservative like Jenny Shipley. I'm agin it.

This does not rule out a higher abatement rate for those in residential care than that for other National Superannuitants, because residents' personal spending covers a narrower range of commodities than when they are living outside.⁹

The thrust of the argument thus far is that the state does not directly touch the capital of the resident elderly. Is there a case for it taking some? Behind the veil of ignorance I acknowledge that a reasonable response is that a person's assets are intimately related to their dignity. This may seem irrational to the economic rationalists who have driven economic policy in recent years, but so be it that humankind is a more complex, interesting, and subtle being than their theories allow.

In addition, there is the case of equity between the Rich Well and the Rich Sick. If allocation to either category is arbitrary, what is the justification for systematically taking from one rather than both? Life may be a game of chance, but the state need not add to the penalties of uncertainty.

If there was a 100 percent estate duty on assets at death, there might be a case for asset stripping. But the initial assumption indicates how implausible the conclusion is. It remains unclear how the government was able to abolish estate duty on the very rich dead and introduce asset stripping on the modest affluent sick in the same year.¹⁰

As it happens this economist is not opposed to an estate duty of reasonable level.¹¹ But what is the logic of a back door introduction of an onerous estate duty on the living sick. It is as if once they enter long term care, they are treated as almost dead.

Thus far this analysis has not addressed who should fund those in residential care, above the costs they cover out of their own income. The amounts involved are not trivial (possibly in the range of \$100m to \$200m a year), so the question cannot be avoided. There is no single answer, but the veil of ignorance suggests some viable options:

- a) Am I willing to pay additional taxes now to avoid an undignified experience in residential care, should that be my fate? The answer is yes.
- b) When I am elderly, am I willing to pay additional taxes when well to avoid an undignified experience in residential care, should that be my fate? The answer is yes.

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- c) Am I willing to have a small levy made on my wealth after my death (irrespective of my health status in retirement) in order to avoid an undignified experience in residential care, should that be my fate? The answer is yes.

Perhaps the elderly, since they feel very strongly about the issue of asset stripping, should decide between the second and third options. That does not mean the young are avoiding the levy, unless their lives end early. The analysis points to I and others of my cohort having to pay additional tax to support others in the community, including the sick. For the logic of the argument applies to other health areas where it is deemed that the individual is entitled to care, including hospital care, laboratory services, and pharmaceuticals. This does not rule out a payment, or co-payment, where the individual has choice, or where transaction costs would otherwise be high.

The logic rests on one having little choice between being well or sick. This eliminates many efficiency gains from user pays, while equity issues predominated. In terms of the box diagram, it is horizontal equity which is paramount. Certainly the rich should contribute more to the care of the sick, but it is difficult to think of a clear reason why the Rich Sick should pay substantially more than the Rich Well, if the notion of dignity is at all important.

In coming to this conclusion this paper has resurrected the traditional concept of "dignity" as central to New Zealand social policy. Indeed that was what the social contract which protesters against asset stripping allude to. The National Government may have thought it abandoned the traditional underpinnings of the New Zealand welfare state with its December 1990 *Economic and Social Initiative*, but there is little evidence that the majority of the populace did. The elderly's concern is reaffirming that century old foundation of human dignity, which was elaborated over the years into what might well be thought of as a social contract best defined by the 1972 Royal Commission on Social Security.

Perhaps politicians have forgot dignity, for they rarely exhibit any themselves. Certainly recent changes in social policy have submerged it below the crudities of economic rationalism, as undignified a theory there is, this side of fascism. Treating one's fellow man and woman with dignity involves sacrifices that the selfish may evade, but it is what the decent society is about.

Footnotes

1 "Economic and Social Trust on New Zealand", 18 Talavera Tce, Wellington. Phone 04-472 8950, Fax: 04-472 5305.

2 I am grateful for comments by Nancy Devlin, John McMillan, David Preston, and Susan St John which improved an earlier draft.

3 It is true that a form of asset stripping has been in place for about 30 years. That does not mean the recent extension is just, if the previous system was not either.

4 It is acknowledged below that the long stay elderly are not necessarily sick. The model still applies.

5 Perhaps one should mention that in practice the distinction is not so clear, even

for the residential needs for the elderly. It may well be that some have entered an expensive care regime, not really needing it. While such people are now probably irreversibly institutionalised, we are likely to see stricter assessments and reviews of entitlement needs in the future. If these are accompanied by better services for alternative care enabling people to stay at home longer, for instance, such testing of physical and emotional needs may not be unwelcome.

6 The economist does not rule out mechanisms which enable the patient to express reasonable choice, such as to the professionals involved and the location of treatment. Indeed the economist would be anxious to develop these choice mechanisms as much as possible, since they would tend to increase efficiency.

7 For instance, it could be provided free to the needful patient, or they could be given the cash to make their own purchases, or anywhere in the spectrum between (including vouchers).

8 NZ is not alone in giving human dignity a central role in public policy. For instance Alfred Marshall, in the introduction to his great turn of the century *Principles of Economics* wrote "The dignity of man was proclaimed by the christian religion: it has been asserted with increasing vehemence during the last hundred years: but only with the spread of education during recent times, are we beginning to feel the full import of the phrase".

John Rawls uses the closely related notion of self respect: "a person's sense of his own value, his secure conviction that his conception of the good, his plan of life is worth carrying out."

9 Income includes income from wealth. The treatment of one's housing raises a special issue. The assessment of the person into the care implied they no longer had a need for the housing. Practically the house should be let, or sold up, and the resulting income treated the same as for any other source. In addition we avoid empty housing deteriorating while their owners are in long term resident care. A practical complication is what happens if the home is jointly owned with a partner.

10 As Susan St John has pointed out, the cap on the user charge favours the very rich. If someone's income exceeds the charge, they experience no wealth abatement. There is a not unusual irony in the current situation that the modestly well-off suffer most.

11 My preference is for favour a lifetime capital receipts tax, which encourages the distribution of estates widely, with the aim of a high degree of private wealth more equally distributed.

Proceedings

Proceedings of the 1993 *International Seminar on Bioethics* are now on sale. The volume comprises 17 papers presented at the Seminar.

Juan Carlos Tealdi traces the development of the definition of death. He argues the current definition is a construction of Bioethics.

The Seminar session on genetic research included presentations by *Ruth Chadwick* and *Gamal Serour*. Chadwick discusses ethical implications of the Human genome project, while Serour outlines ethical issues in genetic research from a Muslim perspective.

In "Hitchhiker's Guide to Assisted Reproductive Technologies in New Zealand" **Janet Elder** stresses the need for public debate about and ethical appraisal of technological advances.

The Proceedings include two papers by **Grant Gillett**. "AIDS, the Individual and Being with Others" outlines some ethical responses to points of convergence between law, ethics and AIDS. "Reproduction, sexuality and mental impairment" considers the case history of a woman with mental disabilities who may have a hysterectomy.

Epidemiologist **Mark Elwood** comments on New Zealand ethics committees. **Robert Blank** considers whether Research and Development should be placed in the Health Care allocation budget,

while nursing's role in Research and Development is explored in **Jenny Conder's** paper.

The multicultural theme of the Seminar is restated in papers by **Segun Gbadegesin** and **Kusum Kumar**. Gbadegesin writes on the African concept of disease and shows how healthcare within this context must take account of their concept to be effective. Kumar introduces a variety of bioethical issues from India.

Daniel Wikler writes an overview of the Clinton health reforms and in "Markets, Standards and Rationing of Health Care" **David Seedhouse** considers the extent to which Bioethics can offer constructive advice on health care rationing.

Alexander Capron and **Lady Jocelyn Keith** comment on standards for health care professionals, with reference to the American context and nursing respectively.

Maria Marama presents the Patient's perspective on the use of health information. **Elizabeth Sturch** writes on the interaction between varieties of feminism and nursing ethics.

Copies are available from the Centre, PO Box 913, Dunedin. Costs (including postage and packaging) are \$15 within NZ, \$NZ17 for Australian buyers and \$NZ21 for all other overseas purchasers.

Call for papers

The Fourth Annual Meeting of the Association for Practical and Professional Ethics is calling for papers for its meeting April 2-4, 1995, at Crystal City Virginia, USA.

Presentations may take the form of 1) formal papers 2) pedagogical demonstrations and curriculum projects 3) case studies 4) posters, and 5) nominations of books by members for Breakfast with the Authors.

Further information available from the Bioethics Research Centre, or from Association for Practical and Professional Ethics, 410 North Park Avenue, Bloomington, Indiana 47405, USA.